Possibility of Change in Homosexual Orientation
A study of research supportive of sexual orientation change

Ann E. Gillies Ph.D.

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Abstract

There is currently extreme resistance to opening the dialogue regarding change therapy in the area of Same Sex Attraction (SSA), thought, behaviour, orientation and/or identity. Proponents of the possibility of change claim that those who experience sexual confusion and/or unwanted same-sex attraction are able to reduce or change their attractions toward the same sex.

Those who seek to ban therapeutic or religious interventions (all categorized under conversion therapy) claim that all such intervention is unethical and in fact harmful to the individual.

This paper is an attempt to add to the knowledge and understanding of why some individuals seek change therapy for unwanted homosexual thoughts, desires, and behaviours. It also revisits claims of transformation in sexual attraction, behaviours, orientation, and identity by reviewing research supportive of sexual orientation change efforts (SOCE) and incorporating lived experience stories.

The Rising Resistance to "Conversion Therapy"

What is Conversion Therapy?

The term "Conversion therapy" (CT) traditionally referred to various coercive and aversive psychological or medical practices and/or treatments intended to change a person's sexual orientation from homosexual to heterosexual. Such coercive practices of the mid-twentieth century eventually fell out of practice. However, the term is now being used to describe "any practice, treatment or service designed to change an individual's sexual orientation or gender identity, or to eliminate or reduce sexual attraction or sexual behaviour between persons of the same sex" (*Bill S-260, An Act to Amend the Criminal Code (Conversion Therapy)*, 2019).

Reparative therapy, a holistic therapeutic model developed by Joseph Nicolosi Sr. (Nicolosi, 1991) to help individuals who experience unwanted same-sex attraction, has also been equated to conversion therapy. This therapeutic technique is based on the premise that homosexuality in males is an adaptation to trauma often rooted in a same-sex attachment disturbance that leaves the boy alienated from his masculine nature.

The term CT also applies (since 2015 in Ontario) to therapeutic techniques that are intended to assist individuals in aligning their self-perceived identity with their biological sex. This aspect will be discussed toward the end of the paper.

In this paper, I will be focusing on CT with respect to the LGBTQ culture.

What are the Central Arguments and the History behind this Controversy?

Currently there are three widespread suppositions regarding homosexuality:

1. As a matter of biology: the belief that homosexuality is innate, a genetically predetermined aspect of humanity

2. As a matter of psychology: that homosexuality is irreversible and that attempts to change require a deep denial of self

3. As a matter of sociology: that homosexuality is a "normal" state

Five decades ago, the overwhelming majority of consensus among leading psychiatrists, psychologists and mental health professionals was that homosexuality was a condition that, though difficult to treat, could be treated successfully. Even when mental health professionals generally viewed homosexuality as a psychological disturbance amenable to change via therapeutic means, a minority of professionals questioned the majority position by suggesting that homosexuality was innate.

By the mid-70's, this minority of professionals within the American Psychological Association (APA) became a strong voice advocating for a category change for homosexuality in the Diagnostic and Statistical Manual (DSM). They successfully had the disorder removed from the

manual and conceptualized as a sexual orientation. They proposed the theory that homosexuality was inherent and therefore immutable.

Now the pendulum has shifted. Only a minority of mental health professionals believe that changes in sexual attraction and related behaviours are possible for homosexuals wishing to pursue same-sex attraction change.

In 1993, the *Atlantic Monthly* published an article by journalist Chandler Burr, who claimed that "Five decades of psychiatric *evidence demonstrates that homosexuality is immutable* [emphasis added] and non-pathological and a growing body of more recent evidence implicates biology in the development of sexual orientation." Burr also wrote that "science has long since proven that homosexuality is biological and unchangeable and *there is simply no disagreement among scientists* [emphasis added]" (Satinover, 1996, pp. 37–38). But, is the debate really over? Both in current research and within the LGBTQ community itself, the immutability of homosexuality remains a hot topic.

Beckstead and Morrow (2004, p. 652) indicated that polarizing debates have failed to solve the complex issues faced by conflicted same-sex-attracted individuals. Shidlo and Schroeder (2002) highlighted benefits to participants of the so called "conversion therapy", such as increased relief resulting from self-disclosure, increased hope and insights, effective coping strategies, improvements in self-esteem, increased sense of belonging, improvements in relationships, and increased spiritual and religious feelings.

Unfortunately, when some individuals did not receive their expected therapeutic outcome, they became convinced "*that change in sexual orientation was impossible* [emphasis added]" (Beckstead & Morrow, 2004). Feelings became facts. By this standard, *any* method of therapy used to treat *any* clinical disorder or mental or emotional anguish (e.g. marriage therapy) in which some clients do not achieve success should be considered incapable of causing change!

How and why are researchers so quickly jumping to these conclusions? These queries are part of the focus of this paper. Researcher assumptions or bias are readily observed as one reads studies from both sides of this debate. This is a consequence of the human condition to which all of us are subject. The problem comes when one cannot let science speak for itself, but instead chooses to add statements of conclusive evidence when no such evidence exists.

Scientists and academics, like politicians, are subject to bias. The best scientific research minimizes bias, including confirmation bias, by following a systematic approach and deriving conclusions based on the evidence produced.

Contrary to what Burr (1993) alleged in the *Atlantic Monthly*, there remains a desperate lack of unanimous or long-term agreement on the possibility of change. This has not, however, prevented the American Psychological Association from asserting an absolute answer regarding this controversy (S. L. Jones & Yarhouse, 2007). The APA's statement is that homosexual change is not possible (APA 2008). Such a statement – that change is impossible – is highly unusual within the field of psychology.

Doctrinaire statements about the immutability of homosexuality are explicitly contradicted by the evidence of numerous studies published from the 1930's onward (Satinover, 1996, pp. 185–186). After reviewing the evidence, Satinover concludes, "The APA vote to normalize homosexuality was driven by politics, not science" (1996, p. 32). Likewise, the APA's statement that homosexual change is not possible (2008) is driven by politics, not scientific research.

Holding with certainty that any particular behavioural change is impossible is counterintuitive to the field of psychology itself. The APA's statement can be challenged if even one individual shows change in the direction of sexuality. Disproof of such an absolute claim simply requires the evidence of one individual achieving long term change in the nature of their sexual course. Are there actually individuals who have achieved such a goal? Absolutely, see the Appendix for some of their stories).

The American Psychiatric Association published a position statement in 2000 in which it stated:

> Psychotherapeutic modalities to convert or 'repair' homosexuality are based on developmental theories whose scientific validity is questionable. Furthermore, anecdotal reports of 'cures' are counterbalanced by anecdotal claims of psychological harm. In the last four decades, 'reparative' therapists have not produced any rigorous scientific research to substantiate their claims of cure. Until there is such research available, [the American Psychiatric Association] recommends that ethical practitioners refrain from attempts to change individuals' sexual orientation, keeping in mind the medical dictum to first, do no harm (p. 1719).

The APA expanded on that position with the following statement in 2013:

> The American Psychiatric Association does not believe that same-sex orientation should or needs to be changed, and efforts to do so represent a significant risk of harm by subjecting individuals to forms of treatment which have not been scientifically validated and by undermining self-esteem when sexual orientation fails to change. No credible evidence exists that any mental health intervention can reliably and safely change sexual orientation; nor, from a mental health perspective, does sexual orientation need to be changed (Scasta & Bialer, 2013).

The Purpose of this Review

There are many within the LGBTQ community who do wish to change their sexual behaviour and/or preferences and wish to access the health care necessary to achieve their goals. The fact that homosexuality is no longer considered a disorder neither automatically renders it immutable nor entails that an adult should not seek the therapy of their choice for the possibility of achieving a desired change. Sexual struggles did not automatically change after homosexuality was declared an orientation in 1973.

The objective of this paper is to review studies in order to ascertain:

a) if any change is possible and

b) if the threat of harm is substantive
c) if APA claims regarding the ineffectiveness of SOCE are unwarranted

It is important to compare the studies of those who have found change therapy effective and of those who have expressed a felt sense of harm. The APA claim that forms of treatment used have not been scientifically validated needs to be challenged.

According to the 2009 response of the National Association for Research and Therapy of Homosexuality (NARTH), experiential clinical studies demonstrate that it is possible for men and women to diminish their unwanted homosexual attractions and develop their heterosexual potential (Sprigg, 2018).

Sprigg (2018) also suggests that there is substantial evidence that sexual orientation may be changed through reorientation therapy. Treatment success for clients seeking to change unwanted homosexuality and develop their heterosexual potential has been documented in the professional and research literature since the late 19th century (Phelan et al., 2009). A century of research, including research published by APA members in APA peer-reviewed journals, found that, when the therapy is done right, people change (Haynes, 2020).

Keep in mind that even one individual achieving change of their sexual attraction thoughts or behaviour or orientation through means of therapy should be enough to at least open a discussion on the possibility of change. It is this very possibility which may propel individuals to seek therapy. It behooves the APA to explore the claims of change of sexual orientation rigorously.

Banning Therapy

At the dissolution of the Canadian Parliament for the general election in 2019, Bill S-260 was under review in the Senate of Canada. A second bill, S-202, was introduced in December 2019. On March 9, 2020, the House of Commons introduced Bill C-8, an act to amend the criminal code (conversion therapy). The preamble of Bill C-8 states:

- "Whereas conversion therapy causes harm to the person, and in particular the children, who are subjected to it;
- Whereas conversion therapy causes harm to society because, among other things, it is based on and propagates myths and stereotypes about sexual orientation and gender identity, including the myth that a person's sexual orientation and gender identity can and ought to be changed;
- And whereas, in light of those harms, it is important to discourage and denounce the provision of conversion therapy in order to protect the human dignity and equality of all Canadians;"

These are the very contentions that I wish to address in this paper. Are these statements based on sound scientific research?

A subsequent document entitled "Conversion Therapy in Canada: Roles and Responsibilities of Municipalities," published by MacEwan University in Edmonton and endorsed by Dr. Kristopher Wells, broadens the discussion**:**

> conversion "therapy" (also known as "reparative therapy," "reintegrative therapy," or "sexual orientation and gender identity change efforts") is any form of treatment, including individual talk therapy, behavioural or aversion therapy, group therapy treatments, spiritual prayer, exorcism, and/or medical or drug-induced treatments, which attempt to actively change someone's sexual orientation, gender identity, or gender expression (K. Wells, 2019, p. 2).

The Purpose of Sexual Orientation Change Efforts (SOCE)

The following treatments have been commonly used in sexual change therapy: psychoanalysis, other psychodynamic approaches, hypnosis, behaviour therapies, cognitive therapies, sex therapies, group therapies, and pharmacology. In many cases, combinations of therapies have been found to be successful for individuals seeking same-sex attraction and behavioural change. These therapeutic techniques are widely used by therapists and counsellors to treat all kinds of unwanted thoughts and behaviours and have been found to be highly validated and reliable.

According to Hicks (1999), reparative therapy, as a program of psychotherapy, attempts to cure homosexuals by transforming them into heterosexuals. Such statements need to be understood in the context of psychological reality. "Cure" is not a word considered appropriate for use in the field of psychology due to the understanding that "curing" behaviour is not considered the objective. Change of thought and behaviour would be a much more appropriate goal in this context.

Behavioural Therapy has come under attack from LGBTQ activists, but it continues to be used to treat many different kinds of conditions, such as depression, anxiety, panic disorders, anger issues, eating disorders, post-traumatic stress disorder (PTSD), bipolar disorder, ADHD, phobias, obsessive compulsive disorder (OCD), self-harm, and substance abuse. This therapeutic technique is based on the psychological concept of behavioural states and accepts that most behaviours are learned and, therefore, can be changed.

Phelan et al. (2009) and Haynes (2020) have identified a century of research publications, mostly peer reviewed, that explore same-sex attraction change efforts and span over 125 years. A significant number of these studies reported positive outcomes. It is, therefore, imperative to review at least a small representation of these studies.

Separating Conversion from Therapy

What conversion therapy actually is has been the subject of much controversy and as you can see here, much refining and change. These two words used together are actually quite mystifying, so let me quote the definition of conversion from the Merriam-Webster dictionary:

> **1:** the act of *converting* **:** the process of being converted
> **2:** an experience associated with the definite and decisive adoption of a religion (n.d.-a)

"Conversion" is not a word normally used in the context of a therapeutic technique or practice. It has a different connotation altogether. It has been and is used regularly in the sense of a religious conversion. According to Judeo-Christian belief, conversion is a spiritual experience, a radical change or transformation happening within the individual.

Therapy is different; it is the "therapeutic medical treatment of impairment, injury, disease, or disorder" (Merriam-Webster, n.d.-b).

Therapy, then, is medical treatment administered by medical doctors and/or mental health professionals. It does not come from a theological worldview, but these two words are used together to create a combined perspective of providing therapeutic techniques in order to "convert" someone.

People visit therapists for all sorts of reasons, including grief, trauma, and employment or relationship difficulties. Marital and career dissatisfaction are not mental disorders or health problems. Marital therapy and career counselling treat areas of dissatisfaction in one's life and desire for change. There are other areas where a person may experience dissatisfaction and want change. People who previously identified as "gay", including those who have had "same-sex experiences" but ultimately did not find them satisfying, should be able to access therapy that helps them set goals to achieve the change they desire.

The problem remains that there is *no therapeutic technique* that psychiatrists or psychologists study in order to perform "'conversion therapy". There is no psychology course on 'conversion therapy', nor is there such a course available for those who study religion in seminaries. There is no specific therapy or set of therapies that go by the name "conversion therapy". It is an umbrella term first used by LGBT activists to disparage any therapy with the goal either of changing sexual orientation or gender identity, or of reducing any feelings or behaviors related to those experiences (Done, 2019).

This leads to the question of why it is necessary to ban a type of therapy that no longer exists. Why the need to vilify "reparative therapy" and all other therapeutic or spiritual interventions that serve individuals experiencing sexual identity confusion? This is really the bigger picture: the tendency of activists to speak for all LGBTQ people and to suppress individuals who consider their SSA unwanted.

Academic Confusion

The American Psychological Association's Task Force of 2009 (Glassgold et al., 2009) explained that it was unable to conclude that either affirmative or change-allowing therapy is safe or effective because there was no research that met the scientific standards of the Task Force. Although some research participants indicated that they changed sexual behaviour or attraction through therapy, others reported that they were harmed by it. In short, the APA first dismissed the century of research that reported people changed and then accepted self-perceptions of harm as anecdotal evidence and based its recommendation on one-sided

anecdotal, not scientific, evidence. At a minimum, the APA should have used the century of evidence that people changed as anecdotal evidence and given it at least as much weight as it gave the smaller number of studies indicating that some people felt harmed.

The Task Force reported that one of the "key findings in the research" on which it "built" its conclusion was that sexual orientation (by which the Task Force meant the enduring pattern of same-sex attraction, heterosexual attraction or bisexuality) does not change through life events. This finding has been disproven by members of the Task force themselves.

In 1992, Laumann and colleagues published the findings of the National Health and Social Life Survey, which is highly regarded to this day as the most comprehensive study ever conducted on sexuality in America. It is still regularly cited. It stated that it discovered that "homosexuality is…stable over time…" (2008, p. 283). As you will see below, this statement is clearly false.

Academic Bias

In 2007, the American Psychological Association convened the Task Force on Appropriate Therapeutic Responses to Sexual Orientation, which conducted a review of journal literature on sexual orientation change efforts (Glassgold et al., 2009). This Task Force consisted of professionals selected for their anti-SOCE ideology. Clinical and research experts who advocate for change-allowing therapy were intentionally excluded (Haynes, 2018; Rosik, 2017; Yarhouse, 2009).

This Task Force reported that some participants in the studies by Beckstead and Morrow (2004) and Shidlo and Schroeder (2002) *perceived* harmful effects such as confusion, depression, guilt, helplessness, hopelessness, shame, social withdrawal, suicidality, substance abuse, stress, disappointment, self-blame, decreased self-esteem and authenticity to others, increased self-hatred, hostility and blame toward parents, feelings of anger and betrayal, loss of friends and potential romantic partners, problems in sexual and emotional intimacy, sexual dysfunction, high-risk sexual behaviours, a feeling of being dehumanized and untrue to self, a loss of faith, and a sense of having wasted time and resources.

Nonetheless, a causal link between conversion therapy and these forms of mental illness and issues should not be made. The symptoms attributed here to SOCE are the very same as I have seen repeatedly as I treat those who have been chronically abused, and they are identified constantly in child sexual abuse literature, with the exception of wasting time and resources.

The APA Task Force concluded the following:

1. There is no conclusive or convincing evidence that sexual orientation may be modified or changed through Sexual Orientation Change Efforts (SOCE) therapy techniques.

2. There are people who perceive they have been harmed through SOCE (Beckstead & Morrow, 2004; Nicolosi et al., 2000; Schaeffer et al., 2000; Shidlo & Schroeder, 2002),

just as other studies document those who perceive benefit from SOCE (Beckstead & Morrow, 2004; Nicolosi et al., 2000; Schaeffer et al., 2000).

3. Studies reporting perceptions of harm indicated retrospective self-reports of depression, anger, anxiety, confusion, depression, grief, guilt, hopelessness, deteriorated relationships with family, loss of social support, loss of faith, poor self-image, social isolation, intimacy difficulties, intrusive imagery, suicidal ideation.

4. Given the limited amount of methodologically sound research, we cannot draw a conclusion regarding whether recent forms of SOCE are or are not effective.

5. There is no greater pathology in the homosexual population than in the general population (Phelan et al., 2009).

Statements by the APA Task Force seem prematurely conclusive, given the more recent research validating previous studies and testimony from those who have successfully changed their unwanted SSA attraction, thoughts, behaviour, and/or orientation/identity.

In 2002, Shidlo and Schroeder produced a study called *Changing Sexual Orientation*. The initial goal was to document negative effects of harm done by conversion therapies. According to Shidlo and Schroeder, this area had not been empirically studied. This study was initially entitled "*Homophobic Therapies: Documenting the Damage*" (Shidlo & Schroeder, 2002, p. 251). The title was changed after the first 20 interviews when they discovered that some participants reported having been helped. They subsequently broadened the inquiry.

The APA Handbook of Sexuality and Psychology, on which the American Psychological Association conferred its sanction and which it declared "authoritative," serves as a correction to the APA Task Force report. According to the *APA Handbook,* same-sex attraction, behaviour, romantic partnerships, and identity all change: "...research on sexual minorities has long documented that many recall having undergone notable shifts in their patterns of sexual attractions, behaviors, or identities over time." (Diamond, 2014, p. 636). The US Supreme Court's Obergefell ruling, which declared sexuality to be "immutable," is already out of date. Diamond states bluntly, "we know it's not true…Queers have to stop saying: 'please help us, we were born this way and we can't change' as an argument for legal standing" (Diamond, 2013).

The APA goes on to state, "Although change in adolescence and emerging adulthood is understandable, change in adulthood contradicts the prevailing view of consistency in sexual orientation" (Rosario & Scrimshaw, 2014, p. 562). According to Mustanski et al. (2014, p. 619), "Over the course of life, individuals experience changes or fluctuations in sexual attractions, behaviors, and romantic partnerships…"

It is clear that the description of being "born that way" and the idea of immutability are central topics that need to be examined and investigated as we address the issue of same-sex attraction.

Immutable State

Possibility of Change in Homosexual Orientation

Is sexual orientation truly an immutable characteristic (not capable of or susceptible to change)?

Arguments based on the innateness of sexual orientation have been around for at least 150 years, but the theory of immutability in sexual orientation started gaining momentum in the 1960s. In the last 30 years, it has become the dominant position, both in the scientific community and among the general public.

> Today, versions of this general argument from etiology for LGB [sic] rights-what I call the "born that way" and "not a choice" arguments-are so popular that dissent of the idea that LGB [sic] people's sexual orientations are innate and immutable is treated as tantamount to opposing LGB [sic] rights (Stein, 2014, p. 598).

The impression of not having a choice about feelings, of any kind, does not mean that you were born with such feelings. Therapists help people every day to change traits, feelings, desires, behaviours and tendencies they did not choose (and do not want).

The Two-Sided Argument: Born That Way and Not a Choice

"Born that way" arguments begin with the genetic claim that sexual orientations are innate, whereas "not a choice" arguments begin with a psychological claim that sexual orientations are impossible (or almost impossible) to change and that individuals are unable to control their thoughts and emotions.

Sullivan (1995) states that "…Homosexuality is an *essentially involuntary condition* that can neither be denied nor permanently repressed.... So long as homosexual adults as citizens insist on the involuntary nature of their condition, it becomes politically impossible to deny or ignore the fact of homosexuality… The strategy for obtaining LGB[sic] rights is to seek full public equality for those who, through no fault of their own, happen to be homosexual" (Sullivan, 1995, pp. 170–171).

Gene Studies

Biological arguments gained momentum throughout the 1990s with the publication of studies on the causes of homosexuality. Many of these studies, such as LeVay (1991) and Hamer et al. (Hamer et al., 1993), have since been criticized for methodological errors and/or broad interpretive recommendations.

Sexual orientations cannot be biologically based in quite the same way as something like eye or skin colour because sexual orientations are mediated by awareness. "This means having a sexual orientation requires mental states such as beliefs, desires, and thoughts" (Stein, 2014, p. 604). It is important to note here both that a pre-disposed genetic linkage does not equal determinism, and that current research has not replicated prior gene-based studies.

The largest gene study ever undertaken looked at all the genes of nearly a half million people and concluded that genes do not predict someone will have same-sex behaviour. This study suggests "that on the genetic level, there is no single dimension from opposite-sex to same-sex

preference" (Ganna et al., 2019, p. 6). Satinover notes, "a certain genetic constitution may make homosexuality more readily available as an option, but it is not a cause of homosexuality … a realistic assessment of the research shows that the genetic component, though not zero, is likely to turn out to be far smaller than that [25-50% aforementioned]" (Satinover, 1996, pp. 114–115).

Several extensive reviews of data are available (Dawood et al., 2009; Hill et al., 2012). Looking at one of the largest recent studies, the findings of which align with those of other similar studies, researchers analyzed the genomes of more than 23,000 men and women that had been collected by the company 23andMe and found no genetic point of location that was significantly associated with sexual orientation in either men or women (Drabant et al., 2012).

Several of the results pointed to the importance of sociocultural context. Changes in prevalence of reported same-sex sexual behavior across time were noted, which raised questions about how genetic and sociocultural influences on sexual behaviour might interact (Ganna et al., 2019). The study also found genetic overlap with some health-related behaviours (e.g., smoking, cannabis use) and with risks for certain psychiatric conditions (schizophrenia, bipolar disorder, and major depression) (Ganna et al., 2019).

Another consideration here is that an initially quite mutable characteristic can become increasingly neurologically fixed as a result of choices. Our neuropathways are flexible. This is why psychotherapeutic techniques such as behavioural change, thought-stopping, refocusing and imagery are highly successful when used consistently. The old adage that how we think becomes who we are applies here. For instance, those suffering from low self-esteem can receive great relief through cognitive-behavioural therapy, but it takes effort and commitment to change an ingrained characteristic.

At the same time, many do not recall choosing same-sex attraction, although they may be aware of certain decisions on their journey to a sexual orientation. Even if sexual orientations were proven to be strongly biological, actually engaging in sexual acts with a person of the same sex, publicly or privately identifying as an LGBTQ person, deciding to establish a household with a person of the same sex, and raising children as an openly LGBTQ person are all choices. These are choices that one might decide not to make, since any individual, regardless of sexual attraction or orientation, can choose to be celibate, closeted, single, and childless.

SSA Instability

Prior to the 1990s there had not been any large-scale prospective studies on the stability of same-sex attractions. Several such studies have now been completed (Dickson et al., 2013; Mock & Eibach, 2012; Ott et al., 2011; Savin-Williams et al., 2012), and they unequivocally demonstrate that same-sex and other-sex attractions do change over time in some individuals. Although the *degree* of change seems difficult to reliably estimate, the *occurrence* of change is indisputable (Diamond & Rosky, 2016, p. 369). These studies refute the immutability claim and support the feature of choice to pursue feelings of same-sex attraction. They also point to the perspective of sexual fluidity and, again, support the individual's right to choose.

Possibility of Change in Homosexual Orientation

The Gay and Lesbian Medical Association submitted a brief to the US Supreme Court titled "Concerning the immutability of sexual orientation" (Vargas & O'Donnell, 2013), attempting to explain scientific findings to show that sexual orientation was biologically-based rather than chosen. In striking down state laws against same-sex marriage, the US Court declared that, in recent years, "psychiatrists and others [have] recognized that sexual orientation is both a normal expression of human sexuality and immutable" (*Obergefell v. Hodges*, 2015, p. 8). The question is whether this statement is supported scientifically.

Several extensive reviews of data are available (Dawood et al., 2009; Hill et al., 2012). Looking at one of the largest recent studies, the findings of which align with those of other similar studies, researchers analyzed the genomes of more than 23,000 men and women that had been collected by the company 23andMe and found no genetic point of location that was significantly associated with sexual orientation in either men or women (Drabant et al., 2012).

Sexual Fluidity

One of the emergent concepts in the science of sexuality is that of gender fluidity. Sexual and gender fluidity is the concept that one's sexual identity can change over time.

Diamond and Rosky (2016) maintain that advocates for sexual minorities have argued that sexual orientation is a fixed, biologically based trait that cannot be chosen or changed (e.g., Burr, 1996; Caramagno, 2002; Halley, 1994; Simon LeVay, 2011; Mucciaroni & Killian, 2004; Stein, 2014), but they go on to state that "[a]rguments based on the immutability of sexual orientation are unscientific, given that scientific research does not indicate that patterns of same-sex and other-sex attractions remain fixed over the life course" (p. 364).

Diamond, a self-avowed lesbian and co-editor-in-chief of the APA Handbook now states that "born-that-way-and-can't-change" is not true. What is affirmed is that same-sex attraction is not simply biologically caused like skin color (Diamond, 2014, p. 636).

She explains, "Hence, directly contrary to the conventional wisdom that individuals with exclusive same-sex attractions represent the prototypical 'type' of sexual-minority individual, and that those with bisexual patterns of attraction are infrequent exceptions, the opposite is true. Individuals with nonexclusive patterns of attraction are indisputably the 'norm,' and those with exclusive same-sex attractions are the exception." This pattern has been found internationally (2014, p. 633). Indeed, most people who experience same-sex attraction also experience opposite sex attraction (Haynes, 2019).

Equally important, according to the American Psychiatric Association (2013) and the American Psychological Association (Bockting, 2014a, p. 744), "transgender identity fluctuates, and the vast majority of gender dysphoric minors will eventually accept their chromosomal sex." This was, of course, prior to the current affirming stance now taken which supports early hormonal intervention that lessens or eliminates the possibility of identity change for gender dysphoric children and adolescents.

Kleinplatz and Diamond (2014) urge that "it is critically important for clinicians not to assume that any experience of same-sex desire or behavior is a sign of latent homosexuality and instead to allow individuals to determine for themselves the role of same-sex sexuality in their lives and identity" (p. 257).

It has been known since at least 1994 that same sex attraction and behaviour are not stable over time (Haynes, 2019). "Research on sexual minorities has long documented that many people recall having undergone notable shifts in their patterns of sexual attractions, behaviors, or [orientation] identities over time" (Diamond, 2014, p. 636). In response to these documented changes in sexual attraction and behaviour, Diamond and Rosky (2016) offered a review of scientific evidence on sexual orientation showing that immutability claims have been oversimplified and generalized. They again acknowledged the near-universal agreement from scientists:

> Sexual orientation has no single cause rather, multiple biological and non-biological factors interact to shape the adult expression of same-sex sexuality, and the mix of causal factors may differ from person to person, and for males versus females (p. 365).

The final and crucial reason to set aside arguments based on immutability, according to Diamond and Rosky, is that they misrepresent and marginalize those sexual minorities who experience their sexuality as chosen, nonexclusive, or variable. Yet even with these strong statements, Diamond has gone on record saying that she opposes psychotherapy that is open to sexual attraction change (Rosik, 2016).

The fact of identity fluidity within the Gender Dysphoric population is becoming much more obvious as one studies this phenomenon. The affirming stance seems counter-intuitive to the principles of therapeutic intervention. It is the therapist's responsibility to provide accurate information and to recommend alternative courses of action based on the client's needs and goals. Scientific research maintains that sexuality and identity are flexible, and clients desiring change need to be apprised of such information.

Psychological and environmental influences are always present in the trajectory of SSA and gender identity. It has been found that childhood sexual abuse may lead to having same-sex partners for some (Rosario & Scrimshaw, 2014, pp. 579, 583).

Naturally Occurring SSA Change

Research in the area of same-sex attraction provides clear evidence of naturally occurring fluidity. The best and most reliable data on 'naturally occurring' change in sexual orientation come from studies that have longitudinally tracked large, population-based samples of heterosexual and sexual-minority individuals (Dickson et al., 2003; Mock & Eibach, 2012; Ott et al., 2011; Savin-Williams et al., 2012; Savin-Williams & Ream, 2007).

The National Longitudinal Study of Adolescent to Adult Health (McQueen et al., 2015), a four wave study from 1999 to 2005 of over 20,000 youth, indicated that all attraction categories other than opposite-sex [heterosexual] were associated with a lower likelihood of stability over time.

That is, individuals reporting any same-sex attractions were more likely to report subsequent shifts in their attractions than were heterosexuals (Savin-Williams et al., 2012, pp. 103–110).

"The data showed that 29.2% of 100% homosexual men shifted towards heterosexuality. Among the same sex-attracted youth who changed, 57% of the men's changes and 62% of the women's changes involved switching to completely heterosexual" (Savin-Williams et al., 2012, p. 108). "Of those who chose one of the non-heterosexual descriptors at Wave 3, (when the cohort was between 18 & 26 years old), 43% of the men and 50% of the women chose a different sexual orientation category six years later. Of those who changed, two-thirds of homosexual men changed to the category 100% heterosexual" (Diamond & Rosky, 2016, p. 369). It is obvious from this substantial study that sexual orientation can and often does spontaneously change over time.

"Those who engaged in same/both-sex [homosexual or bisexual] behaviour during the first two waves of interviews were more likely to report at Wave 3 exclusive opposite-sex [heterosexual] behavior" (Savin-Williams & Ream, 2007, p. 387).

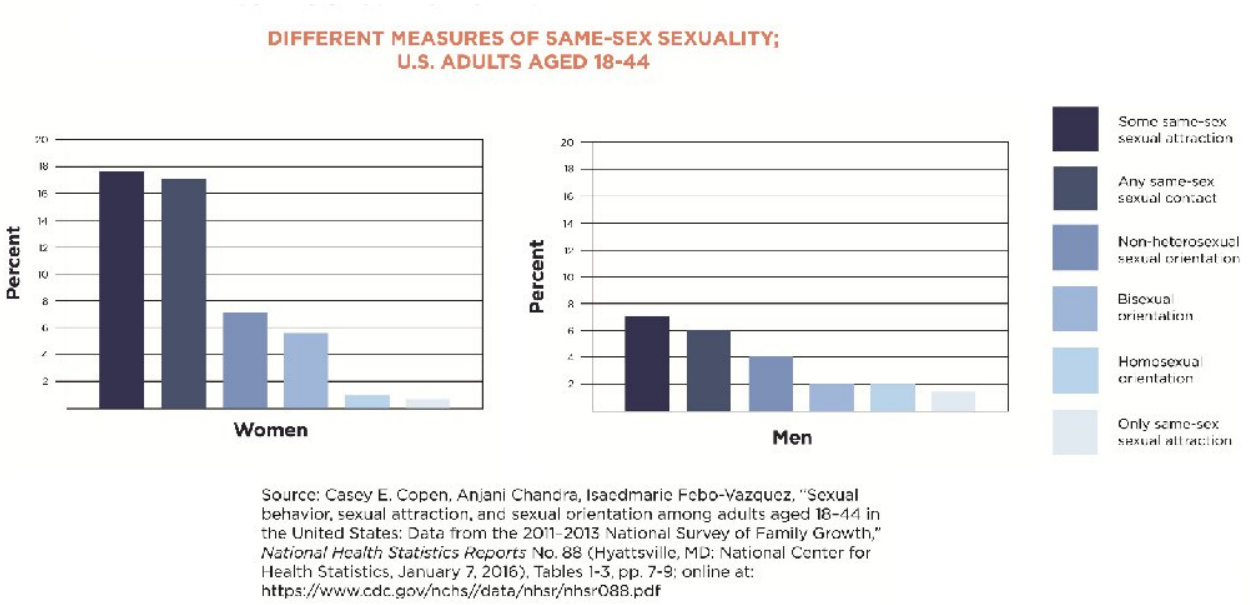
Movement from some same-sex behaviour to *exclusively* opposite-sex (heterosexual) behaviour was much more common than movement from heterosexual behaviour to *any* same-sex sexual behaviour (Sprigg, 2018). Udry and Chantala (2005) found that 48%, nearly half, of exclusively homosexually attracted boys aged 16 became exclusively heterosexual one year later at age 17.

Savin-Williams and Ream (2007) found a high degree of stability for opposite-sex attraction and behaviour but little consistency for same-sex attraction and behaviour. Reports of heterosexual identity typically range from 90 to 98% (Dickson et al., 2003; Herbenick et al., 2010; Mosher et al., 2005). Sexual minorities report more lifetime change in sexual orientation than heterosexuals (Kinnish et al., 2005).

Dickson et al. (2003) explained that a 5-year study of same- and opposite-sex attraction in a national sample of young adults found that 95% of opposite-sex attracted men and 84% of opposite-sex attracted women maintained a consistent rating of attraction over 5 years (i.e., no change). Only 65% of the men with same-sex attraction and 40% of the women with same-sex attraction showed consistency of attraction. Diamond (2008) found that there was a consistent decline in same-sex behaviour among women over a 10-year period.

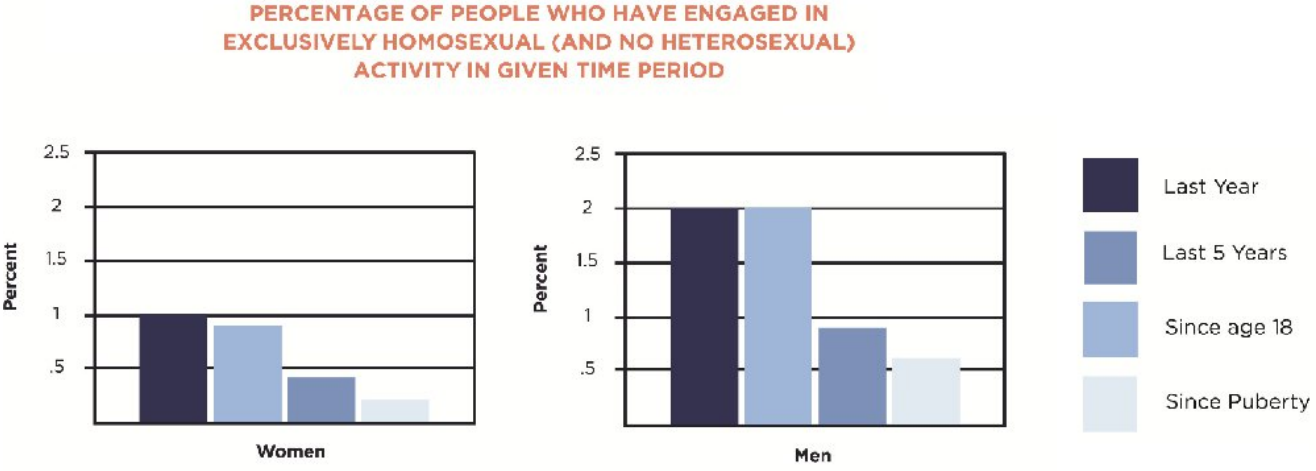
The National Survey of Midlife Development (MIDUS) assessed sexual identity at two different points in time. Over 3,000 Americans aged 25 to 74 participated in the survey; the mean age was 47 at the first assessment. Mock and Eibach (2012) examined reports of sexual orientation/identity stability and change over a 10-year period drawing on data from the MIDUS I and II survey and tested for three patterns: (1) heterosexual stability, (2) female sexual fluidity, and (3) bisexual fluidity. This study asked individuals whether they were homosexual, heterosexual, or bisexual, rather than simply asking about their same-sex and other sex attractions. Less than 1% among both men and women described themselves as homosexual or bisexual. Yet among this group "*64% of the women and 26% of the men identified their sexual orientation differently 10 years later*. Half of the men's changes and 55% of women's changes involved switching to heterosexuality" (Diamond & Rosky, 2016, p. 370).

As shown in the charts below, the actual percentage of people who are exclusively homosexual in their behaviour for a lifetime still remains an exceptionally small portion of the population.



Source: Casey E. Copen, Anjani Chandra, Isaadmarie Febo-Vazquez, "Sexual behavior, sexual attraction, and sexual orientation among adults aged 18–44 in the United States: Data from the 2011–2013 National Survey of Family Growth," *National Health Statistics Reports* No. 88 (Hyattsville, MD: National Center for Health Statistics, January 7, 2016), Tables 1-3, pp. 7-9; online at: https://www.cdc.gov/nchs//data/nhsr/nhsr088.pdf

(Copen et al., 2016, pp. 7–9)



Edward O. Laumann, John H. Gagnon, Robert T. Michael, and Stuart Michaels, The Social Organization of Sexuality: Sexual Practices in the United States (Chicago: University of Chicago Press, 1994), p. 310-12.

(Adapted from Laumann et al., 1994, pp. 310–312)

The Dunedin Multidisciplinary Health and Development Study (DMHD) is a longitudinal study involving 1037 participants that began in the early 1970s and still continues. The DMHD was founded as a multidisciplinary research enterprise. Seven research themes have evolved over the past 40 years: mental health and neuro-cognition, cardiovascular risk, respiratory health, oral

health, sexual and reproductive health, psychosocial functioning, and application of results on behalf of New Zealand's indigenous peoples (Poulton et al., 2015, p. 679). There have been over 1200 papers and reports published as result of this study. It is well situated to address contemporary issues on human development. This study indicates that rates of change in sexual attractions do not appear to decline as respondents get older.

Nigel Dickson is the Principal Investigator in Sexual and Reproductive Health in the Dunedin Multidisciplinary Health and Development Study Specialist Pediatrician. In 2003, Dickson et al. compared answers at ages 21 and 26 by DMHD participants to questions that were asked about sexual attractions and behaviours. Here is a short summary of their findings.

> By age 26, 10.7% of men and 24.5% of women reported being attracted to their own sex at some time. This dropped to 5.6% of men and 16.4% of women who reported some current same-sex attraction. Current attraction predominantly to their own sex or equally to both sexes (major attraction) was reported by 1.6% of men and 2.1% of women. Occasional same-sex attraction, but not major attraction, was more common among the most educated. Between age 21 and 26, slightly more men moved away from an exclusive homosexual attraction (1.9% of all men) than moved towards it (1.0%), while for women, many more moved away (9.5%) than towards (1.3%) exclusive heterosexual attraction. These findings show that much same-sex attraction is not exclusive and is unstable in early adulthood, especially among women (p. 1607).

Diamond and Rosky (2016) maintain that,

> Among the same-sex attracted men reporting change, between 67% and 100% of the changes were toward heterosexuality, and this also was true for 83% to 91% of the same-sex-attracted women undergoing changes. Overall, changes among men who identified as heterosexual were observed in 1% to 2% of men and ranged from 4% to 12% among heterosexual women. Given the consistency of these findings it is not scientifically accurate to describe same-sex sexual orientation as a uniformly immutable trait (p. 370).

They also explain that, even if sexual orientation were wholly determined by genes or by perinatal hormones, sexual orientation may still not be immutable.

> The status of a trait as biologically determined is often combined with its capacity to change over the life course. The fact that genes and/or perinatal hormones may contribute to the development of sexual orientation says nothing about whether sexual orientation undergoes change, or whether it can be consciously chosen by individuals who possess no genetic or neuroendocrine predisposition for it (p. 368).

Utilizing the longitudinal research from the Dunedin Multidisciplinary Health and Development Study from New Zealand, Dickson et al. (2013) examined the prevalence of different sexual attractions at all four assessments of the study and how they differ by sex and age. Their findings do not support a general progression towards a fixed sexuality during early adulthood. Changes were observed in attraction, experience, and identity and were most likely for those who claimed a bisexual identity (Dickson et al., 2013, p. 761).

These studies constantly affirm the flexibility of same-sex attraction and identity.

The Flexible Brain – Neuroplasticity

Childhood sexual abuse disrupts secure attachment and emotional regulation. "Every experience begins and ends in your brain. The physical patterns of the brain have a dramatic impact on how we think, feel and behave from moment to moment" (Amen, 1998, p. 36). The thoughts and emotions we "feed" as we mature become strengthened, while those we ignore diminish—some to the point of annihilation. The more we practice an activity, the more ingrained it becomes in our brain, mapping our brains for future similar experiences (Doidge, 2008). As the saying goes, neurons that fire together, wire together (Doidge, 2008, p. 63).

Human beings exhibit an extraordinary degree of sexual plasticity, as suggested by Doidge (2008).

> One homosexual man had successive relationships with men from one race or ethnic group, then with those from another, and in each period he would be attracted only to men in the group that was currently "hot." After one period was over, he could never be attracted to a man in that group again. He "acquired a taste" for these types in quick succession and seemed more smitten by the person's category or type than by the individual. The plasticity of this man's sexual taste exaggerates a general truth: that the human libido is not a hardwired, invariable biological urge, but can be easily altered by our psychology and the history of our sexual encounters. Our libido can be finicky (p. 95).

Michael Merzenich, whose contributions to the field of brain plasticity are numerous, helped people to redesign the brain by training specific processing areas, which he called brain maps. He discovered that the shape of our brain maps change depending on what we do over the course of our lives. He declares that plasticity exists from cradle to grave (Doidge, 2008, p. 46).

Substantial research on the plasticity of the brain indicates that it is indeed flexible and malleable. Dr. Amen (1998) titled one of his books *Change Your Brain Change Your Life* for a good reason. The brain is adaptable. It will adapt to the thoughts you constantly entertain and the environment you live in.

Hebb's rule of learning applies here (Hebb, 1949). He suggests that the connections between two neurons might be strengthened if the neurons fire simultaneously, hence the common analogy of neurons that 'fire together, wire together'. This means that our brains have the ability to adapt and change, dependent on what input is mapped in the brain – and these maps have been shown to change though brain scans. "This process is called *cognitive fluidity*" (Doidge, 2008, p. 292).

It stands to reason then that our perceptions of self and others are subject to change and that, if we choose to 'quit firing' on one area of our sexuality, our neurological brain map will subsequently change. I believe this puts into context the capacity of some same-sex attracted,

individuals to not only identify their unwanted same-sex attraction, but also to make the choice to change their desires.

It is also interesting to note that "when people change cultures they learn to perceive in a new way" (Doidge, 2008, p. 302). Such is the case when individuals venture into a new culture, such as the LGBTQ community or an unfamiliar religious culture. Often they are exposed to two very different 'cultures' and they have the amazing ability to choose how to perceive their worldview. Many of those who leave SSA have in fact been involved in a Christian church or other religious affiliation.

This then, once again, gives rise to the question: "Why are we trying to prohibit these individuals from seeking therapy to help in this process?" Are LGBTQ activists are simply working in their own best interests, or are they perhaps actually attempting to prohibit a individuals from leaving the community?

Sexual Orientation Change Efforts (SOCE) and Faith Perspectives

Many people promote messages that all SSA individuals should be "true to themselves" and live openly in same-sex relationships (Stack, 2018). "Living authentically" is the statement often made (by those within the LGBTQ community), but for some who are same-sex attracted, living authentically means reducing sexual compulsions, pursuing a more heterosexual experience, pursing spiritual goals, or reducing same-sex thoughts and attractions for the purpose of staying in a heterosexual marriage.

According to Yarhouse et al. (2005), many SSA individuals do not adopt a lesbian, gay, or bisexual (LGB) identity because they prioritize their other-sex attractions, do not act on their same-sex attractions, and/or do not see themselves reflected in the LGB social-identity labels.

As many as half (52%) of lesbian, gay, bisexual, transgender, and queer (LGBTQ) adults reported affiliation with a religion, with a third of those individuals reporting conflict between their sexual minority identity and religious beliefs (Pew Research Center, 2013).

Although many experience distress (Dehlin et al., 2014), for at least some of these individuals, their conservative faith may buffer the negative effects of internalized homonegativity on well-being (Lefevor, Blaber, et al., 2020).

Despite the multiplicity of ways in which sexual-minority individuals reconcile conflict with conservative religion, the resolution of this conflict in an authentic way appears to be central to both satisfaction with life and health (Lefevor, Blaber, et al., 2020). Indeed, when religious identity is prioritized over sexual identity, minority stress is mitigated (Crowell et al., 2015; Lefevor, Sorrell, et al., 2020).

"Some who experience same-sex attractions choose to reject sexual minority identity labels and to describe themselves as same-sex attracted (SSA), heterosexual, or child of God" (Brown, 2015). This practice and terminology is similar to the phrase "same-gender loving" among Black

Christians because these individuals consciously avoid identifying with the LGBQ community in order to identify with other communities (Lassiter, 2015).

Sexual orientation change efforts (or SOCE) continue to be sought out by people with *unwanted* same-sex attractions wishing to overcome such attractions and/or abstain from homosexual behaviour. SOCE may include professional therapy or less formal (often religious) counseling. It is only offered for willing clients. These individuals are considered to be more active with their faith and in their faith commitment, and to hold faith more centrally in their lives, such that leaving their faith would cause more distress than staying in a faith that is not affirming of their sexuality (Grigoriou, 2014).

A 2019 study of SSA and LGBT people of Mormon faith indicated that such individuals report different relationship goals, with faith-based SSA individuals who chose not to label themselves as LGBTQ aspiring more frequently to lives of celibacy or a mixed orientation relationship. Of note, a substantial percentage of Mormons who adopted an LGBTQ identity also endorsed being celibate or being in a mixed-orientation relationship (40%, compared to 85% of SSA individuals (Lefevor, Sorrell, et al., 2020, p. 954).

LGBTQ individuals seek out therapy for all kinds of reasons (M. A. Jones & Gabriel, 1999). The Journal of Gay and Lesbian Psychotherapy (name changed in 2007 to Journal of Gay and Lesbian Mental Health) was specifically devoted to gay and lesbian therapeutic techniques (Zucker, 2003).

Many report successes on same-sex attraction change on a variety of levels and do not report harm from such interventions. This, of course, is the dilemma: the under-reporting of positive change experiences and shifts in SSA and orientation give an incomplete and inaccurate picture of the reality of change SSA individuals are experiencing.

SOCE Perceptions and Blame

While Shidlo and Schroeder (2002) indicated that a majority of subjects in their study *perceived* psychological harm, one thing that must again be acknowledged here is idea of perception. A *perception of harm*, left undiscussed with the therapist/spiritual advisor, could lead to increased depression thoughts of failure, lack of self-esteem, and other significant disorders. What must be determined is the answers to these questions: “Were these symptoms intensified by the exposure to therapeutic techniques, or did individuals instead become more aware of these pathologies and receive diagnosis as a result of therapy? Was their depression, suicidal ideation, etc., intensified by the exposure to therapeutic techniques, or did they instead become more aware of these pathologies and receive diagnosis as a result of therapy?”

It is not unusual, when therapy or other interventions fail, for the individual to place blame on others, i.e., for a client to blame the therapist, technique, or relationship for therapeutic failure. Their internalized anger finds a voice as disillusionment and thereby becomes directed outward.

Research in the area of LGBT studies has often shown both a lack of standards and poorly defined concepts. There is little evidence that chronic, repetitive, and intense discrimination based on sexual orientation remains a health issue (Regnerus, 2020). Depression, anxiety, and other mental health issues are not always associated with issues of sexuality, and basing research solely on an individual's perception of experience does not produce clinical significance.

I cannot help but wonder what we are missing here? Is it possible that therapy ended prematurely or did not address underlying pathologies? It is also possible that follow up could have helped mitigate such effects and address the sense of anger and disillusionment that some participants feel over therapeutic failure.

Pre-existing Conditions

Studies reporting harm will need to be explored in order to understand which, if any, conditions were evident and/or diagnosed prior to therapy. It is important to understand that all of the symptoms identified can be associated with childhood sexual abuse or other early childhood traumatic events (ie. death, loss of a parent), which often cause PTSD. Likewise, the claim that there is no greater pathology in the homosexual population (Glassgold et al., 2009) needs to be scrutinized closely and not casually accepted as absolute truth. Unwarranted conclusions from data by the APA Task Force and the neglect of recognizing the validity of the confounding variables of trauma and abuse when reporting harm due to therapy show neglect of scientific reasoning and implementation of a double standard with respect to expectations and risks of treatment. Trauma continues to be evident in the lives of SSA men. Childhood sexual abuse and other significant traumatic experiences continue to be heavily represented in the life stories of LGBTQ individuals (see "Childhood Trauma Increases Risk" in this paper).

A Reality of Change

According to the 2009 response of the National Association for Research and Therapy of Homosexuality (NARTH), experiential clinical studies demonstrate that it is possible for men and women to diminish their unwanted homosexual attractions and develop their heterosexual potential (Phelan et al., 2009; Sprigg, 2018).

Sprigg (2018) also suggests that there is substantial evidence that sexual orientation may be changed through reorientation therapy. Treatment success for clients seeking to change unwanted homosexuality and develop their heterosexual potential has been documented in the professional and research literature since the late 19th century.

Beckstead and Morrow (2004) provide a comprehensive outline of the internalized need for congruence and the motives for entering therapy. They identified an unexpected finding: that *both* proponent and opponent participants described positive experiences from 'conversion therapy' (Beckstead & Morrow, 2004, p. 668).

Participants' sense of being "lost and alone" decreased when they heard treatment was available that fit their needs. They found a place to belong and fit in. Meeting others with similar struggles helped most participants feel normal and resolve feelings of isolation. As one participant related:

> I did find the brotherhood, safety, and connection I was longing for in our little group… The most therapeutic thing for me was forming bonds with the men in my group; at last I had found some place where I fit in and was accepted (Beckstead & Morrow, 2004, p. 669).

Sexuality became congruent with values. Most proponent participants described learning to manage their sexuality by not sexualizing same-sex others. Indeed, many people with same-sex attraction are much more interested in finding a broader identity than the label they have adopted or that has been given to them.

Seeking Change

Beckstead and Morrow (2004)found four societal environmental conditions that propelled individuals in their study to seek therapy:

a) religious society,
b) family,
c) peers, and
d) "straight" society (p. 662).

The inner dissonance of which they speak often comes from a religious 'ideology' revolving around the importance of obedience and self-sacrifice. One participant stated: "You can't, nor would I want to change my heritage, my upbringing, my beliefs. They have become my own" (Beckstead & Morrow, 2004, p. 663). I believe that this becomes the real crux of the debate around banning any kind of therapy that would allow such individuals to reorient themselves around their internalized beliefs.

Because of the controversy, change is approached from two separate and diametrically opposite belief systems. The first is a "reparative therapy" philosophy that is both politically and ideologically conservative; and the other is from the social constructionist movement, which is "leftist" both politically and ideologically (Zucker, 2003). Rhetoric in this heated dialogue is largely focused on ethics and sexual politics (Brookey, 2000; Davison, 1978; Drescher, 2002; Green, 2003; Haldeman, 1991, 1994; Rosik, 2003; Shidlo et al., 2001).

In 2001, Spitzer delivered a controversial paper, "Can Some Gay Men and Lesbians Change Their Sexual Orientation?" at the 2001 annual APA meeting. Based on a study of 200 self-selected participants, he argued that it is possible that some highly motivated individuals could successfully change their sexual orientation from homosexual to heterosexual, and in 2003 he published a paper derived from this study.

It is of note here that Spitzer (2003a) responded to comments made about his research on the effectiveness of 'reparative therapy.' The Spitzer study was published as a "target article" with the understanding that it would be followed by a series of peer commentaries, followed by a reply by Spitzer (2003b). In the abstract of his earlier paper, Spitzer (2003a) clarifies the sample and objective of this paper and provides an overview of its results:

> The majority of participants gave reports [by telephone interview] of change from a predominantly or exclusively homosexual orientation before therapy to a predominantly or exclusively heterosexual orientation in the past year. Reports of complete change were uncommon… Either some gay men and lesbians, following reparative therapy, actually change their predominantly homosexual orientation to a predominantly heterosexual orientation or some gay men and women construct elaborate self-deceptive narratives (or even lie) in which they claim to have changed their sexual orientation, or both. For many reasons, it is concluded that the participants' self-reports were, by-and-large, credible and that few elaborated self-deceptive narratives or lied. Thus, there is evidence that change in sexual orientation following some form of reparative therapy does occur in some gay men and lesbians (p. 403).

Spitzer said he "began his study as a skeptic," but the study revealed that "66% of the men and 44% of the women had arrived at good heterosexual functioning," defined as "being in a sustained, loving heterosexual relationship within the past year, getting enough satisfaction from the emotional relationship with their partner to rate at least seven on a 10-point scale, having satisfying heterosexual sex at least monthly and never or rarely thinking of somebody of the same sex during heterosexual sex" (Spitzer, 2003a, p. 408).

In Spitzer's (2012) reassessment of his 2003 study, he identifies what he called a "fatal flaw" in his original study:

> I offered several (unconvincing) reasons why it was reasonable to assume that the participants' reports of change were credible and not self-deception or outright lying. But the simple fact is that there was no way to determine if the participants' accounts of change were valid (p. 757).

It would perhaps be better to challenge the authenticity of those who claim *harm* by therapists, rather than claiming that therapists are breaking the law, as records would show if such things were discussed and/or legal processes taken.

So, what is to be made of this? It seems that Spitzer yielded to pressure within academia when his work did not conform to the required script when researching change efforts, i.e., the view that they are harmful and ineffective. Spitzer's apology also raises questions regarding the reliability of *any* self-reported study results. *If Spitzer's subjects are not to be trusted, then why are those who claim to have been harmed by SOCE, yet have provided only their perceptions of harm, so readily believed?*

Outcome from Recent Surveys of Those who Sought Change Therapy

Table 1 **Compilation and Overall Average Outcome of Recent Surveys of Reorientation Therapy Consumers**

Survey	N	*Number and percent reporting exclusive opposite-sex attraction shift fully successful*
Nicolosi et al. (2000a)[1]	318	56 (17.6%)
Shidlo & Schroeder (2002)	202	8 (4%)
Spitzer (2003a)[2].	183	96 (52%)
Total	703	218 (31%)

1. There was a total N = 883 for the entire study; however, only 318 reported being exclusively homosexual pre-treatment and 56 of these reported themselves exclusively heterosexual post-treatment.

2. There was a total N = 200 for the entire study; however, only 183 were included in calculations of exclusive post-treatment opposite-sex attraction.

(Adapted from Phelan et al., 2009, p. 15)

The Nicolosi et al. (2000) study had a total of 882 subjects, 689 men and 193 women. Of the 318 who identified themselves as exclusively homosexual before treatment, 56 (17.6 %) reported that they viewed themselves as exclusively heterosexual following treatment, 53 (16.7 %) as almost entirely heterosexual, and 35 (11.1 %) as more heterosexual than homosexual. Thus, 45.4% of the participants who reported exclusive homosexuality before treatment retrospectively reported a major shift in their sexual orientation. On the other hand, 35.1% of participants were unsuccessful in making significant changes in orientation. Nonetheless, the majority of participants reported that they were functioning better emotionally after the treatment , even though in most cases the shift toward heterosexuality was not complete (Phelan et al., 2009, p. 13).

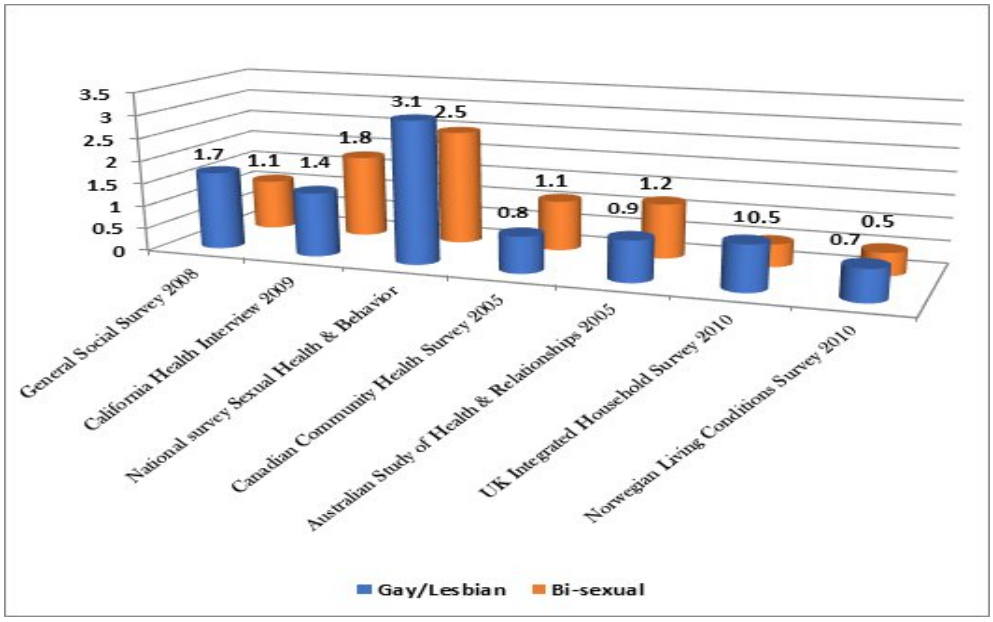
Sexual identity is a broad construct that has become an increasingly important concept in the study of human sexuality and sexual behaviour. Sexual identity development is now considered to be a complex, multidimensional, and often fluid process. The impacts of cognitive, social, emotional, cultural, and familial complexities, as well as other aspects of the individual's experiences, are all considered integral to this process.

Sexual orientation and/or identity is considered a multifaceted phenomenon, integrating sexual attractions, sexual arousal, sexual fantasy, sexual behaviour, and sexual identity (S. L. Jones & Yarhouse, 2007; Klein et al., 1985; Vrangalova & Savin-Williams, 2012; Rosario & Scrimshaw,

2014). If this is truly the case, then changes in sexual arousal, sexual fantasy, sexual behaviour, and sexual identity could in principle be achieved on a continuum from SSA to same sex orientation and identity.

Although there has been a very recent increase in homosexual behaviour and identity among millennials in the last decade, the actual percentage of men and women identifying as homosexual has remained steady from the 1960s to the 2000s as identified in the following charts.

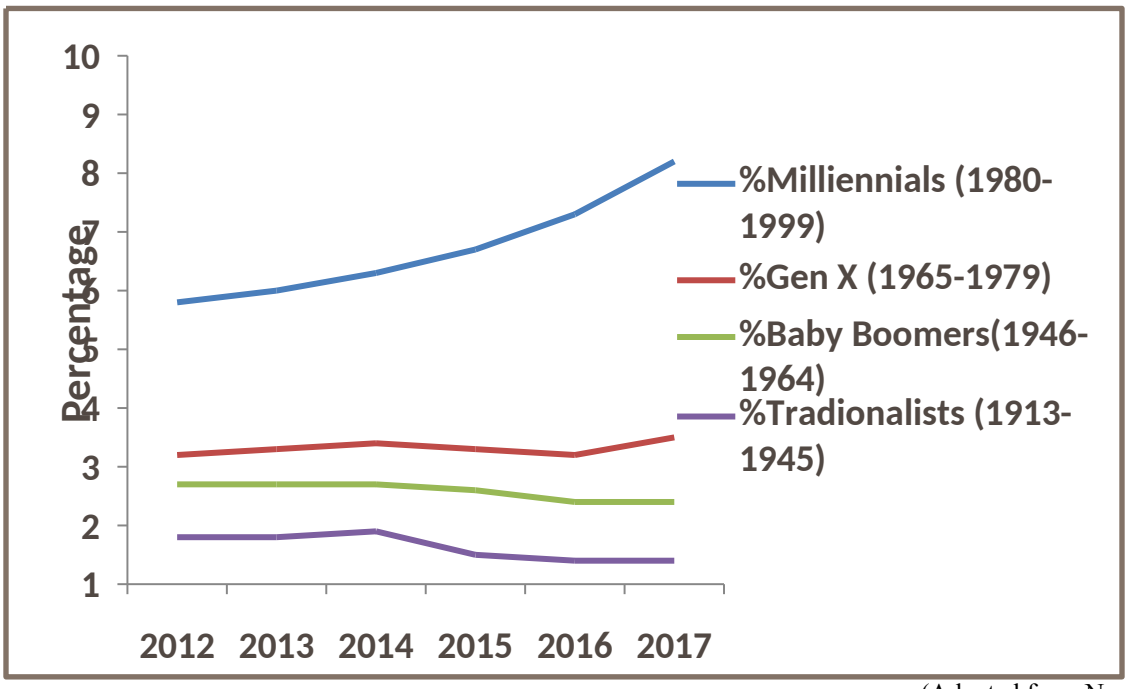
Percentage of Adults who report Same-sex Attraction and Behaviour *



(Gillies, 2017, p. 87)

* The National Survey of Sexual Health and Behavior included surveys in 2009, 2012, 2013, 2014, 2015, 2016, and 2018.

Percentage of Americans Identifying as LGBTQ by birth cohort (based on 340,000 interviews)



(Adapted from Newport, 2018)

As of February, 2021, one in six (about 16%) Gen Z youth now identify as LGBTQ (‘Gallup Poll’, 2021).

Absence of Empirical Information

As Zucker (Zucker, 2003) readily acknowledges, the absence of empirical information is all too common for many psychological treatments for many “problems in living” and/or disorders. It is therefore not surprising that, despite the multiplicity of published works on affirmative psychotherapies for LGBTQ individuals, they too lack any clear empirical foundation, at least if one uses standard guidelines for empirically validated treatments (Zucker, 2003, p. 400).

Diamond and Rosky (2016) emphasize that none of the studies they reviewed can claim to have definitively assessed the core construct of sexual orientation, given its inherently multidimensional nature. This, of course, is true. A simple core construct of sexual orientation is not something that has ever been accomplished because, as noted previously, sexual orientation is a multifaceted phenomenon. Therefore, critiquing change effort studies on the issue of a core construct is not valid. The research must be evaluated according to what is actually being studied.

The truth is that all therapeutic change is considered on a continuum, and not all who enter therapy, for whatever reason, reach their ultimate goal. There will always be a percentage of

clients who drop out, who give up, and who may not reach all their goals. Some of these individuals may suffer from lowered self-esteem as a result.

Effects of Sexual Orientation Change Experience (SOCE) – Help or Harm?

Continued Bias

Bias regarding statements of SOCE harm and efficacy has been particularly evident in the APA Task Force's *uneven implementation of the standards of scientific rigor* in evaluating efficacy in published findings (S. L. Jones et al., 2010). It is telling that, in subsequent references to the report, the potential for harm has morphed into "the potential to cause harm to *many* clients [emphasis added]" (APA, 2012, p. 14).

Rosik (2019) states that the APA Task Force:

> has no way of knowing if the prevalence of reported harm from SOCE is any greater than that from psychotherapy in general. Research demonstrates 5-10% of clients report deterioration while up to 50% experience no reliable change during treatment (Hansen et al., 2006; Lambert, 2013; Lambert & Ogles, 2004; Nelson et al., 2013; Warren et al., 2012). 40-60% of youth drop out of all forms of psychological treatment early (Nelson et al., 2013; Wierzbicki & Pekarik, 1993). The high dropout rates among youth in all forms of psychotherapy add insight to the risk of premature termination in SOCE, wherein emotional distress arising from initial discussions of difficult issues may not be allowed sufficient therapeutic process to be adequately resolved.
>
> The Task Force utilized a far lower methodological standard in assessing harm and other aspects of the science than it did in assessing SOCE outcomes… The Report references the many varieties of methodological problems deemed sufficient to render useless most of the SOCE research. Yet the Report is ready to overlook such limitations when the literature addresses preferred conclusions.
>
> Take for instance the work of Hooker (1957), which is routinely touted as ground-breaking in the field and affirmed in APA publications as evidence indicating no differences in the mental health of heterosexual and gay men. However, this research contains serious methodological flaws.
>
> Among the many methodological problems, as noted by Schumm (2012), the control group was told the purpose of the study in advance, and *clinical experts were not blind to the objectives* of the study. There was an *imperfect matching of participants, low scale reliability*, the use of a *small and recruited control group* rather than existent national standardized norms, the post hoc removal of tests that actually displayed differences, and the screening out of men from the study if they appeared to have pre-existing psychological troubles" .

Rosik goes on to write:

> Perhaps the most extreme example of the Task Force's methodological double standard is evidenced in their substantial reliance on the Shidlo and Schroeder (Shidlo & Schroeder, 2002) […] research in conclusions about harm from SOCE. Shidlo and Schroeder's study contains several methodological problems, which they cite in order to dismiss the SOCE in outcome literature:
>
> - These studies were conducted in association with the National Gay and Lesbian Task Force, initially with the explicit mandate to find clients who had been harmed and document ethical violations by practitioners, which was made clear in their original title "Homophobic therapies: Documenting the damage".
>
> - Over 50% of the 202 sample participants were recruited through the GLB media, hardly a random or generalizable sampling procedure
>
> - Only 20 participants in this study were women, creating significant skew toward gay male accounts.
>
> - Twenty-five percent of study participants had already attempted suicide before starting therapy, making very dubious the claim that suicide attempts were actually caused by the therapy.
>
> - Finally, these subjects reported their experiences came from a mix of licensed therapists, non-licensed peer counselors, and religious counselors, leaving open the reasonable suspicion that negative therapeutic experiences might differ significantly by level of training".
>
> The Task Force seems to ignore warnings from the study's authors: "*The data presented in this study do not provide information on the incidence and prevalence of failure, success, harm, help, or ethical violations in conversion therapy*" (Shidlo & Schroeder, 2002, p. 250, emphases in the original)" .

It is important to note that *any* type of psychological treatment can result in unwanted outcomes, including the potential for perceived harm, complete failure, and possible relapse (Lambert & Ogles, 2004; Shidlo et al., 2001; Shidlo & Schroeder, 2002). Consider, for instance, the relapse rate of those with addictive behaviours. Not only is it common to have relapse during treatment, but therapists usually discuss this possibility with their clients.

Significant Efficacy

Karten (2006) defined successful reorientation as "an increase in heterosexual functioning, a decrease in homosexual functioning, improved psychological well-being, and a greater heterosexual self-identity" (p. 59). Subjects in this study on average reported statistically significant decreases in discomfort with expressions of caring between men, significant decreases in homosexual feelings and behaviour, and a corresponding statistically significant increase in heterosexual feelings (pp. 143–144).

On average, the men in this study also reported very significant *positive changes with respect to psychological well-being as a result of their change efforts*. Impressively, 100% of the men reported increases in self-esteem and 99.1% in social functioning while 92.3% reported decreases in depression, 72.6% in self-harmful behaviour, 58.9% in suicidal ideation and attempts, and 35.9% in alcohol and substance abuse (pp. 87–88).

Proving Harm or Providing Relief?

In Jones and Yarhouse (2007), a surprising outcome was noted. Subjects who classified as "truly gay" with high levels of homosexual sexual attraction/fantasy and exclusive or highly disproportionate levels of homosexual behaviour and strong self-identification as gay or lesbian according to the Kinsey and Klein scales reported *the greatest amount of reorientation change*, both away from homosexual attraction, fantasy, and behaviour and toward heterosexual (S. L. Jones & Yarhouse, 2007, pp. 259–261, 267–269, 326).

Jones and Yarhouse also found little evidence of harm for the participants. They concluded that "the findings of this study appear to contradict the commonly expressed view that sexual orientation is not changeable and that the attempt to change is highly likely to result in harm for those who make such an attempt" (2007, p. 387).

A well-designed research study by Santero, Whitehead, and Ballesteros (2018) generated a significant amount of data from a survey questionnaire with more than 90 questions and 125 participants. They found that the number of individuals expressing harm after receiving therapy for same-sex attraction mirrors that of general psychotherapy. Only one out of the 125 men surveyed expressed extreme negative effects after therapy.

Coauthor Dr. Neil Whitehead, in his firsthand account of the study's publication and subsequent retraction, noted that:

> A number of participants changed a dramatic extent—they said from completely same-sex attraction to completely opposite sex attraction. Of the whole sample, about two-thirds moved a significant amount towards heterosexual, and the rest mainly did not show any change. A very few actually became more same-sex attracted. However, it was rather remarkable how therapy was found very good, even among those who did not change. One can surmise they had lots of help for other issues and found real fellowship in the support groups (Whitehead, 2019, p. 76).

Due to "accusations that therapy might be damaging to mental health", questions in the survey asked about several issues, such as suicidality, depression, and self-esteem. Although respondents reported an average of three mental health issues, though not severe, before participating in the therapy, they reported lots of help from the therapy and the support groups they attended (Whitehead, 2019, p. 76).

"The major outcome, as found in previous surveys, was that there was *real change, little harm, much good*" (Whitehead, 2019, p. 76). These findings are very close to those of Jones and Yarhouse (2007, 2011).

Of note here is the retraction of the study "Effects of Therapy on Religious Men Who Have Unwanted Same-Sex Attraction" from the Linacre Quarterly. Dr. Whitehead wrote about this retraction as follows:

> I am a research scientist involved in the derivation and interpretation of results in many fields. I have published over 150 papers, in a span of 50 years of research, with lots of use of statistics, but I have to say this has been the most difficult paper to publish of any. There was a 7.5-year gap between survey and publication, and this is very long. In fact only 4% of all papers take more than 5 years (Powell, 2016), so 7.5 years might put this paper in the 2% category. But the results in the paper were so clear that it was well worth persevering.
>
> Some months after publication, there was a change of editor, and more questions were asked about the researchers' qualifications and sources of funding. Nearly a year after publication, the journal withdrew the paper on the basis that it had not been adequately statistically reviewed, even though the statistical review was completed before publication.
>
> I have not heard of any other such post publication unilateral retraction except in the case of fraud or plagiarism, neither applicable here. Usually any doubts about a paper's content are addressed in another article in the journal or perhaps a letter to the editor (Whitehead, 2019, pp. 75–77).

Such journal and academic retractions of research supporting SOCE or challenging Transgender philosophy (see Littman, 2018) is becoming more common.

It is important to compare and contrast those who have found change therapy effective with other studies that found such interventions harmful. Consider this statement from my own son, who underwent successful sexual orientation change and states, "Ceasing to find my identity in 'homosexuality' allowed me to finally find that my identity was so much more than my sexuality" (personal correspondence, 2020). The restraints were gone, and he was finally able to explore other areas of identity in his life, releasing himself from the concept and label of being bisexual or homosexual and freeing him to pursue heterosexual thought, attraction, and finally marriage and family, enabling him to live the life of his choosing.

Many who have left the LGBTQ culture have done so with difficulty, not because homosexuality is, as often stated, "innate", but due to the extremely compulsive behaviour involved. A participant in the Beckstead and Morrow study explained:

> "Once I was fully immersed in my double life of sexual addiction, I considered myself bisexual—my 'addict' self was 100% homosexual, while my sane, non-addict self was mostly heterosexual (Beckstead & Morrow, 2004, p. 665)."

A summary of studies by Whitehead and Whitehead showed that about "about half of those with exclusive SSA [same-sex attraction] were once bisexual or even heterosexual" (Whitehead & Whitehead, 2020, p. 195).

Cummings (2007), a former APA president, served as Chief of Mental Health with the Kaiser-Permanente Health Maintenance Organization. During a 20-year period ending in 1980, he estimates that he saw more than 2,000 patients, and that his staff saw another 16,000, who presented with concerns regarding homosexuality. Most did not express a goal of reorienting, but rather entered treatment to resolve a number of issues and dissatisfactions concerning their lifestyle, including the transient nature of their relationships, disgust or guilty feelings about promiscuity, fear of disease, and the wish to have a traditional family. Cummings and his staff did not try to reorient those with same-sex attraction. The majority of these patients (at least 10,000 of the 18,000) attained a happier and saner homosexual lifestyle with more stable relationships; another approximately 2,400 clients successfully reoriented their sexuality to heterosexuality (Phelan et al., 2009, p. 18).

These statistics, though dated, harken back to a time when LGBTQ individuals could seek out the help they wanted. Most did not express the goal of re-orienting, but rather sought to resolve other issues very pertinent to their lifestyle. While at least 10,000 treated by Cummings and his staff attained a 'saner' lifestyle, approximately 1/4 of them successfully reoriented from homosexual to heterosexual.

It is interesting to note that the remainder of the individuals had unsuccessful outcomes: approximately 5,500 of them continued to experience unhappiness and compulsive behaviours. It would seem to me that the 'unhappy' population, those who have not found therapy successful, are likely the ones who are now calling for the ban of "conversion therapy". Perhaps it is long overdue for those who have found therapy to be helpful, whether or not they reoriented their sexuality, to start speaking out about truth.

The evidence of significant risk of harm must be explored (Byrd et al., 2008). This would mean comparing those who found it effective with those who express a felt sense of harm. How many of those who have received change therapy interventions have experienced harm and to what degree? Is there proof of torture? We expect proof in other areas of investigation. Have activists' claims been authenticated?

No Greater Pathology or Risk among LGBTQ?

At the population level, the physical and mental health of LGBT individuals is far more compromised than many are prone to acknowledge (Frisch & Brønnum-Hansen, 2009), but the APA Task Force conclusion was that *"there is no greater pathology in the homosexual population than in the general population"* (Glassgold et al., 2009).

Minimizing or actually denying such risks puts this group of people at further risk and increases the overall cost to society. It is time that we stop turning a blind eye to the suffering endured by many in the LGBTQ community. It is detrimental to this community to minimize the risk and impact of sexual and addictive behaviours in order to promote a bias and misguided ideology.

LGBTQ Mental Health

Possibility of Change in Homosexual Orientation

High rates of mental illness in the LGBTQ culture have been well documented for years and are still being attributed to homophobia. While the LGBTQ narrative continues to blame homophobia, we do a disservice to that community when we fail to realistically assess the extent to which other confounding variables give rise to their higher levels of pathology. Mental health issues within the LGBTQ community are extremely high and are on the rise, despite the tremendous increase of social acceptance of these individuals.

The association between sexual orientation and mental health has been recognized for certain conditions including:

- suicide attempts
- eating disorders
- substance-use disorders
- panic attacks
- depression
- anxiety disorders (Sandfort et al., 2001)

The National Alliance on Mental Illness reports:

> [T]here is strong evidence from recent research that members of this community are at a higher risk for experiencing mental health conditions — especially depression and anxiety disorders. LGB adults are more than twice as likely as heterosexual adults to experience a mental health condition. … LGB youth also experience greater risk for mental health conditions and suicidality. LGB youth are more than twice as likely to report experiencing persistent feelings of sadness or hopelessness than their heterosexual peers. (n.d.)

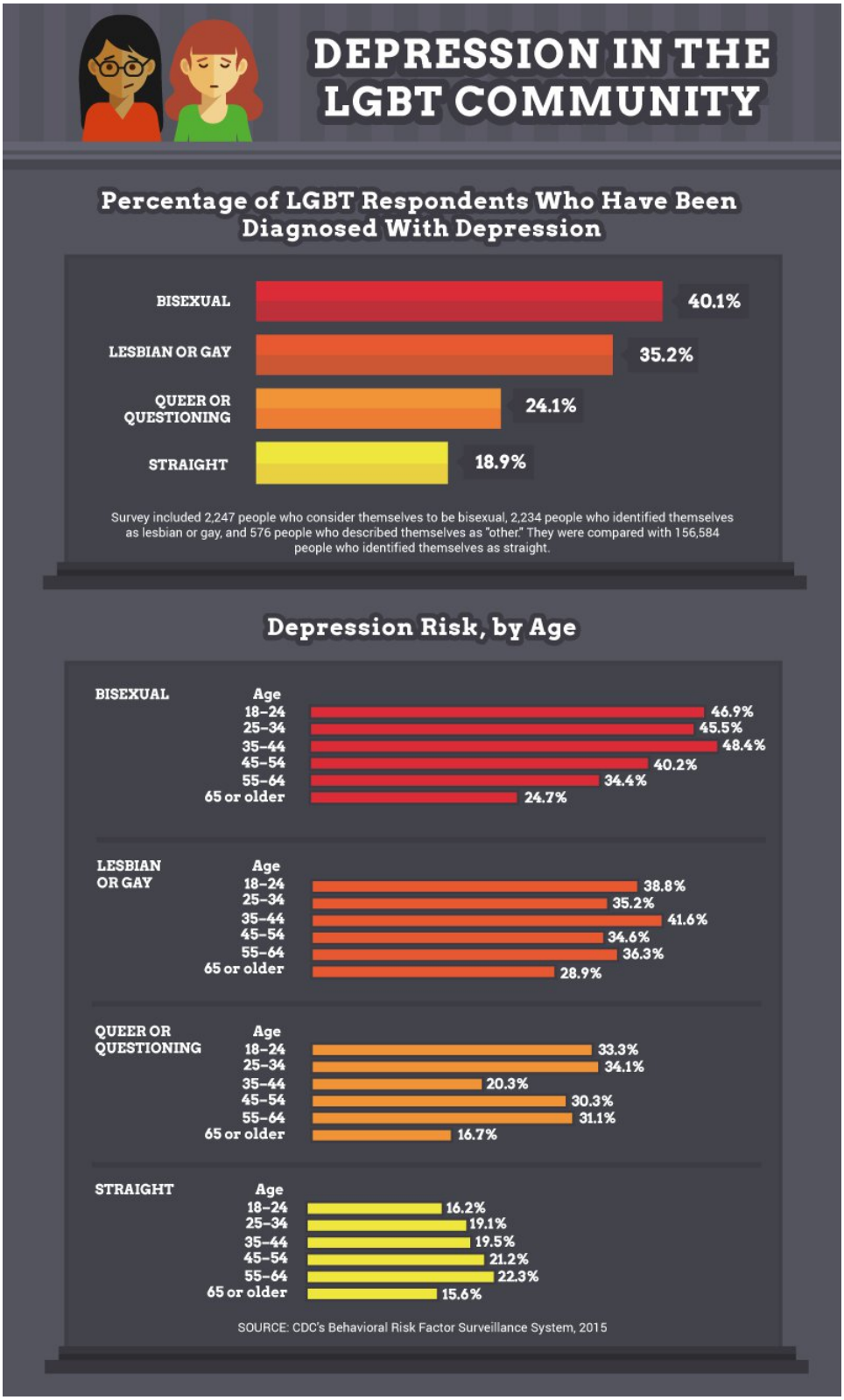
The Trevor Project, an American organization focusing on providing crisis intervention and suicide prevention services to LGBTQ persons under the age of 25, explains that:

> - Suicide is the 2nd leading cause of death among young people ages 10 to 24.
> - LGB youth seriously contemplate suicide at almost three times the rate of heterosexual youth.
> - LGB youth are almost five times as likely to have attempted suicide compared to heterosexual youth.
> - Of all the suicide attempts made by youth, LGB youth suicide attempts were almost five times as likely to require medical treatment than those of heterosexual youth.
> - Suicide attempts by LGB youth and questioning youth are 4 to 6 times more likely to result in injury, poisoning, or overdose that requires treatment from a doctor or nurse, compared to their straight peers.
> - In a national study, 40% of transgender adults reported having made a suicide attempt. 92% of these individuals reported having attempted suicide before the age of 25. (n.d.)

According to MentalHelp.net (n.d.):

> Roughly four out of 10 people who identify as bisexual report having been diagnosed with depression – a rate even higher than the one-in-three gay and lesbian Americans who have experienced depression, and more than double the rate of those who identify as straight. Our interviews with community members show that their sexual orientation or

gender identity can significantly influence their experiences with depression. The secrecy of personal struggles exacerbate these symptoms, while the opportunity to be open and supported in their identity often helped relieve their condition.



(MentalHelp.net, n.d.)

It is imperative that we look beneath current dogma to determine whether homophobia is truly the cause of the present mental health crisis of LGBTQ individuals. Studies indicate a disparity in mental health conditions between the LGBTQ community and the general population (Becerra-Culqui et al., 2018; Bechard et al., 2017; Sandfort et al., 2006). There are many contributors to this disparity, including promiscuity, risk of infections, and cancers linked to same-sex behaviour; these factors could lead an individual to desire to change their sexual attractions, thoughts, behaviours, and even their sexual orientation (Becerra-Culqui et al., 2018; Bechard et al., 2017; Sandfort et al., 2006).

Research indicates that same-sex orientation is associated both with higher rates of mental health diagnosis and comorbidity, and with use of mental health services. "Among gay–bisexual men 85.3%, (*SE* = 8.4%) were more likely than heterosexual men (45.2%, *SE* = 3.1%) to report that they had received mental health services" (Cochran et al., 2003, p. 59). This study indicated that approximately "20% of gay–bisexual men and 24% of lesbian–bisexual women met criteria for two or more disorders in the year prior to interview, a comorbidity rate three to nearly four times greater than that observed among heterosexuals of the same gender" (Cochran et al., 2003, p. 60). In general, comorbidity is a predictor of illness severity and higher rates of treatment use (Kessler et al., 1999). These statistics do not indicate a healthy community.

Suicide

In one Netherlands study (de Graaf et al., 2006) involving 7,000 participants, "younger homosexually-oriented people were found to be at greater risk of suicidality than older homosexually-oriented people" (Phelan et al., 2009, p. 69). This would seem to indicate that liberalization of social mores in the Netherlands has not lowered the risk of suicidality in youth.

A 2019 study has revealed little evidence that same-sex marriage laws have reduced suicide attempts among teen sexual minorities, nor have they decreased the likelihood of suicide planning, suicide ideation, or depression. Instead, there was "some evidence that same-sex marriage legalization via judicial mandate is associated with *worse* mental health for these individuals". The authors then postulate that this is "consistent with a story of social backlash" (Anderson et al., 2019). This conclusion needs to be evaluated, as the premise of equal rights should have nullified the effects of social backlash for millennials. It is important to let the facts speak for themselves without introducing bias.

High rates of mental illness in the LGBTQ culture have been well documented for years and are still being attributed to "homophobia." While not disputing past stigma resulting from this lifestyle, such stigma has lessened immensely. Even so, the mental health issues within this population seem to be *rising*, giving much cause for concern. Could this rise be a result of this population not addressing deep issues of trauma and abuse in their lives?

Childhood Trauma Increases Risk

Profound sexual orientation disparities exist in risk of PTSD and in violence exposure, beginning in childhood (Roberts et al., 2010). Childhood Sexual Abuse (CSA) is not only associated with same-sex orientation, but also with mental health problems (Mullen et al., 1993, 1994) and it is a

major risk factor in suicidal ideation. “Sexual abuse by someone of one’s own sex was found to be related to a same-sex orientation and sexual orientation was associated with different levels of perceived parental closeness” (Eskin et al., 2005, p. 186).

The median CSA prevalence among non-heterosexuals is estimated to be 35% for women and 23% for men, compared to 3-27% of heterosexual women and 0-16% of heterosexual men respectively (Rothman et al., 2011). Xu and Zheng (2015) observe, “It is possible that CSA causes an individual to develop a same-sex sexual attraction” (p. 328).

The disparities in CSA between non-heterosexual and heterosexual individuals are in addition to the much greater odds of exposure non-heterosexuals have to multiple adverse developmental factors beyond physical, sexual, and emotional abuse. Such adverse life events in childhood could reasonably be expected to contribute to attachment insecurity among children, which has predicted atypical gender identity and a lack of gender contentedness (Cooper et al., 2013).

Courtois (2014) describes the trauma caused by childhood sexual abuse “as a subset of the full range of psychological trauma that has as its unique trademark a compromise of the individual’s self-development” (p. 16). Sexual abuse in childhood has repeatedly been found to damage self-esteem, self-concept, relationships, and the ability to trust (Gillies, 2016).

Symptoms of Complex Traumatic Stress Disorder

A distorted sense of self
Low self-esteem and self-hatred
Self-blame for the abuse
High degrees of guilt and shame
Severely impaired identity formation which can lead to identity confusion
Severely impaired trust that interferes with the development of healthy relationships, resulting in disrupted attachment

(Adapted from Gingrich, 2013, p. 19)

Meta-analysis has revealed that sexual minority individuals (ie, lesbian, gay, bisexual, and questioning) are up to 3 times more likely to have experienced abuse during childhood (Friedman et al., 2011).

Sexual minority individuals are also more likely to report various forms of parental abuse and household dysfunction during childhood (Friedman et al., 2008; Ryan et al., 2009).

Among young women participating in a 2008 study, those describing themselves as “mostly heterosexual” reported higher rates of childhood sexual abuse (nearly half) than did those describing themselves as heterosexual (Austin et al., 2008). A meta-analysis of 46 studies of the relationship between childhood sexual abuse and HIV risk behaviour among women found that there was an increased risk of unprotected sexual activity; having multiple partners; engaging in sexual intercourse in exchange for money, drugs, or shelter; and sexual victimization in adulthood (Arriola et al., 2005).

It is very likely that childhood sexual abuse precipitates gender confusion. It is readily acknowledged that subsequent abuse and post-traumatic stress usually continue throughout the lifespan of individuals who have experience chronic abuse in childhood. A 2009 study found that most homosexual men surveyed described aspects of their sexuality as having been influenced in some way by their childhood sexual abuse experiences (Roller et al., 2009). Many men have indicated that the sexual abuse they experienced as children influenced how they came to view themselves as sexual beings, causing them to experience shame, confusion, and low self-esteem regarding their sexuality, and they questioned whether the abuse accounted for their sexual problems, contributed to their sexual orientation, or caused them to question their relationship and intimacy issues. An important but largely swept under the rug statistic is that *the experience of child sexual abuse triples the likelihood of later homosexual orientation* (Laumann et al., 1994).

Research examining the sexuality of Childhood Sexual Abuse survivors found that most participants described aspects of their sexuality that were influenced in some way by their CSA experiences. "Many indicated that their abuse caused them to engage in high-risk sexual behaviours, such as having sex at an early age, having many sexual partners, having frequent or unprotected sex and having sex while using drugs or alcohol to excess. CSA influenced how they came to view themselves as sexual beings. They talked about experiencing shame, confusion and low self-esteem about their sexuality (Roller et al., 2009, p. 53)."

Children who have been sexually abused can develop a distorted sense of love. Their childhood confusion can lead to a lifetime of self-punishment through addictive behaviours, primarily with drugs, alcohol, sexual deviance, and sexual addictions.

Despite evidence supporting these multidimensional correlations between same-sex attraction and high levels of child sexual abuse, the American Psychiatric Association (2011) stated that

> *no specific psychosocial or family dynamic cause for homosexuality has been identified, including histories of childhood sexual abuse. Sexual abuse does not appear to be more prevalent in children who grow up to identify as gay, lesbian, or bisexual, than in children who identify as heterosexual.* (Emphasis added.)

A further note on the condition of professional organizations and their ability to speak on behalf of health professionals: the APA lost 10% of its members between 2008 and 2013 and *now represents less than 44% of psychologists* in America (Robiner et al., 2015). The American Medical Association now *represents less than 20% of physicians* in that country (Rosik, 2019, p. 24).

Contrary to the repeated claims of the APA Task Force Report that "no empirical studies or peer-reviewed research supports theories attributing same-sex sexual orientation to family dysfunction or trauma" (Glassgold et al., 2009, p. 86), there currently exist recent, high quality, and large-scale studies that provide empirical evidence consistent with the theory that familial or traumatic factors potentially contribute to the development of sexual orientation (Bearman & Brückner, 2002; Francis, 2008; Frisch & Hviid, 2006; Roberts et al., 2013; J. E. Wells et al., 2011; Wilson

& Widom, 2010). Despite their significant relevance for scientific discussions on the etiology of same-sex attractions, these studies were ignored by the Task Force (Rosik, 2019).

Childhood sexual abuse (CSA) remains closely associated with same-sex attraction in the development of homosexuality. One study (Valente, 2005) containing data on the life stories of 24-year-old males found that sexual abuse prompted the boys to question who they were and why this happened to them. *Normal development of gender identity, self-esteem, and self-concept was disrupted*. The boys felt that they must be flawed and that their behaviour signaled they were less masculine, more vulnerable, and more inadequate. Some feared that sexual abuse would make them homosexual or that they must have already been homosexual and that is why they attracted the abuse in the first place.

A large 2009 study of men who have sex with men (MSM) found that 39.7% of the 4295 participants had a history of Childhood Sexual Abuse (Mimiaga et al., 2009). This study supports previous research on the association between CSA and men who have sex with men (Bartholow et al., 1994; Laumann et al., 1994; Zierler et al., 1991).

Previous studies have found elevated rates of Post-Traumatic Stress Disorder—a mental disorder that develops in response to exposure to a potentially traumatic event, including violence (e.g., childhood abuse, sexual assault, effects of war)—among sexual minorities in comparison with heterosexuals (D'Augelli et al., 2006).

Health Risks

According to the Williams Institute 2011, whereas only 1.6% of LGBTQ persons claim monogamy while 83% of heterosexuals are faithful in their relationship (Gates, 2011). High rates of multiple partners increase the potential of risk of sexually transmitted disease within this population.

The 1995 Massachusetts Youth Risk Behaviour Surveillance found that gay, lesbian, and bisexual orientation was associated with having had sexual intercourse before age 13, with having four or more partners in a lifetime, and with having experienced sexual contact against one's will (Garofalo et al., 1998). In 2011, among adolescent males aged 13–19 years, approximately 93% of all diagnosed HIV infections were from male-to-male sexual contact (National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention: Division of Adolescent and School Health, 2014).

A 2003 British study (Mercer et al., 2003) reported that the majority of homosexual men (60%) engage in anal sex, frequently without a condom and even when they know they are HIV positive. In 2014, gay, bisexual, and other men who have sex with men (MSM) accounted for 83% of syphilis cases where the sex of partner was known (Centers for Disease Control and Prevention, 2016).

Other Risks within the LGBTQ population

Low self-esteem and the inability to maintain close relationships, along with the psychological problems that haunt abuse survivors, mirror the mental health issues of many in the LGBT culture. Same-sex relationships are much more likely to break up than those in heterosexual homes, which of course has a dramatic negative effect on children (Regnerus, 2012).

Intimate Partner Abuse

Intimate partner violence and sexual assault in adulthood are also disproportionately prevalent among sexual orientation minorities. Walters et al. (2013) found the highest prevalence of intimate partner violence—40.4% among lesbians and 56.9% among bisexual women.

Turrell's (2000) study of gay men experiencing abuse by a partner showed the following results:

- 13% experienced sexual abuse
- 17% experienced stalking
- 37% experienced financial abuse
- 41% experienced coercion
- 44% experienced physical abuse
- 45% experienced threats
- 63% experienced shaming
- 83% experienced emotional abuse

The statistics on mental and physical health in this population do not indicate a healthy community. In fact, contrary to the LGBTQ spokespeople, these statistics are very concerning, and the reality of mental illness and health risks need to be brought to light and addressed, not swept under the rug, which the American Psychiatric Association, American Psychological Association, the Canadian Psychological Association, the College of Psychologists, Canadian Medical Association, and many other such organizations across Canada, the USA, and UK are doing.

Conversion Therapy Bans

"The adamant contention of SOCE ban supporters is that naturalistic change occurs spontaneously and hence can never be achieved through the agency of clients in change-allowing talk therapies. This is essentially to contend that sexual orientation change may occur via many influences and in a variety of settings, with the singular exception of involving the assistance of a licensed therapist. Such a stance overlooks the reality that clinicians engaged in change-allowing talk therapies often address these exact influences of change with their clients" (Rosik, 2019, p. 20).

Research in the area of same-sex attraction provides clear evidence of naturally occurring fluidity (Cass, 1990; Diamond, 2003b, 2003a, 2012, 2014; Diamond & Rosky, 2016; Galupo et al., 2014; Gartrell et al., 2012; Savin-Williams et al., 2012; van Anders, 2015). Why then is there a need to suppress the ability of individuals with unwanted same-sex attraction to seek the therapy they wish? This seems a counterintuitive proposal that targets the most vulnerable within the LGBTQ culture: those who are struggling with unwanted sexual attractions.

Those who have experienced childhood same-sex abuse (CSA), should be able to access desired therapy that can help them change their attractions and behaviour. Denying them this access further abuses the victims of CSA.

Many SSA individuals are in heterosexual relationships and desire therapy to help them be faithful and keep their families together. Each person should be able to decide whether sexual orientation or gender identity represents an authentic or positive variation of sexuality for themselves. No activist organization, professional organization, or legislature should decide that for others (Haynes, 2019).

Canadian Provinces and Municipalities Move to Ban "Conversion Therapy"

In a memorandum by the Canadian Council of Christian Churches, Bussey (2020) summarizes the recent provincial and municipal bylaws:

> *Manitoba*
>
> In 2015, Health Minister Sharon Blady announced (News Release – Manitoba, 2015) that Manitoba's regional health authorities and regulatory colleges were required to take "immediate steps" against conversion therapy. The prohibitions included an explicit emphasis on protecting minors from exposure to the practice. The government also encouraged "individuals who may receive such treatment from a regulated health-care professional to file a complaint with the respective college or association".
>
> *Ontario*
>
> Also in 2015, Ontario passed Bill 77: "Affirming Sexual Orientation and Gender Identity Act, 2015." The legislation focuses on health care professionals, stating that "[a]ny services that seek to change the sexual orientation or gender identity of a person are not insured services," and that parents or guardians cannot provide consent for "treatment that seeks to change the sexual orientation or gender identity of a person under 18 years of age" (Legislative Assembly of Ontario).
>
> *Nova Scotia*
>
> Following a media outcry over the Seventh-day Adventist Camp Pugwash's 2018 program that was to feature speakers from "Coming Out Ministries", legislators in Nova Scotia were galvanized to pass Bill No 16, the "Sexual Orientation and Gender Identity Protection Act". (Furey 2018).
>
> MLA Susan LeBlanc (2018) also commended the bill for specifying that "no person in a position of trust or authority towards a young person … shall make any change effort with respect to the young person" (p. 401) She noted, "[t]his will make sure that camp counsellors are not allowed to engage in this kind of practice, teachers, religious leaders I would suspect, and I think it's an essential part." (LeBlanc, 2018, p. 401).

Municipalities

> In June 2018, Vancouver became the first Canadian municipality to pass a ban on conversion therapy for youth and adults. Other municipalities, including Fort McMurray and Edmonton, have since followed suit.

In commenting on the Edmonton ban, Dr. Kristopher Wells, an LGBTQ activist and an Associate Professor at MacEwan University, states: "What makes this bylaw so powerful is that it captures *all forms of conversion therapy, whether they are medical, spiritual, or religious*" (Labine, 2019, emphasis added). In Dr. Wells' view, this by-law is not only a model for Canada, but for the world. It is of note that this ban and others proposed or enacted recently in Canada also include prohibitions on any efforts to reduce "sexual *behaviour* between persons of the same sex." Reducing *behaviour* has nothing to do with changing sexual orientation or gender identity, and it is not included in any officially approved definitions of "conversion therapy".

Calgary Bans the Right to Therapeutic Choice

As Calgary's bylaw concerning conversion therapy is the most extensive one to date, I believe it is important to describe it at some length. The short title of the bylaw (Bylaw number 20M2020) is "Prohibited Business Activity". It introduces this description of 'Conversion Therapy':

> "Conversion therapy" means a practice, treatment, or service designed to change, repress, or discourage a person's sexual orientation, gender identity, or gender expression, *or to repress or reduce non-heterosexual attraction or sexual behaviour.*
>
> For greater certainty, this definition does not include a practice, treatment, or service that relates (a) to a person's social, medical, or legal gender transition; or (b) to a person's non-judgmental exploration and acceptance of their identity or development.
>
> A business in this bylaw means:
>
> > (i) a commercial, merchandising or industrial activity or undertaking,
> > (ii) a profession, trade, occupation, calling or employment; or
> > (iii) an activity providing goods or services;
>
> whether or not for profit and however organized or formed, including a cooperative or association of persons (Prohibited Businesses Bylaw, 2020, pp. 1–2).
>
> This bylaw also includes advertising of therapy for those in the LGBTQ community seeking help to reduce unwanted same-sex attraction and *proof of one transaction or that the business has been advertised is sufficient to establish that a person is engaged in or operates the business* (Prohibited Businesses Bylaw, 2020, p. 2).

The Summary Conviction Offence (Prohibited Businesses Bylaw, 2020, p. 3) is as follows:

> (1) Any person who contravenes any provision of this Bylaw by doing any act or thing which the person is prohibited from doing, or by failing to do any act or thing the person is required to do, is guilty of an offence pursuant to this Bylaw.
>
> (2) The owner of real property, who is registered on title at the Land Titles Office, shall be responsible for any act of a person carrying on business on the premises located on the property that constitutes an offence under this Bylaw, in the same manner and to the same extent as though the act were done by the owner.
>
> (3) For the purposes of this Bylaw, an act by an employee or agent of a person is deemed to be an act of the person if the act occurred in the course of the employee's employment or agency relationship with the person.
>
> (4) If a corporation commits an offence under this Bylaw, every principal, director, manager, officer, employee, or agent of the corporation who authorized, assented to, acquiesced, or participated in the act that constitutes the offence is guilty of the offence whether or not the corporation has been prosecuted for the offence.
>
> (5) If a partner in a partnership is guilty of an offence under this Bylaw, each partner in the partnership who authorized, assented to, acquiesced, or participated in the act that constitutes the offence is guilty of the offence.
>
> (6) Any person who is convicted of an offence pursuant to subsection (1) is liable on summary conviction to a fine not exceeding ten thousand ($10,000.00) dollars and in default of payment of any fine imposed, to a period of imprisonment not exceeding one (1) year.

There are several interesting events that happened in Calgary. First, the actual bylaw was not released until one week prior to the vote. In the time between the vote on the Edmonton ban on therapeutic counselling choice and the Calgary vote, a new group, *Free to Care*, predominately Christian in nature, rose up and contributed to the dialogue on this bylaw. This group submitted over 300 pages of data and testimony in an attempt to suggest amendments to the bylaw.

In all there were 121 oral presentations (a provincial record, perhaps a national record, for a proposed bylaw) and 1800 written submissions, with approximately half coming from those who were opposed to the wording of the bylaw, yet none of the suggestions supporting the freedom of choice in therapy were adopted.

In summation comments, one Councillor (Carra) stated that the bylaw "absolutely applies to churches." He further indicated that the range of activities that constitute a criminal office include:

> pastoral counseling, especially anything on an ongoing basis, and speaking events (presumably outside of actual preaching) where same-sex behaviour is called into question. Furthermore, the ban on advertising in the bylaw would also apply to word-of-mouth advertising, though admittedly this would be difficult to prove (Van Maren, 2020).

This bylaw restricts pastors and lay leaders from:

- Helping a person to resist temptation to engage in same-sex behaviour
- Helping a person to embrace a Christian identity that lets God define who they are as a man or woman
- Helping a child with gender dysphoria to accept the gender of their biological sex
- Helping youth who feel they do not fit in to their peer group to become confident in themselves and their biology
- Helping an adult de-transition (which will be considered conversion therapy)
- Helping a person as they experience any changes in who they are attracted to
- Offering seminars that discuss sexual fluidity toward heterosexuality or present a perspective of marriage as being between a man and a woman.

Conversion Therapy Ban Reversals in the USA

In Tampa, Florida, a court case (*Vazzo et al. v City of Tampa*, 2019) challenged the City of Tampa's municipal ordinance prohibiting sexual orientation change efforts ("SOCE") on minors during licensed psychotherapy and counseling. The Court chose to overturn the previous ordinance after determining that "the City has never before substantively regulated and disciplined the practice of medicine, psychotherapy, or mental health treatment within City limits. Nor does the City possess charter or home rule authority to do so" (*Vazzo, R. and Soli Deo Gloria International INC (New Hearts Outreach) v City of Tampa.*, 2019, p. 2). The following points were listed in the Court judgement (*Vazzo, R. and Soli Deo Gloria International INC (New Hearts Outreach) v City of Tampa.*, 2019, pp. 32–33):

- Minors can be gender fluid and may change or revert gender identity.
- Gender dysphoria during childhood does not inevitably continue into adulthood.
- Formal epidemiologic studies on gender dysphoria in children, adolescents, and adults are lacking.
- One Tampa expert testified there is not a consensus regarding the best practices with prepubertal gender nonconforming children.
- A second Tampa expert testified consensus does not exist regarding best practices with prepubertal gender nonconforming children, but a trend toward a consensus exists.
- Emphasizing to parents the importance of allowing their child the freedom to return to a gender identity that aligns with sex assigned at birth or another gender identity at any point cannot be overstated.
- One cannot quantify or put a percentage on the increased risk from conversion therapy, as compared to other therapy.
- Scientific estimates of the efficacy of conversion therapy are essentially nonexistent because of the difficulties of obtaining samples following individuals after they exit therapy, defining success, and obtaining objective reassessment
- Based on a comprehensive review of this work, the APA's 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 SOCE outcomes. More recent studies claiming benefits and/or harm have done little to ameliorate this concern.
- 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.

- No known study [looking at same 2014 article] has provided a comprehensive assessment of basic demographic information, psychosocial wellbeing, and religiosity, which would be required to understand the effectiveness, benefits and/or harm caused by SOCE.
- Although research on adult populations has documented harmful effects of SOCE, no scientific research studies have examined SOCE among adolescents.
- With extraordinarily well-trained counseling "in a hypothetically perfect world" it may be an appropriate course of action for a counselor to aid a gender-dysphoric child who wants to return to biological gender of birth.
- There is a lack of published research on efforts to change gender identity among childhood and adolescents.
- As of October 2015 no research demonstrating the harms of conversion therapy with gender minority youth has been published (internal citations removed).

A footnote added that, "at oral argument the City's lawyer conceded no council member had skilled knowledge in the field. The main sponsor of the Ordinance on the council was unaware of the difference between talk therapy and aversive practices, and testified that council and participating staff are untrained in the mental health field" (*Vazzo, R. and Soli Deo Gloria International INC (New Hearts Outreach) v City of Tampa.*, 2019, p. 32).

The Court noted "as the citations above show, the City's highly-credentialed experts, one or both, expressly agreed with the above bullet points. This illustrates the complex and dynamic subject matter of human gender and sexual preference" (*Vazzo, R. and Soli Deo Gloria International INC (New Hearts Outreach) v City of Tampa.*, 2019, p. 33).

In 2018, New York city passed a bill that banned all forms of conversion therapy done for a fee, but in response to a lawsuit filed by Orthodox Jewish psychotherapist Dr. Dovid Schwartz (Schwartz v The City of New York, 2019), the New York City Council voted to repeal this ordinance which censored private conversations between counselling professionals and their patients (Alliance Defending Freedom, 2019). ADF also recognized that the law only prohibits counsel in one direction—assisting a patient who desires to reduce same-sex attraction or achieve comfort with their biological sex. Schwartz is quoted as stating, "the government does not belong in a therapist's office" (Alliance Defending Freedom, 2019).

"Over the course of his over 50 years of general practice, Schwartz has regularly encountered and served patients who want his help overcoming same-sex attraction. Because of their religious beliefs and personal life goals, clients who seek his counsel often desire to experience opposite-sex attraction so they can marry, form a natural family, and live consistently with their Orthodox Jewish faith. A number of patients have pursued and achieved those goals with the aid of his psychotherapeutic services. Schwartz uses no techniques in working with his patients other than listening and talking—yet the 2018 law claimed to forbid even that" (Alliance Defending Freedom, 2019).

City Council Speaker Corey Johnson, who himself is openly gay, stated: "This was a painful decision that was made after leading LGBTQ advocates requested that the Council repeal our 2017 bill. Ultimately, I think this is the responsible, strategic, and right thing to do" (Ottaway,

2019; Rawles, 2019). It was reported that LGBTQ advocates were concerned that the Schwartz case could possibly go all the way to the U.S. Supreme Court.

Reconciliation and Growth

In 2013, a group of highly qualified therapists and academics from 'opposing sides' of the debate of banning therapeutic choice, joined together to produce *The Reconciliation and Growth Project* (Beckstead et al., 2017).

According to this report, the continued use of terms such as: "torture, abuse, hateful, reparative, conversion, sexual orientation change efforts, and 'affirmative' therapies" fuel adversarial tensions. Such terms obscure the common ground between diverse perspectives.

> The desire is to move beyond adversarial strategies and focus instead on *collaborative efforts* that will foster a respectful dialogue to "*facilitate individual self-determination*; and *do no harm.*
>
> The *ethical principle of self-determination requires that each individual be seen as a whole person* [emphasis added] and be supported in their right to explore, define, articulate, and live out their own identity" (Beckstead et al., 2017, p. 8).

The basic principles of Reconciliation and Growth are:

- First, and most importantly, the person *is not mentally ill.* We acknowledge that shifts in sexuality and gender identity can & do occur for some people.
- Secondly it is important to *accept that a person's desire to bring their life* into harmony with closely held religious beliefs may very well be their possible and desired outcome of treatment (Beckstead et al., 2017, p. 9).

Harm has been reported when highly religious or sexual and gender minority clients are *pressured to identify* one way or another. Clients should feel safe to explore the many relationship options available to them including heterosexual relationships & marriage, or celibacy (Beckstead et al., 2017, p. 13).

Faith identity and development is unique to each person. Assuming that all should believe a certain way, may damage the capacity for authentic faith expression in that person. Clients must not be restricted from pursuing their own healthy identity development. An integrated process will:

- **increase** overall mental health and functioning,
- **decrease** client distress, and
- **invite** the client to examine and modify unhealthy expressions of sexuality, gender, and/or faith (Beckstead et al., 2017, p. 15).

A good therapist will listen well as the client shares their history, their stories, and then help that individual make sense of their life.

The Devastation of Constructionist Theory

Why is there such a deep division of ideas and research? Social constructivism has dominated the humanities, influencing the current state of academia and subsequent research.

Social constructivism is a sociological theory of knowledge according to which human development is socially situated and knowledge is constructed through interaction with others (McKinley, 2015). Strong social constructivism as a philosophical approach, which is rampant in sociology and psychology, tends to suggest that "the natural world has a small or non-existent role in the construction of scientific knowledge" (Boudry & Buekens, 2011). This line of academic thought has directly affected the course of research in LGBTQ studies and is seen most aggressively in current research on gender dysphoria and the 'transgendered' child.

To consider any theory other than social constructivism as having validity is now considered heretical in the humanities. In fact, many who are health care workers have been silenced through an agenda of intimidation.

Gender Dysphoric to Transgender

While this paper has not delved into the ongoing research on the Gender Identity and Transgender movement, I do wish to present a summary of this issue. Currently emerging therapy bans are very precise in their conclusions that gender dysphoric (GD) and transgender individuals should not be exposed to "conversion therapy" as defined by activists.

According to the American Psychiatric Association's DSM 5 (2013), rates of persistence of Gender Dysphoria into adulthood are very low. Resolution of biological sex confusion occurs in up to 97.8% of boys and as many as 88% of girls (p. 455). This means that the vast majority of these children no longer continued to exhibit signs of Gender Dysphoria as adults.

What has happened in the last several years is the development of a new category of personhood: the Transgender Child or Adolescent. "Transgender" is not a scientific or medical term. It is an activist and political term that has gained incredible acceptance due to media representation along with an educational agenda to train children under the guise of acceptance and diversity. Such curriculum is now deeply ensconced in all levels of education and in each field of study (Biggs, 2019a, p. 18).

Teaching this material at young ages has literally changed the brains of our children. We now know that children are often confused by it, even to the point of changing their "identity" several times a day. Daily affirmation by trusted adults that a boy is a girl or a girl is a boy is likely to have a self-fulfilling effect.

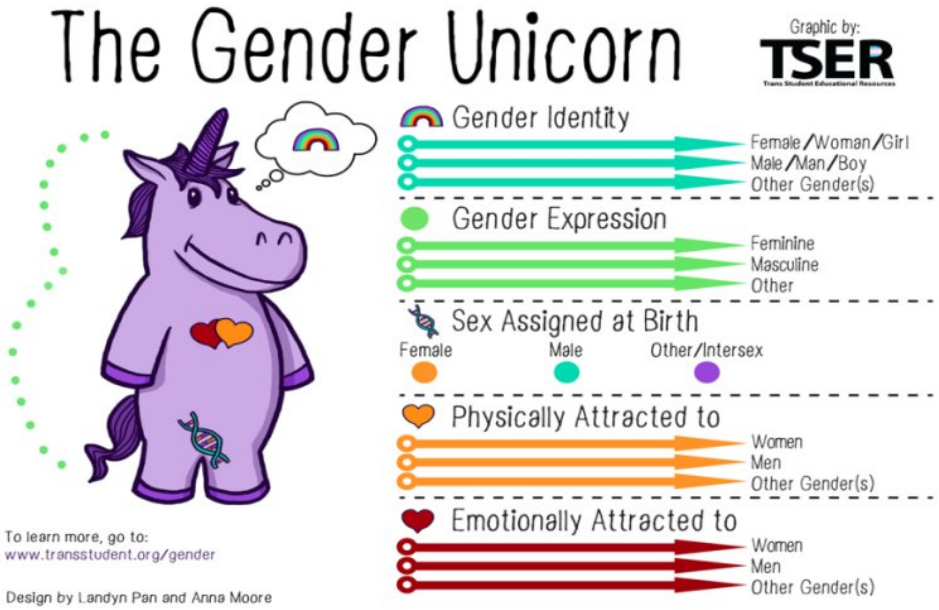
According to Barbara Kay of the National Post (2019):

> one Ontario family is asking a school board to ensure that lessons do not devalue, deny or undermine the female identity. The family filed a human rights complaint after their six year old watched two YouTube videos in school: "He, She and They?!?—Gender: Queer

> Kid Stuff #2." The video contained statements such as, "some people aren't boys or girls," and that there are people who do not "feel like a 'she' or a 'he,'" and therefore might not have a gender. The young teacher, whom I will refer to by her initials, JB, continued to teach gender theory throughout the semester. According to N's feedback to her mother, JB told the children that "there is no such thing as girls and boys," and "girls are not real and boys are not real.

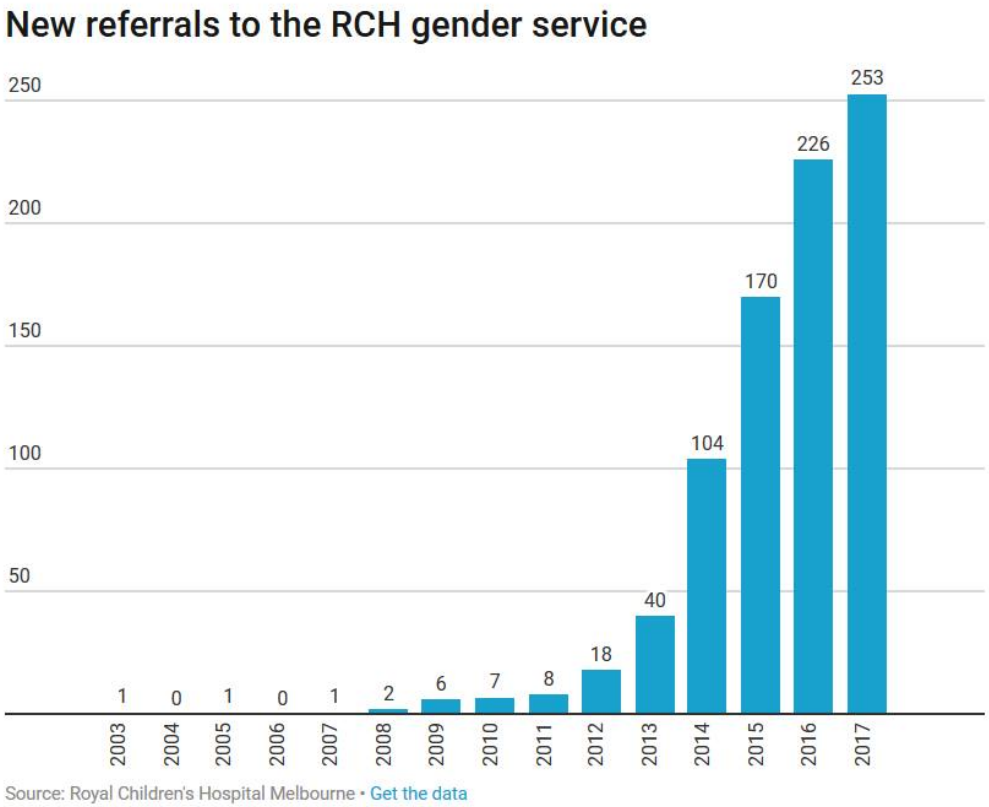
The child even asked her parents if she could go "to the doctor" to discuss the fact that she was a girl. The parents became alarmed by their daughter's confusion. She had never shown any signs of being confused about her gender before (Lawrence, 2019).

I would suggest Canadian children would benefit tremendously by minimizing such confusion rather than expanding it. We are now experiencing an *exponential* rise in the number of children and adolescents attending clinics either with a diagnosis of Gender Dysphoria or the claim of being transgender, which I believe is the outcome of teaching on gender diversity as identified below in the Gender Unicorn in our education system (Sikkema, 2017).



(*Gender Unicorn*, n.d.)

The following chart shows the rampant growth of referrals in one Australia hospital with a GD clinic from 2003 to 2017 (Hancock, 2018).



In the UK, referral rates for gender dysphoria rose exponentially between 2011 and 2018: 4,415%, for girls and 1,151% for boys.

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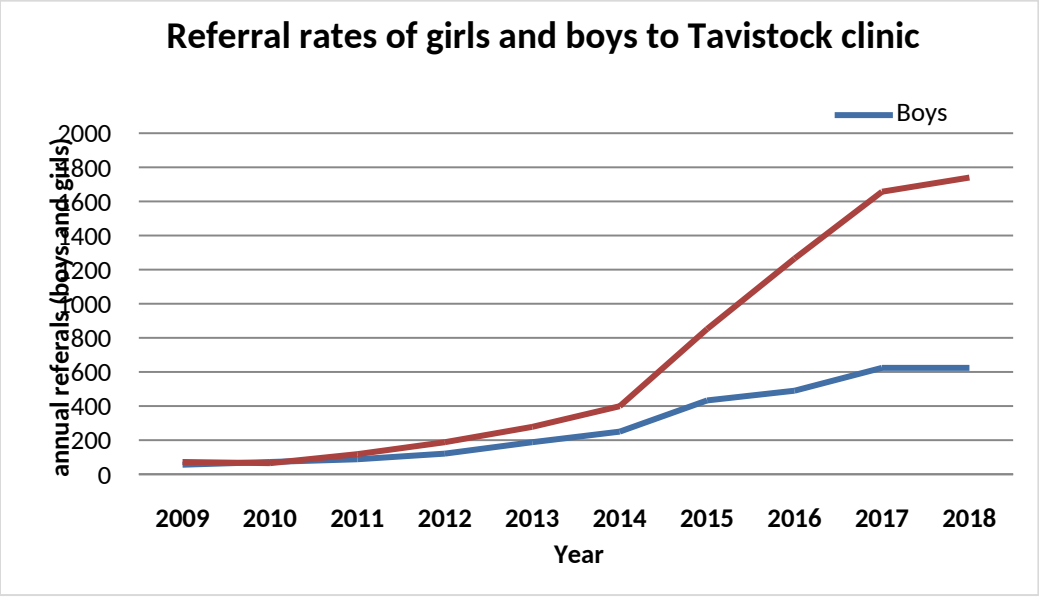


(Transgender Trend, 2019)

*Both charts above note the rise from 1 or 0 admissions prior to 2008, followed by aggressive growth of referrals since a "progressive" curriculum was implemented in elementary and high schools.

In 2018, CNSNews released a news report entitled "Transgender Kids in the UK: Number of Girls Jumps 4,415%, Number of Boys Rises 1,151%" (Bannister, 2018). It reports that, "In 2017, 800 children were given drugs to stall the onset of puberty, including some aged 10, with some also given hormones to start the process of changing sex; 45 children age six or under were referred to the UK's National Health Service (NHS) for treatment, with at least one being only four years old" (Bannister, 2018).

The UK's Government Equalities Office is looking into whether the influence of social media and the teaching of transgender philosophy by the educational system have contributed to the striking increase in referrals (Rayner, 2018).

The Tavistock Institute of Medical Psychology, the founding organization of the Tavistock and Portman NHS Foundation Trust, commonly known as the Tavistock Clinic, opened 100 years ago and is world renowned in its application of Psychoanalytic ideas to the study and treatment of mental health. The Tavistock Clinic's Gender Identity Development Service is the largest and oldest in the UK. In 2019, Marcus Evans, one of the governors of The Tavistock and Portman NHS Foundation Trust, resigned after accusing management of having an "overvalued belief in" the expertise of its Gender Identity Development Service (GIDS) "which is used to dismiss challenge and examination" (Doward, 2019).

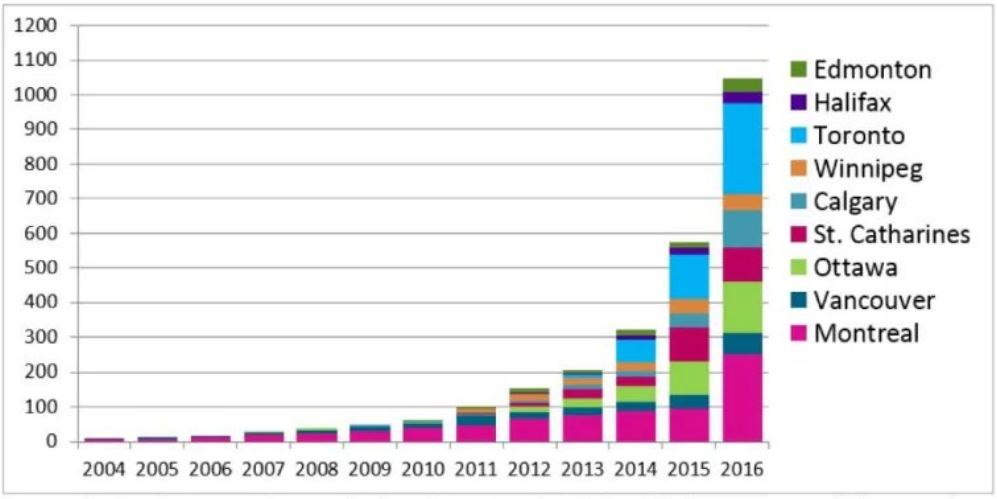
In December 2019, the UK National Health Service warned of over-diagnosing of children undergoing treatment for gender dysphoria. From 2017 through 2019, 35 psychologists resigned from London's Gender Identity Development Service (GIDS) at the Tavistock and Portman NHS Foundation Trust (Donnelly, 2019). "GIDS had 2,590 children referred to them [in 2018] , compared with just 77 patients a decade [previously]" (Lockwood & Lambert, 2019).

Carl Heneghan, director of the Centre of Evidence-Based Medicine at Oxford University asserts that, "Given paucity of evidence, the off-label use of drugs [...] in gender dysphoria treatment largely means an unregulated live experiment on children" (Dyer, 2019).

Developments in Canada appear to be following the same trajectory as data reported in Australia and the United Kingdom. For example, the Hospital for Sick Children in Toronto reports that the number of GD related referrals they are receiving has doubled since 2013. Stephen Feder, who co-directs the gender diversity clinic at the Children's Hospital of Eastern Ontario, explained that it is getting hard to keep up with the increasing demand his clinic is seeing. About a decade ago, Feder said his hospital would perhaps see one or two patients each year struggling with gender dysphoria. In 2018, over 189 patients were referred to the CHEO gender clinic. This clinic serves patients living in eastern Ontario and western Quebec (Smith, 2019).

The following chart from Trans Youth Canada is broken down into Gender Dysphoric referrals by clinic across the country.

Pediatric patient referrals to specialist clinics for hormone treatment for gender identity issues: 9 Canadian clinics



* Some referral numbers estimated. Some referrals are for prepubertal youth, though blockers are not prescribed prior to puberty.

(Bauer & Lawson, 2017)

These reports seem to indicate the exponential spread of Gender Dysphoria and claims of Transgender identity. While not in the same category as a contagious disease, I would suggest that this ascending trajectory can be considered a social contagion.

The Endocrine Society's guidelines for treating gender dysphoria suggest starting puberty blockers for transgender children when they hit a stage of development known as Tanner stage 2, which usually occurs around 10 or 11 years old for a girl and 11 or 12 years old for a boy. The same guidelines suggest giving cross sex hormones—estrogen for transgender girls and testosterone for transgender boys—at age 16 (Hembree et al., 2009). The Canadian Medical Association Journal has published a review article urging doctors to prescribe hormone blockers to "trans kids" as young as 10 years old (Kirkley, 2019).

The current approach by mental health and other medical associations in the West to the treatment of Gender Dysphoria in children and adolescents is to affirm their patients' perceptions as reality. Guidelines provided by The World Professional Association for Transgender Health (WPATH) are part of a commitment by medical associations in Canada, the US, and the UK to 'affirm' a child's thinking that they are in the wrong body, supporting the highly experimental use of medications for physically healthy children. These guidelines ignore decades of solid research on child development, as well as sound psychological interventions that act in the best interest of the child, parents, families, and society. Without thorough mental health assessments, comorbid conditions such as Asperger's Syndrome, child abuse and neglect, early childhood trauma, disorganized parental attachment, etc., that have been discovered to be associated with Gender Dysphoria (formerly Gender Identity Disorder), teens are left untreated, thereby creating greater dysfunction and increasing the risk of suicidal ideation. These children will be started on experimental medical interventions that have probable lifetime implications and many unknown risks. Hormone replacement medications will need to be taken for life, in order to maintain the appearance of the opposite sex. Sex reassignment surgeries are sometimes unsuccessful, and the

person may find themselves having multiple surgeries to get the effect they wish. These of course continue to come with a high psychological, emotional, physical, and financial cost.

Flawed Research?

In the early 2000s, the National Health Service (NHS) of Britain was seen by gender specialists worldwide as a conservative outlier, offering puberty blockers only to young people aged 16 or over. Recognizing a weak evidence base for prescribing puberty blockers for children, the British Society of Pediatric Endocrinology and Diabetes recommended earlier use of puberty blockers, but only as part of a research study (Cohen & Barnes, 2019).

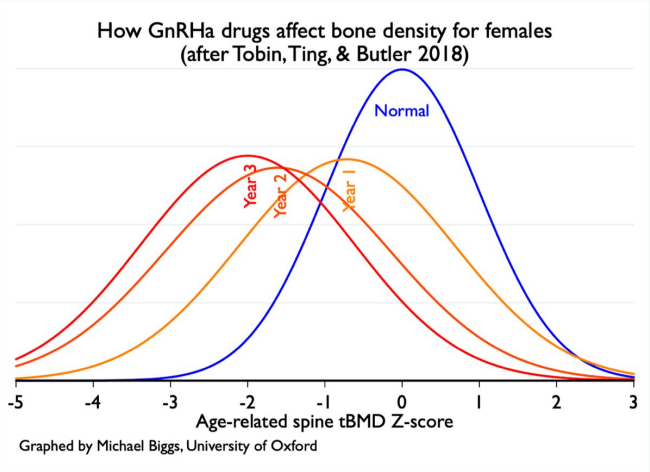
"In 2010 GIDS and University College London's Institute of Child Health applied for ethical approval to conduct a cohort study offering puberty blockers to a 'carefully selected group of adolescents; with gender dysphoria in early puberty" (Cohen & Barnes, 2019). This study has come under much criticism, with critics alleging that the "researchers had downplayed interim findings that might suggest increased suicidality" (Cohen & Barnes, 2019).

In 2014, just after the London study "had finished recruiting participants, NHS England approved policy changes to permit GIDS to offer puberty blockers as described in the study protocol, following evaluation" (Cohen & Barnes, 2019). In addition to lowering the age limit from 16 to 12, as per the study, puberty blockers could now also be considered for children under 12 in established puberty. The NHS declared that the policy was changed on the basis of "international evidence and clinical expertise" (Cohen & Barnes, 2019). Following this change, the director of the Tavistock Gender Identity Disorder Service stated, "The results thus far have been positive" (Manning & Adams, 2014).

In 2019, new allegations became known demonstrating that researchers might have broken rules when seeking ethical approval. "Michael Biggs, an Oxford University sociologist, used freedom of information requests to obtain the early intervention study's protocol and information sheets for young people and parents, and alleges that the GIDS has suppressed 'negative' data" (Cohen & Barnes, 2019). Biggs (2019b) concluded that the 2010–2014 data from GIDS showed:

> no evidence for the effectiveness of GnRHa [a puberty blocking drug]: there was no statistically significant difference in psychosocial functioning between the group given blockers and the group given only psychological support. In addition, there is unpublished evidence that after a year on GnRHa children reported greater self-harm, and that girls experienced more behavioural and emotional problems and expressed greater dissatisfaction with their body—so puberty blockers exacerbated gender dysphoria.

Of further concern, Biggs found that follow up has not been possible because transgender activists successfully lobbied the NHS to provide new health record file tracking numbers to patients and to change the 'gender' on their medical records. Biggs indicates the effect of puberty blockers on the bone density of females as shown in the graph below:



(Biggs, 2019a)

Of the children placed on puberty blockers in the Dutch clinic that pioneered this treatment, every single one of them persisted in their transgender identity. For them, taking puberty blockers and then cross-sex hormones led to irreversible infertility (Greenall, 2019). "Puberty blockers have not been certified as effective or safe in the treatment of gender dysphoria by the National Institute for Health and Care Excellence (NICE) or their manufacturers. They remain an experimental treatment, but new prescriptions were recently running at 300 per year (Greenall, 2019).

Experts are extremely wary of speaking publicly for fear of reprisal, although they noted that the London study had no control group, outcome measures were not well defined, and there was no definition of what would constitute a serious adverse event (Cohen & Barnes, 2019).

Many people with Gender Dysphoria continue on with sex reassignment surgery, but a 2011 Swedish study (Dhejne et al., 2011) concluded that "Persons with transsexualism, after sex reassignment, have considerably higher risks for mortality, suicidal behaviour, and psychiatric morbidity than the general population. Our findings suggest that sex reassignment, although alleviating gender dysphoria, may not suffice as treatment for transsexualism, and should inspire improved psychiatric and somatic care after sex reassignment for this patient group" (p. 2).

Not only are these individuals in need of lifelong hormone therapies, but longitudinal studies show that reassignment surgeries do not reduce suicidality or alleviate psychiatric comorbidities.

While ignoring decades of successful treatment using wait-and-see or psychotherapeutic techniques, the risk is that teens will be started on irreversible medical interventions that have lifelong implications and unknown psychological and physical risks. Those who regret transitioning are increasing in number, and many are beginning to speak out (Transgender Trend, 2019).

Multifactor Influencers in Gender Dysphoria

As with homosexuality, there seem to be multiple influencers in the sexual development of children diagnosed with Gender Dysphoria (Zucker, 2004; Zucker & Bradley, 1995).

Affirmation only therapy has become the only acceptable therapeutic treatment in Canada. This inception of this policy resulted in the firing of Dr. Ken Zucker from the Canadian Centre for Addiction and Mental Health in 2015 (Anderssen, 2016; Singal, 2016). Zucker, one of the forerunners and most respected clinicians and researchers on children experiencing Gender Dysphoria had been treating this population successful for 30 years.

Successful therapies practiced up to 2015 (see Zucker, 2004; Zucker et al., 2002) which that employed a 'wait-and- & see' method and helped the child identify with their biological designation showed a success rate between 80 and 97%. Such a success rate for any therapy is astronomically high in the field of psychology. There was no need for puberty blockers or hormone therapy or subsequent surgeries. These children did not risk infertility, increased suicidality, and the multiple other health risks associated with puberty blockers and hormone therapy. 'Conversion therapy' in this sense was extremely successful. But wherever conversion therapy bans are enacted, this treatment becomes illegal.

There are many complexities that therapists treating gender dysphoric children and youth need to be apprised of in order to effectively help the individual and family.

Presently, there is little to no openness in psychological and other medical associations to discussing the co-morbidity of mental health conditions that exist with regard to Gender Dysphoria, but this unwillingness to discuss comorbidities does not negate their existence.

A serious consideration is the potential link between Autism Spectrum Disorder (ASD) and gender dysphoria that was noted by researchers as early as 1981, when they recognized that 10% of 30 children with a clinical diagnosis of autism had trouble answering a gender identity question ("Are you a little boy or a little girl?") that fewer than 1% of neuro-typical children of the same age struggled with (Vrangalova, 2017).

Gender Dysphoria and Autism Spectrum Disorder are rare conditions. Both conditions indicate low population prevalence rates "between 1 in 10,000 and 1 in 50,000 individuals exhibiting GD" (Zucker & Lawrence, 2009, p. 8). According to Blumberg et al. (2013) between .2% and 2% of people exhibit ASD. Significant increases in both conditions have been reported since 2007. "The magnitude of the increase was greatest for boys and for adolescents aged 14–17" (Blumberg et al., 2013, p. 1). These adolescents are most likely those with Rapid Onset Gender Dysphoria.

It was not until the 2010s that more systematic research on this topic began to emerge. Nine larger-scale studies have been published in medical and psychological literature, from the U.S., the UK, Canada, Finland, and the Netherlands, that identify Autism Spectrum Disorder (ASD) as a contributor to gender dysphoria (Vrangalova, 2017). Across these studies, almost without exception, rates of ASD or autism traits range from 5% to 54% among those with gender dysphoria, significantly higher than among the general population (Vrangalova, 2017).

The APA's 2014 *Handbook of Sexuality and Psychology* confirms that there may be evidence of a relationship between psychopathology and the development of transgender identity (Bockting, 2014b). The use of puberty blockers and hormone therapy has been criticized. In the past, some specialists have preferred either a wait-and-see approach or biological affirming therapy (Zucker, 2004, 2018; Zucker et al., 2002; Zucker & Bradley, 1995). Yet, the only clinically sanctioned treatment now available for children, adolescents, and adults in Canada who self-determine their identity, is to affirm this new identity. Clinicians are prescribing puberty blockers and hormone therapy without exploring personal attachment and abuse histories, childhood traumas, or other kinds or concurrent pathologies caused by such traumas.

I believe that the rise in gender transitioning is just the beginning, as new Gender Clinics are opening to keep up with the new demand for service across North America. The continuing escalation of the diagnosis and treatment of children as gender dysphoric or transgender would be considered an epidemic if it were regarding any other health issue (see Marchiano, 2017). This trend definitely needs sound scientific research without the present and ongoing pressure from academia to suppress such studies. According to Butler and Hutchinson (2020), there is now a pressing need for research and services for gender desisters/detransitioners.

Positive Developments in the UK

In the spring of 2020, the UK moved to ban sex reassignment surgery to change the gender of children (Swerling, 2020). The new rules will protect the wellbeing of those under 18. This happened as Britain's National Health Service set in motion a review of puberty-blocking drugs and the rules pertaining to when youth are allowed to begin gender-transitioning and comes on the heels of the previously mentioned 4,440% spike in Gender Dysphoria cases and the resignation of 35 psychologists from the Tavistock Clinic due to their concerns regarding initiating gender affirming treatments and medications too quickly.

The Minister for Women and Equalities also informed the House of Commons that "additional protections for female-only spaces are coming, such as changing rooms, women's refuges, and restrooms."

The Threat of Repressive Social Justice

Most university officials, professors, and students have embraced a political ideology called social justice, identifying categories of people based on race, gender, sexual preference, ethnicity, and/or religion (Salzman, 2018).

Instead of unifying the populace, current social justice philosophy has increasingly divided groups of individuals according to their level of oppression. The concept of Intersectionality stems from the overlap of social identities, such as race, sex, gender, socio-economic status, which are determined to contribute to oppression and discrimination. While the initial intent of dividing people according to these overlapping groups may have been honourable, what has actually transpired is the creation of a victim mentality.

Offences are bound to come to each one of us. Dealing with offence by radical suppression of free speech in order to provide protection from offence is unproductive. Only in an open and honest dialogue without viewpoint discrimination can there be improvement in relationship, either on a personal or collective perspective

For two millennia, Christian compassion has championed the cause of the downtrodden based on the conviction that we are all created in God's image and equally precious to Him. Instead of stimulating division, this principle worked to create equality between individuals and groups.

In an attempt to provide a venue for free speech, the Provincial Government of Ontario mandated Ontario universities to introduce a Free Speech Policy by January 1, 2019 (Jeffords, 2018). "Colleges and universities should be places where students exchange different ideas and opinions in open and respectful debate. Our government made a commitment to the people of Ontario to protect free speech on campuses," stated the Premier (Office of the Premier, 2018).

"Students and student groups must be free to challenge and criticize views with which they disagree, but they must not, under pain of disciplinary punishment, interfere with the freedom of others to express their views. These principles apply to faculty, students, staff, administration, and guests, and universities are responsible for compliance" (Salzman, 2018).

When McGill University anthropology students were asked whether they favored human rights, (as set out by the United Nations Universal Declaration of Human Rights, endorsed by almost all countries in the world), or cultural relativism, which takes the view that all cultures are equally good and valuable and that no judgments should be made across cultural boundaries, the students overwhelmingly favored cultural relativism (Salzman, 2018).

Cultural relativism has had a devastating impact on the minds of students over the last several decades. According to Barone (2018), "College and university campuses have been transformed over the past half-century from the zone of our society most tolerant of free speech to the zone least tolerant. A recent poll of college students found that just 35 percent of women favor free speech over inclusion and diversity."

Social justice theory, along with the prevailing ideas on intersectionality, seems to converge with the issue of conversion therapy in an unlikely manner. Individuals struggling with unwanted same-sex attraction, behaviour, identity, or orientation are not considered oppressed in the manner of other LGBTQ individuals.

Discussion

There is much anger and division between various groups under the LGBTQ umbrella. LGBTQ individuals who choose to re-identify as heterosexual are habitually maligned and ostracized by many within the LGBTQ community. For example, many bisexuals feel marginalized by gay and lesbian voices; lesbians are expressing great concern with transgender activists; and those with unwanted same-sex attraction who seeking help may soon be left without options of care. They may be able to identify as bi-sexual without repercussions, but if they are unwilling to continue in a same-sex manner, they are quickly ostracized.

Consider these words from a feminist lesbian, who recently spoke out about what she calls the "Hive minded radical left." She says, "Anyone who goes against the grain and thinks for themselves is immediately outcast. That's not a community: That's a hive-mind cult." "The atmosphere has become so intolerant that some leftists insist she is bisexual — and not a lesbian — because she once dated a woman who later declared that she had become a transgender man" (Scarcella, 2020).

Scarcella continued, "I don't believe that general preferences are transphobic or that there are 97 genders. I don't think that male sex offenders belong in the women's prisons. I don't think it's normal for people to be praised for walking around with shirts that say kill TERFs. Never in my life have I been more canceled, tortured, tormented, harassed than by members of my own community. Never have I witnessed literal mentally ill individuals who are latching themselves onto the LGBT community without actually being LGBT for the sake of oppression points, external validation, and sympathy" (Biles, 2020).

These observations need to be acknowledged. They are deeply concerning when we consider the probable suppression of those within the LGBTQ community who seek therapy for unwanted same-sex attraction – *anyone who thinks for themselves is an immediate outcast!*

Certainly, there are many academics who would agree with these three statements:

- that homosexuality is biologically innate,
- that psychologically it is irreversible, and
- that sociologically it is a "normal" state.

Yet research has shown that these statements are inaccurate. How do we then deal with such opposing views? We must shine a light on what research (and testimony) have acknowledged. Autocratic statements of dogma that CT *never* works and is *always* harmful contradict both the scientific method and the weight of significant evidence.

There is a pervasive lack of viewpoint diversity within professional organizations in regard to sexual orientation research that has led to abandonment of the practice of sound scientific discovery within same sex research.

Ideas shown throughout this paper:

1. There is substantial evidence that sexual attraction, experience, orientation and even identity may be altered or changed either spontaneously or through change therapy.

2. Therapy that is open to change is generally not a particular form of therapy, but rather openness to the client's freely chosen goal to reduce or change sexual thought, behaviour and orientation using any contemporary form of therapeutic technique. Modern licensed mental health professionals do not use coercion or aversive methods. If any exceptions occurred, licensing boards would address these issues (Haynes, 2019).

3. Sexual orientation is not immutable, unlike skin color. Sexual orientation is not resistant to change. The American Psychological Association recognizes same-sex orientation change through natural processes.

4. Change from exclusively homosexual attraction to exclusively heterosexual attraction occurs frequently among adolescents (Udry & Chantala, 2005).

5. The American Psychiatric Association and the American Psychological Association recognize that gender identity fluctuates for the vast majority of minors.

6. Immutability arguments marginalize those who do not experience a fixed sexuality.

7. For homosexuals wishing to function heterosexually, change is a worthwhile aim, but as with many longstanding unwanted behaviours, homosexual orientation can be difficult to change.

8. Attachment theory has long recognized the need for early childhood trust and security in the parental or caregiver relationship. Trust can be disrupted in many ways, especially through childhood sexual abuse. Other threats to secure attachment include neglect, rejection, physical abuse, or sudden loss (especially of a parent). Each of these disruptions of trust has been found to be highly correlated with same-sex attraction.

9. There is highly credible scientific evidence that childhood sexual molestation is linked to same-sex orientation (Francis, 2008; Frisch & Hviid, 2006; Udry & Chantala, 2005).

10. The most current research disputes the claim that SOCE is ineffective or harmful (S. L. Jones & Yarhouse, 2011; Santero et al., 2018; Sprigg, 2018). Efforts to change unwanted homosexual attractions are not generally harmful according to many who have experienced change therapy or received spiritual guidance for unwanted SSA.

In summary, researchers need to investigate pre-existing traumas, suicidal ideation, and mental health conditions of those claiming that therapy has caused traumatic conditions. In summary, there are many issues regarding the APA's position on immutability that need to be further explored. The Task Force chosen to bring understanding to the issue of 'conversion therapy' definitely seems biased, as Dr. Laura Haynes explains:

> The APA task force Chair refused expert change-allowing clinicians and researchers who offered to serve on the Task Force and chose LGB professionals who were already committed to the conclusions based on political or philosophical grounds. I am a first-hand eye witness. I, and other of my colleagues, personally wrote to the Chair of the APA Task Force and asked her to include on the Task Force clinical and research experts who actually did change-allowing therapy. And I, among other of my colleagues, received a personal letter from her refusing (Haynes, 2018, p. 59).

The denial of evidence for SOCE by the APA and other organizations needs serious investigation. Repeated retractions of sound research point to a much wider issue occurring within humanities research, that of political involvement and maneuvering.

Conclusion

In this paper, I have sought to explore some of the research suggesting that same-sex attraction, thought, behaviour, identity, and/or orientation can be changed. The objective of this paper was to review SOCE studies in order to ascertain if any change is possible, if the threat of harm from SOCE is substantive, and if APA claims are unwarranted. What research has shown is that change is possible and that many people have found the help they sought and did not suffer harm.

Although a century of such studies have been produced, both for and against SSA change therapy, there remains a deep divide between those who suggest SSA can be changed and those who deny that such individuals can choose chastity or heterosexuality through therapy.

The fact remains that some individuals have changed their sexual preferences, a little or a lot, either by spontaneous choice as shown in the National Longitudinal Study of Adolescent Health Study, or by choosing to address their unwanted SSA in counselling or through religious practice.

An important issue that has been raised is the question of whether personal stories of those who report success in therapy be trusted. Each person's story is their own. Whether it be a story of success in reducing unwanted same sex attraction, or of failure in doing so, each should be considered equality valid. Failure of outcome does not equate to failure of therapy.

It is difficult to ascertain how future research in this area will continue, given that the APA and CPA both actively discourage therapists from administering therapy to clients seeking change of SSA. The ability to choose the type of therapy or counsel desired should be considered fundamental to client autonomy and self-determination.

Future research needs to draw on the expertise of those who research and practise- in the area of change therapy, including therapists, ministry leaders, and the participants themselves, bringing conclusions based on clinical experience rather than just select participants' perspectives.

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Appendix

The following pages contain a few personal stories of individuals who have successfully changed their sexual orientation through SOCE. Many more such stories can be found at www.oncegay.com.

My Secret War
Bob Davies

Outwardly, I was a mature and stable Christian. But a secret war raged within that threatened to destroy me.

The attic room was hot and stuffy, but the pounding of my heart wasn't due to the temperature. I was reading a small paperback for teens on the "facts of life," and the contents of chapter 10 filled my 14-year-old mind with dread.

"Do you have attractions to members of your own sex?" the book asked, then described the symptoms of something called "homosexuality."

All these symptoms apply to me, I thought. I must be homosexual. Horrified, I immediately made two decisions: I would never tell anyone about my discovery. And I would pray desperately that somehow I could "outgrow" these feelings.

Prayer, daily Bible reading and weekly Sunday School attendance were ingrained habits. So how could I have this problem?

Rather than seeking help, I hid my fears, withdrew from everyone, and eventually quit going to church. Why bother, when God seemed irrelevant to my deepest needs?

While studying at the University of British Columbia, I checked out books on homosexuality, and learned of the large gay subculture in many North American cities. Curious, I began visiting adult bookstores and reading homosexual magazines to feed my illicit desires. Only guilt and fear kept me from pursuing sexual relationships with other men.

That summer, I visited my older sister in northern B.C., and soon was employed in the local lumber mill. When she invited me to her small church, I readily agreed. After all, it was a good way to make friends. The people were genuinely warm and when I returned the next summer, the dying embers of my faith were burning brightly again.

Following the example of several church friends, I decided to enrol at Prairie Bible College in Three Hills, Alberta. Arriving on campus in September 1971, I plunged into a full schedule of classes and found them fascinating. For the next three years, I was changed by the constant diet of God's Word, both in the classroom and in my private study.

God began a deep work in my life. I arrived on campus as a withdrawn introvert. But, through my part-time job in the campus post office, God me good friendships with more men than I had known during my lonely years of high school and secular college. But I never told them about my on-going war against homosexual temptations.

Two years after graduation, I attended a "Youth With A Mission" training school in Germany. After the six-month program, I prayed about my future. How did God want me to serve Him?

One morning during prayer, I "saw" myself back home, handing out tracts in front of Vancouver's largest gay bar. My heart sank. "No way," I moaned inwardly. "I'll do anything except that!"

Trying to escape the call of God, I began training to enter medical missionary work, pushing away occasional doubts. Then, in September 1978, I heard a testimony that changed my life. A speaker at church shared his story of years of overseas ministry and many people won to Christ. "God," my heart whispered, "I want my life to count for You just like his."

Then came God's challenge: "Are you willing to pay the price?" I knew God wanted me to fully surrender my confused sexual identity to Him. Despite years of church attendance, a Bible college diploma, and overseas missions experience, I still struggled with wrong same-sex desires. And they were getting worse.

For the next 24 hours I hardly ate or slept, wrestling with the Lord like Jacob. Finally, too exhausted to fight anymore, I said, "God, You win. Do whatever You want with my life."

Though terrified of facing my homosexuality, I wrote Love In Action, asking if I could visit this ministry in California that helped Christian struggling with homosexuality. I then told my family and close friends of my battle. "I feel God is calling me to California to get help," I explained. Although they were shocked, they were also supportive.

Arriving at Love In Action in June 1979, I planned to stay for the summer, then return home to resume "normal" life. Soon, I was volunteering in the office, helping the staff keep up with hundreds of inquiries for help.

That summer I made some startling discoveries. I realized that, because of my own sexual struggles, I could give meaningful support to fellow Christians facing similar battles. And because I had never fallen into homosexual behavior, I could offer valuable insights on perseverance and spiritual warfare. I often felt inadequate, but I had never experienced such exciting and fulfilling ministry.

Months passed. God continued year. Before long, I realized that my life had taken a permanent turn. I began editing the ministry's monthly newsletter, writing new literature, and speaking at local seminars.

Months passed. God continued my emotional healing as I openly confessed struggles with insecurity, fear, and envy of other men. The unconditional love of my church was also crucial to my growth especially support from "straight" men. These friends did not necessarily understand homosexuality, but they understood the power of God.

In 1984, restless, sensing that god had something more for me, I began dating Pam, a woman in my church. From the beginning our relationship was special. One day she sent me a card with the verse: "O Lord...you have worked wonders, plans formed long ago, with perfect faithfulness" (Isaiah 25:1), and we made an amazing discovery. Pam had been praying for her husband-to-be since September 1978 - the very month I had yielded my homosexual struggles to the Lord!

Since our wedding on August 24, 1985, God has continually used my wife to bring further growth and affirmation into my life. I can never take our marriage for granted years ago I never dreamed that someday I would be married. My relationship with Pam is a great gift from a loving God.

As the pro-gay message continues to infiltrate the media, there is an increasing urgency to spread the truth that God has the power to change any individual, including the man or woman struggling with homosexuality. I am just one example of His awesome power. Truly there is nothing too difficult for God.

Secure in my Feminine Identity
Anne Paulk

"Here's a set of keys to my car," Sara said, tossing her blond, mid-length hair. "Anne, you can drive it anytime."

"Gosh, thanks!" I answered, wondering again why Sara had chosen me to be her best friend. From the time we first met in college, Sara had shared her deepest thoughts and secrets with me. And she remained committed to our friendship--in contrast to the men she casually tossed aside every few weeks.

Sara was rich, beautiful, and had gorgeous men clamoring after her. She seemed like the all-American beauty queen, confident and secure in her femininity. I felt exactly the opposite. I had grown up as a real "tomboy," mostly playing cowboys and Indians or cops and robbers.

When I was about 4 years old, an event had happened which profoundly shook my inner security. A teen-age boy approached me sexually, then warned me not to tell my parents. I never said a word, fearful that we'd both get into big trouble. The silence left me to reap a lot of self-inflicted pain, and the whole incident only reinforced my tomboy image. I didn't feel protected or valued as a girl.

I also craved special affirmation as a girl from my dad, but couldn't tell him why. And for years, I believed lies about myself, God, and men. The sexual experience also kept me from embracing femininity which, to me, meant being weak and vulnerable.

Then I found myself having crushes on some of my girlfriends. I was talented at athletics, so I joined the softball team in high school, but continued to avoid most feminine activities. I didn't feel pretty or lovable.

During high school, I began receiving attention from an attractive girlfriend, and I felt a strong sexual pull toward her. But I had just read about Sodom and Gomorrah in my Bible, and felt convicted that it would be wrong to act on those feelings.

At church, the youth group seemed shallow. I felt disappointed that everyone behaved just like the non- Christian kids at school, and I became disillusioned. Soon I discarded church altogether, and began getting into wild behavior: drinking, dating three boys at one time, and eventually exploring homosexual relationships.

Then I went to college and met Sara. She seemed so confident and strong as a woman. Men adored Sara--but they only seemed to ridicule and use me. It was then, in early 1982, I realized my feelings for Sara were sexual, just the way I imagined that men desired women. So I decided to look up an old boy- friend to "test" my orientation. Although he was a nice guy, I felt no attraction for him. After that, I decided to pursue my attractions for women. At the suggestion of a gay counselor, I even joined the college gay/lesbian rap group.

But during one of those meetings, I had a piercing thought: There really is something wrong with this lifestyle. I was heartbroken by the words that shattered my dreams of finding happiness with a female life-partner. After the meeting, I went home and cried. "God," I prayed, "please show

me who You are, and fill the void in my heart."

After that prayer, I began experiencing a new hunger to know Jesus. Within six months, I made a firm decision to forsake homosexuality and follow Jesus Christ.

Unfortunately, none of the Christian leaders on campus or at church knew how to give me hope that my sexual attraction for women would change. And, at a 1984 missions convention, I heard a speaker give a message about sexual purity. In one comment, she excluded those struggling with homosexuality from ever being married. Am I doomed to a celibate and lonely life? I wondered in despair.

Later, I found a book at the local Christian bookstore, written by a former lesbian about her life story. But, by the final chapter, she seemed to have made little progress, resigned to a life of continual lesbian temptations. I felt depressed at the thought of following in her footsteps.

But my commitment to Jesus Christ enabled me to persevere in the face of these discouragements. I immersed myself in Christian activity, although the homosexual attractions never went away.

In 1986, God disciplined me by separating me from my best friend, with whom I had an emotionally unhealthy relationship for three years. I was crushed. "How can You do this to me, Lord?" I cried in frustration. "You don't know how much she means to me."

I was mad at God for a whole year, which led to a sexual relationship with Laura, another Christian girlfriend who struggled with lesbianism. Both Laura and I looked to each other for emotional fulfillment. At first, it seemed like many of my childhood dreams were being fulfilled through our relationship. But along with some satisfaction came conviction, deception, and emotional instability.

Laura became my top priority over work, my parents, and other friends. Other areas in our lives suffered as a result. Laura even battled with suicidal thoughts. Once I thought she was going to kill herself. I was terrified.

Laura and I even tried to remain friends, but stop the sexual part of our relationship. Of course, it never worked because we never addressed the underlying issues.

Finally, after three months of resisting God's conviction, I said a very honest prayer: "Lord, You know that I really enjoy this sin, but I want You to be my first love. I need Your help. I need You to change my heart. I can't fight this alone." It was the summer of 1987, and a major turning point had come in my life.

Shortly after my prayer, Laura talked me into having dinner in San Rafael with a Christian woman who was a former lesbian. Patty Wells listened to our questions, then gently shared the truth with us. After dinner, we took Patty back to her house where there was a support group meeting for Love In Action. I was really impressed with the understanding and wisdom of the leaders.

About two weeks later, my Christian leaders found out about my lesbian relationship with Laura. Even in the midst of being disciplined, I knew that my leaders really cared about Laura and me.

They acted in love and I respected them. Laura and I agreed to give our relationship to God and avoid all contact with each other.

But I was still frustrated and angry about the whole thing. "Lord, why do You always take away what is most valuable to me?" I fumed. "I only feel loved by one person, and that's Laura. Now I'm all alone again." Soon I was sobbing with overwhelming feelings of loss.

To fill the gap in my life, I shared what was happening with members of my Bible study group. I also returned to the Love In Action meetings, and went every week for the next 18 months.

The insights I gained through LIA were incredibly valuable. Finally, I was seeing underlying issues in my life that were so relevant to my struggle against homosexuality, such as forgiving my parents, grieving the loss of former lovers, and learning about emotional dependency.

I also saw the lives of women in the live-in program change almost before my eyes. These women were wrestling with tough areas in their lives, but I saw victory and healing. I decided to apply for the next program.

One night during the fall of 1988, as I anticipated being part of the 1989 live-in program, I heard a quiet voice: "I will heal you, Anne." At first I thought I was day-dreaming, but then I realized it was the Lord speaking to me. His voice was not dramatic, but the words were spoken with quiet authority.

The 1989 program was quite a challenge! A full year is a lot of time to invest, and I entered the program with high expectations of new spiritual growth. And I was not disappointed. Living with five other people amidst dis- agreements, misunderstandings, and different irritating habits is enough to make anyone grow!

The teachings shared during group meetings were helpful, but the Lord used our relationships to really teach us new life lessons and godly patterns of communication.

For example, when the program began, I struggled with attractions to one of the other women. But I became accountable to my house-leaders and soon the wrong desires faded. I learned how to look for patterns in my same-sex attractions, so I could understand the underlying needs which sparked the temptations in the first place.

After the program, my growth continued. At one point, I found myself seeking emotional comfort from one of my roommates. Eventually we almost fell into sexual sin. After that, I spent a lot of time with God, feeling very remorseful about my close call. I mourned inside for several months until finally the Lord broke through with His love. One day at work, my manager forgave me for a mistake I'd made, and suddenly I realized that God had also forgiven me for my other failings. I went to the bathroom and cried tears of relief for a long time.

The following months were filled with joyful intimacy with God. Something had changed deep inside of me. I realized that the Lord had truly changed my sexual identity from ex-gay to godly woman. I was learning that God loved me with a gentle delight, especially when I relied on His strength.

During this time, I found myself having a new interest in men, and began spending time with

them in group situations. Then, in mid-1991, I began dating John, a man in my church. At first, we were so different that our friends said, "John and you dating? What?!" But after seeing us together over time, everyone fully endorsed our relationship. As our friendship deepened, we also met with our senior pastor for counseling.

On December 31, 1991, John presented me with a ring and asked me to marry him. After I said yes, I kept looking happily at the ring, thinking, Wow! Me married! It was a very special moment. Our wedding the following July was a great celebration. I was filled with joy as God established something so beautiful and holy in our lives.

Since then, God has used John to comfort me and to confront areas of distrust in my life. This has been difficult, but the Lord has been faithful to fulfill His promise to heal me, even when the process is uncomfortable.

John and I spoil each other with cards, flowers, and daily calls to each other at work. Some of my co-workers affectionately tease me, making kissing noises in the background when he calls! But they enjoy seeing our genuine love for one another.

I am so glad that my Father took the time to unearth the hurts that held me back from growing into godly femininity. Now I don't need to compare myself to other women and seek to gain femininity from them through emotional dependency or homosexual relationships. My identity is secure as a woman in Christ.

Of Decay and Redemption: One Couple's Story
By "Beth Andrews"

From the outside, everything looked nearly perfect. We were "active" members in our church, attending weekly Bible studies and volunteering for leadership roles. We were outwardly successful, with all the trappings of suburban life. We were visibly considerate and loving to each other, popular with a large circle of friends. Outwardly, everyone we encountered saw two happy, successful people with an enviable married life. At least one couple sought our advice on rebuilding their own marriage, which was filled with emotional pain. As long as Rick and I didn't talk to each other about what was missing, it seemed reasonable to continue believing that everything was OK. But decay was there, like a dead squirrel in the middle of our tidy living room.

Then one autumn afternoon, my life came crashing down. I entered the room where we kept the family computer and saw something I had never imagined. Our children were walking in back of me and I nearly knocked them over like dominoes as I pushed them out of the room. Rick hurriedly closed down the program, but not quickly enough to stop me from recognizing Internet pornography on our computer screen. Perhaps there was indeed a stinking carcass swept under the rug of our lives.

Immediately, my emotions spiraled downward. My first thoughts were, "Why would Rick need to look at pornography? Aren't I enough for him?" Then I found myself wondering, "Exactly who is this man?" I was repulsed at what I saw on that screen, but as usual I did not want to confront this difficult situation. The carcass I discovered was puzzling, but maybe it wasn't so big or nasty after all. I decided that this fixation of Rick's would probably just go away.

Unfortunately, it did not.

My husband's thoughts and emotions were also spiraling downward. Rick was hard-pressed to explain his ugly, secret pursuit of the false intimacy of pornography. After years of silently struggling in secret, he knew he needed help. Even though he had been a Christian for five years, he never fully developed a reliance on Christ. Rick always thought that he could conquer this problem by himself. He was wrong. With our marriage under threat and his self-image obliterated, he knew he had to seek help. But where? Rick felt that he couldn't possibly go to anyone in our church – this sin (and others he would reveal later) was just too much.

Later, Rick remembered the literature rack at our church, where he had seen HARVEST USA's quarterly newsletter. "Maybe Harvest can help me to be rid of this struggle," thought Rick. He didn't know what to expect from Harvest, but he knew our marriage was hanging by a thin thread and I was in devastating emotional turmoil. "Maybe," he said, "you will feel less desperate by knowing that I'm pursuing a 'way out' through whatever it is that Harvest can do for me." He called the number on the newsletter, and was seen immediately by one of the counselors. He found out that he was not alone in this struggle – there were many other men grappling with the same issues. He attended the Foundations support group, where he was amazed that men were relying on Christ to change their wicked hearts. Rick had to take a long, hard look at what had brought him to this place in his life.

My husband learned that to experience healing and change, he had to really, for the first time, confide in me, his wife. Taking a chance, Rick told me that his problems were not just connected to pornography – he also struggled with same-sex attractions. Ten years before, he had even acted on those attractions by having anonymous sex with men on five occasions. "Will you stay married to me? Will I still have you and the kids to come home to?" asked Rick.

You see, Rick grew up emotionally isolated, with an alcoholic father who was rarely available to teach him about finding his way in the world. As one of many in a large family, my husband found himself lost in the crowd. He wanted more affection and connectedness than he was getting from his family, especially his father. Rick has always been socially skilled but emotionally isolated, and he had even considered suicide at age nine. He rejected the idea only because it was such a grave sin against God and would surely land him in Hell. No. That was not the way out. Unfortunately, Rick's household wasn't the kind that recognized or talked about emotions. Not ever.

Rick was a smart kid, learning early on that boys were supposed to be stoic and tough. He never really learned what to do with his emotions, and unwittingly learned to discard them altogether. Then too, Rick didn't understand what was happening to him inside as the hormonally-turbulent teen years transitioned into adulthood. He hated feeling "abnormal" and rejected on a rational plane the concept of same-sex attractions. Rick thought he was cursed with a homosexual drive that felt truly incompatible with his dreams for standard relationships, love, material success and career gratification. Rick hoped and prayed for deliverance but depended, as always, on himself alone for a way out. He wanted it to go away. He didn't know what to do and never discussed it with anyone. Not ever.

When he was 29, Rick met me, and we truly had a magical time falling in love. We courted and eventually got married. Rick was just like everyone else. Just like the normal, successful person he believed himself to be. But as marriage evolved into having children and loads of responsibilities, Rick had to grow up fast. Leisure time vanished like soap bubbles on a sink full of greasy dishes. He found occasional escape in pornography and eventually was unfaithful to me in the form of a few anonymous sexual encounters with men. He knew it was wrong and knew he'd regret it in the extreme. Years later he discovered Internet pornography, and Rick's addictive personality climbed quickly into the grimy world of free porn sites. In the space of six months he became seized with a porn addiction that captured his thought life and much of his free time. I complained that he was ignoring the children and me, but he couldn't stop.

On that ordinary Saturday evening as I walked into Rick's computer room, I spotted those pornographic images on his computer screen before he could click them out of existence. I was shattered, and Rick was speechless. Now that I knew him to be what I thought of as a pervert, I wanted to know what else lurked beneath my husband's otherwise dignified appearance. And when Rick confessed to having homosexual tendencies, my imagination went reeling. What do I do with this? Where does my marriage go under these circumstances? What about our children? It was all way too awful for me to take in.

Rick was initially paralyzed by the burden of his shame, and so was I. In spite of my anger and resentment about what his situation had done to our life together, I agreed not to tell Rick's secret. But I needed help. I needed to talk about this outrageous situation with a trusted friend or

two. By mutual consent, I sought out my closest friend and let out the story of my enormous pain, confusion and grief. I was in fact grieving over the loss of my perfect dream. The possibility of a happy life seemed stolen forever. I became deeply depressed.

Later, I learned that HARVEST USA was starting a support group for the wives of men who struggle with homosexuality and pornography. It was a scary proposition, to walk into that group and be identified as a "wife of", but I knew I needed the support and prayers of other women hurting in the same way. I received much love, strength, and healing from those women, and I am so grateful for Geri Huminski and Shirley Cast for planning and leading the group. Geri and Shirley continually pointed me to Jesus, the only One who could truly heal my wounded heart.

Meanwhile, Christ continued to work on Rick's heart. He moved on from the Foundations group into the Living Waters group, an intensive 14-week discipleship and accountability group. Deep changes were beginning to take place. Rick was learning to take the risks necessary to relearn his patterns of relating to other men in his world. Genuine, same-sex honesty and intimacy were replacing the counterfeit closeness of homosexuality and pornography. Christ has shown Rick that His grace is sufficient and His power is strong enough-- even to deal with these deep issues.

As Rick and I have worked hard on dealing with the decay in our marriage, we have learned to lean on the Lord more than ever before. "God saw us though a very dark period," Rick declares. "It was the only way either of us could have made it." The walk through darkness has been long, confusing, angry, and emotionally draining. I constantly wondered whether there would be love at the end of this long road.

The lessons Rick and I have learned have been difficult and are not yet complete. Rick is learning now what I had thought for years: our marriage lacked real intimacy. Rick didn't know how and I didn't know what to do about it. Confronted with this fact, Rick has asked Barney Swihart, a counselor at HARVEST USA, to help him learn more about his severe emotional blocks and how to concentrate on creating genuine intimacy. Rick knows he still has a long way to go and I realize that I do too. But we've dispensed with our secrets. Our marriage is no longer a superficial exercise in the American Dream. It's more real than ever before. More real than we would have ever imagined.

I have actually come to a point in this journey where I can say that I'm grateful that this trauma happened in our lives. Christ has given me the gift of a husband who is changed. He is able to be intimate in a way that he could not be before. Rick has taken over the spiritual leadership of our home. Our children and I are now the recipients of a loving man who shows that love consistently. What a gift! Our God is the God of changed hearts. And He is good!

Freedom from a Secret
Jason Thompson

I was 14 and sat alone in my grandparents' house with a Bible in my lap. Since my father was an Episcopal minister and I had been raised in a Christian home, I was familiar with many Bible stories. But that day I desperately needed to know what God had to say about homosexuality. After reading, it was clear from His Word that God considered homosexuality a sin (see Romans 1:26, Leviticus 18:22). This discovery made me more confused than ever.

Not long before, I'd had a dream that I was involved in homosexual behavior. I woke up scared and confused. After that, I recognized a growing desire to be physically close to my male peers. I didn't know where these desires were coming from, but I knew that I didn't want them. And I also knew I had to keep this part of me a secret. I prayed earnestly for God to take away the desires but unfortunately, they didn't disappear. *"Why isn't He answering my prayers?"* I questioned. *I wondered if God really even cared.*

High school only brought further confusion. Unsure of my identity, I sought out guys with whom I could be emotionally close, all the while wishing for a physical connection as well. One friend and I engaged in some sexual experimentation, and the experience satisfied some curiosity created by my fantasy life. I continued to pray about my struggles, but God still did not take away my same-sex desires.

As a senior, I finally gathered up enough nerve to reach out for help. I found the number for a teen counseling helpline. After I nervously rattled off my story to the worker, she coldly replied, "The guy who deals with the gays will be in on Friday."

I threw the phone down in frustration and climbed on my red Honda Elite scooter. Speeding through the side streets of Southeast Portland, I felt angry and hopeless; I even thought about killing myself by slamming into a parked car. But God stopped me from acting on that thought and calmed my heart.

By the fall of 1990, I had a "girlfriend" who went to my parents' church. We started to date and I pretended to be interested in her, but the strain of my conflicted feelings was beginning to be apparent to those who knew me.

In a frightening conversation, I confided my homosexual struggle to her. Surprisingly, she had hopeful words for me. She tracked down the phone number of the Portland Fellowship (PF), a local Exodus ministry. I nervously made the phone call that would soon change my life.

Phil Hobizal, PF director, answered the phone. After listening to my struggles, he encouraged me that he could help. Change *was* possible, Phil told me, and we arranged to meet the following week. His words were the best news I had ever heard!

A few days later, while still riding on a wave of excitement, I approached my mom with the intimidating words, *"There's something I need to tell you. I struggle with homosexual tendencies--"* She stopped me and said, "Wait, let me get your father. He needs to hear this, too."

I tried to stop her, thinking I couldn't talk to my dad about my secret. I had always felt distant from him. While I frequently shared my thoughts and feelings with my mom, I never felt like I had that

freedom with Dad.

Nervously, I paced the house as she went outside and called him. I told them that I struggled with homosexual desires but that I didn't want to be gay. I also told them about the hope I had gained from the Portland Fellowship.

I left their house feeling a freedom that I had never before experienced. The weight of the secret I had kept for years began to evaporate. Later I found out that my parents were up most of that night, talking, crying and praying.

The next morning I went to church; before the service, Dad took me outside. He told me that he had seen many people with serous problems during his years of ministry, but he hadn't seen anyone deal with a problem so diligently. He told me that he had never been so proud of me as he was that day. Dad truly blessed me with his loving and supportive words.

My first year of involvement at PF was difficult. During their Tuesday night meetings, I learned about the roots of my homosexual desires, God's plan of forgiveness, and the freedom from homosexual struggle. However, occasionally on weekends, I would drive my scooter downtown and check out what was available in the gay community, hoping someone or something could fill the still-gaping pit of emotional need.

Pornography had a strong pull in my life, which was a barrier to my ability to grow in what I was learning about God. It took a full year of participation with PF before I was able to realize that I could not have it both ways: I couldn't follow God and continue to hold out hope of satisfying the homosexual urges within.

By this time, I was attending Bible College. I lived in the dorm and began to share my struggle with some of the guys. It was a terrifying risk and although not everyone knew quite how to handle this issue, I didn't experience rejection. In fact, one of the first guys with whom I shared became one of my closest friends.

God had heard me and was answering my prayers. His desire was not just to take away all my problems, but to provide the Body of Christ to come alongside to support and encourage me. It was through being open and sharing my struggle with others that I began to have my real needs fulfilled.

I became a small group leader at PF and continued to walk in submission to God. Suddenly I could see the intense emotional needs for male friendship were driving my desires. But slowly, through positive male friendships, my homosexual desires began to fade away.

One of the greatest steps I made in the change process began one night with my dad. We set up a time where just he and I could go out to dinner and talk--straight from our hearts. For the first time, we shared with each other the most personal things in our lives. I felt a new connection to him, one that began to take away some doubt and uncertainty about our relationship.

In January 1994, I joined PF staff. I wanted the opportunity to tell people that change was possible and hopefully reach teenagers with the good news of freedom from a life dominated by sexual sin.

I continued to mature over the next few years, working in ministry and attending classes to complete my degree in Biblical studies. One day, while hanging out with some friends at the college coffee shop, I looked across the table and noticed a beautiful young woman. Her smile and friendly nature attracted my attention. With the encouragement of my friends, I got up the nerve to ask her out. Slowly she became my first real girlfriend.

Amy knew little about homosexuality, but because of her desire to know me better and learn what I did, she participated in the eight-month PF program.

Exactly a year after our first date, I took her to Multnomah Falls--a famous local spot where my dad had proposed to my mom. I dropped down on one knee and asked Amy to be my wife. She was so startled that I almost dropped her ring over the bridge near the falls! Thankfully, she said yes.

Our wedding on March 15, 1997, was a beautiful ceremony, with our friends and loved ones right by our sides and supporting us all the way. We entered marriage with an incredible honeymoon in Puerto Vallarta, Mexico, and have been enjoying marriage ever since.

Jesus Christ is truly a God of mercy and grace. Strangely enough, I am now very grateful to have experienced homosexual struggles. When I submitted them to God, I gave Him permission to mold and shape me into the man I am today. I am thankful He chose me to help reach out to hurting people, and I'm thankful He granted me the desires of my heart. In Him, there are no secrets. He truly is a mighty God!

From Prostitute to Pastor
By Mike Haley

Most days, Mike Haley is hard at work speaking at Love Won Out, holding press conferences, challenging the media's love affair with the "homosexuality is normal" myth, defending ex-gay ministries, answering hate mail and death threats, or simply being a walking billboard of God's mercy in an organization he once despised. And he's never been happier.

But it wasn't always that way.

Born into a family with a strong spiritual heritage—Mike's lineage includes pastors on both sides of his family—he initially received the Lord at the age of 8. But being the only boy born to a controlling father who owned sporting goods stores helps explain the direction his life took.

"I was going to be the best football player, the best basketball player, the best baseball player and the best everything my father could possibly make me."

His father's way of making him a man was to take him on hunting trips. Often, his dad's friends would go along.

But times of supposed masculinity and being "one of the boys" turned into times of humiliation, when Mike shirked the recreational shooting his father relished. His resistance earned him the term "sissy" and "worthless"—angrily pronounced on him in front of his father's macho friends.

At a time when he should have begun to identify with and emulate his father, Mike instead gravitated to the security and acceptance provided by his mother and sisters. Further attempts to teach him sports like baseball only frustrated Mike's dad more, resulting in further humiliation.

"Why don't you just go in the house and be with your mom and sisters because that's where you'd rather be anyway!"

Even though his father showed open hostility, Mike, nonetheless, desperately craved his father's attention and approval.

Before long, a man began to work for Mike's father and provided all the attention Mike desperately longed for. The man took him to Disneyland, the beach, affirmed who he was, appreciated his body . . . something his father never did. At the age of 1l, that attention turned sexual.

Starved for male affirmation, he was too young to call the misguided attention what it really was: sexual abuse. The abuse continued through junior high and high school because the man met a deep need in his life. Before long, Mike had jumped headlong into the homosexual lifestyle, becoming involved with other men in Southern California as well. Being a blond, surfer-type boy, he had no trouble attracting those willing to pay attention to him for sexual needs.

By this time, Mike had bought into the familiar gay rhetoric about a "gay gene" and the 10-percent-of-society-is-homosexual myth. Was that the case for him? A high school counselor seemed to think so:

"You just need to realize you have been born gay, so rid your life of internalized homophobia because you have been raised in the church . . . and embrace it."

Still he was troubled. A year or so later, Mike was counseled by a youth worker at his church that he simply needed to read his Bible and pray more. But it seemed as though the more he read and prayed, the more frustrated and angry he became at the God he had grown up loving, because change was not happening.

Mike moved away, hoping to find the carrot-dangling happiness that always eluded him with a new partner, a new city, a new identity. But through it all, he remained in close contact with his two sisters who provided unconditional love and pictures of his niece and nephews. The letters and snapshots scribbled with 'Uncle Mike, we miss you' made him long for normalcy and family life.

"I wasn't hearing from the church that change was possible. I never heard that in my life."

Finally in 1985, Mike heard for the first time that homosexuals could change. He had gone to a gay gym at 11:00 that night, and found himself making contact with a man he'd seen there and wanting it to lead to sex. He followed the man out to the parking lot where the man abruptly stated that he was a Christian walking out of homosexuality. It seemed like rubbish to Mike at the time.

"I thought to myself that this guy was crazy, and God wouldn't do that for you because I tried it and He didn't do it for me."

As they continued to debate whether change was possible, the man made several references to another man named Jeff Konrad who had left the lifestyle, was studying the root causes and writing a book. While driving from one area to another, the man shared what he had been learning from Jeff, and he challenged Mike in his relationship with his father. Suddenly, the man's eyes widened and he shouted, "Oh my gosh, there's Jeff right now!" Mike then heard a voice saying, "Was My arm too short to rescue you?"

From that point forward, Jeff Konrad became a symbol of hope in Mike's search for wholeness. Back and forth their discussions would go over the next four years . . . Mike arguing that change wasn't possible; Jeff insisting that it was. Through all of Mike's many moves, Jeff continued to write. His cards would say things like, "I don't even know if you are getting this letter, but God loves you, I love you and change is possible." (Their years of letter-writing eventually became the book You Don't Have to Be Gay.)

After living in the homosexual lifestyle for 12 years, Mike had to admit to himself that he wasn't happy. Increasingly, he realized he was just a commodity. And to continue finding worth and value to men, he needed to be an attractive commodity. He worked out two to three hours a day, did injectable steroids, even became bulimic. With effort, he could pull off looking the part, acting the part and dressing the part. But the price was too much to pay. Finally, in December of 1989, he came to the end of himself and picked up the phone. It was a prodigal son moment. But instead of the father, God used Jeff Konrad as the male authority figure Mike needed.

"You have been so faithful to me, surely the Jesus you know can be that much more faithful. Please help me get to know Him."

It was the beginning of his journey back to a wholeness he hadn't known since the age of 11. He left the lifestyle, moved in with a sister and attended an Exodus International conference not long after.

"There were 800 other men and women sitting in the pews in this church with the same hurts, same pains, who wanted to know Jesus in a way that would help deliver them from this life-dominating sin. It was the most unbelievable thing I had ever experienced in my entire life."

While there, Mike learned about a residential program for men and women struggling with homosexuality. Because of his sexual addiction, he knew he needed that type of 24-hour care. Before he left the Exodus conference, several men and women gathered to pray over him. One of the men read Jeremiah 15:19:

"Therefore, thus says the Lord, if you return then I will restore you. Before Me you will stand, and if you extract the precious from the worthless, I will make you My spokesman."

Mike began to realize that God thought of him as precious and not "worthless"—as his father had.

The night Mike got home from the conference, he happened to meet a girl named Angie—a friend of a friend—who was also coming back to the Lord. She and Mike quickly became fast friends. When Mike ended up moving to Northern California in December of 1990 for the reparative therapy program, Angie stayed close emotionally, providing long distance support while he walked out of homosexuality. Mountains of hurt and rejection melted as Mike found a freedom he had not known before. He never again had a sexual encounter with a man.

Mike had always dreamed of being a youth pastor, a calling he had received at the age of 15 during youth camp. But because of his past, he believed it would be impossible. So he took a degree in Christian education from Biola University and applied for his teaching credentials. However, because he had a sexual arrest on his record—he was booked for prostitution in 1987—his application for a teaching license was denied.

Again, Mike found himself frustrated with the Lord because He had been given a passion for youth. Yet, there seemed to be no way to fulfill it. In the meantime, he consoled himself with Angie, with whom he had fallen in love.

By now, Mike was on staff of the reparative therapy ministry, and was in the process of moving with the ministry to Memphis, Tennessee from Northern California. But there was one important thing he needed to do before setting out for Memphis. On December 4, 1994, Mike married "the most beautiful woman on earth."

As Mike and Angie were beginning to settle down into their new life in Tennessee, Mike felt increasingly restless with his work at the parachurch ministry. Yes, he was bringing men and women out of homosexuality—some from all over the world—but the passion for youth was still there. That year, during an anniversary celebration at Central Church, Tony Campolo spoke a word that troubled his soul for weeks: "God's call is irrevocable."

Mike thought, "What does that mean for me? I live in the South, used to be gay and a prostitute,

and I want to work with youth, but how?"

Two weeks later, the youth pastor position at his church opened up and Mike decided to apply. He gave his testimony to the pastor, then the parents and students, then the deacons and elders, the "pianist" . . . anyone at the church who cared to listen. Nine months later, a lifelong dream came true: Mike officially became a youth pastor! He and Angie thrived in their God-given callings; they loved the kids and the kids and their parents adored them. Through it all, the Lord showed Mike that there are still churches that believe in the complete, life-changing power of Jesus Christ.

Mike served in that position for almost three years, but in May of 1998, he got a phone call from an old friend who now worked for Focus on the Family. John Paulk encouraged him to apply for a position in Focus' new gender identity outreach. Mike politely said no. John offered it two more times. And two more times Mike turned it down. Having been out of the Lord's will so long, he couldn't bear the thought of leaving that secure place he'd spent his whole life trying to find.

But God had other ideas. One morning at 4:30 a.m., Mike was sleeplessly skimming a book entitled Spiritual Leadership, when the Lord spoke saying, "I want to sound the note through you." He reminded Mike of the Jeremiah verse and His desire to use him as His spokesman. That was all Mike needed to hear.

He and Angie began the job at Focus in October of 1998. Instead of just ministering to kids at his church, Mike now speaks to youth all over the country . . . and enjoys a fulfillment in life he never expected to have. He is living proof that homosexuality is not inborn, but God's ability to change hearts, is.

The homosexual community—stubborn holdouts in the "once gay always gay" debate—does have its surprising admirers of the Love Won Out message. They come to Mike and John Paulk quietly and unceremoniously, much like Nicodemus approached Jesus. One recent remark is typical: "I just want to let you know I hated you. I hated Focus on the Family before I came. When I heard the message that I heard, I now believe change from homosexuality is possible, and I actually hope to be working with you someday at Focus on the Family."

Responses like that make the death threats tolerable. Those who leave names and phone numbers get a return call from Mike and an invitation to talk. He tells them, "Come and hear our message. Because it'll tell you that what your gay friends and the gay media are telling you, is so far from what our message really is." "I'm secure in who I am. I'm not going back. I was there for 12 years. I know what it has to offer me. And what I have now, I wouldn't trade for the world."

P.S. Christmas came early last year for Mike and Angie. Son Bennett Michael arrived Dec. 15, 1999, an "exclamation point" in a full-circle story from wounded son to warring father of many spiritual children.

My Path to Lesbianism
by Diane Mattingly

It was hatred of women that drove me there, and Christ in community that led me out.

Here's an old family recipe I've recently uncovered. Take two broken people and let them have children. Once the children are born, stir in the unmet needs and expectations of the parents while blending in the hurts and disappointments of their pasts. Pour the batter into a deep baking dish and place in the oven, which is fueled by the ups and downs of the household and of life. Recipe yields enough dysfunction to serve a family of four, or more.

For me, the dysfunctional yield of that recipe was a search for a home and a name, a place where I could feel like I belonged. That search led me down many paths, including the path of lesbianism. But I found a fork in the road and took it. What I discovered was a way of hope and healing that I never thought possible. My healing has come first by making a decision to give my life, including my sexual orientation, over to God; and second, by beginning to deal with the wounds that left me with an intense desire to connect with a woman. One area I've had to come to terms with is misogyny. The hatred or devaluation of women shows through sexual, physical, emotional, verbal, or spiritual abuse, pornography, and the ideology that women are less than men.

I grew up in a home where this was the case: both my mother and father favored my brother. He excelled in athletics and was an above-average student. It is said that children are the best recorders, but the worst interpreters, of information. I interpreted this favoritism to mean that my brother—and not me - was the one who was supposed to succeed. As I watched my parents pour their hopes and dreams into him, I felt like I was on the sidelines. I could either cheer him on or sit back and watch. I chose to cheer.

Cheering for him meant that I gave up on myself. I developed patterns of not following through with commitments and giving up on anything that was difficult. I was never taught how to persevere, how to handle pressure, or how to set and achieve a goal. I didn't learn how to compete, how to win, or even how to lose. I lived in a vacuum I created with self-destructive behavior that included drugs, alcohol, and self-mutilation, and I have battled the effects of depression for many years. Over time, misogyny eats away at the core of women's souls and leaves them feeling unprotected, ashamed, vulnerable, and frightened. That's how it left me.

I remember a time when, as adults, my brother and I, living on opposite ends of the country, both bought computers. As I was telling my father about my computer, we soon found ourselves in an argument as he insisted that my computer wasn't as good as my brother's. It was ludicrous: The two computers had the same amount of memory, same speed, same software applications, same everything. I could only conclude that mine was inferior just because it was mine.

Then there were the college degrees. My father said to me one day that my master's degree wasn't as good as my brother's master's degree because his was an MBA and mine was just an MA. He didn't say that his was more useful in the marketplace or that it would yield more money, but that mine was just not as good.

Cut Off And Alone

Little girls need a strong masculine presence as a covering and as a protection, but also to call us out to take risks and to make us feel comfortable in our girlishness so that growing into a woman won't feel unnatural, uncomfortable, awkward, or unsafe. Our fathers are the ones who are supposed to do this for us. Mine didn't.

As I watched and listened to my mother and father interact and comment on my friends, my brother's friends, their friends, and even movie stars, I, too, began to form a low opinion of women. The messages I received from my father were that women are weak, stupid, supposed to look sexy, and that they are to serve men. One of his favorite sayings was that my mother couldn't find her way out of a wet paper bag. Because she didn't learn to drive until she had children, she read maps poorly and wasn't as good at finding her way as my father was.

Misogyny isn't always meted out by men. The messages I received from my mother were that women are only as good as they look, and they are manipulative and unpredictable. She once told me that the reason I didn't have a man was because I was too independent. She said men don't like independent women, and that I should learn how to play coy so I wouldn't overpower men. If our mothers are full of self-hatred or feel inferior to other women, are not comfortable with their own femininity, or "bend into" men, they can pass down their brokenness to us, their daughters.

Mary Beth Patton, a psychologist, counselor, and researcher of same-sex attraction who is on the board of Portland Fellowship, an Exodus International-affiliated ministry, so described what happens to women like me: "Women who deal with same-sex attraction often possess a history of dis-identification with their mothers, and therefore with their femininity. This leads to a longing for connection with the feminine that becomes sexualized in adolescence."

Girls disconnected from their mothers often begin to hate their emotions and all the other things that make them women. I don't necessarily mean those things that make us look feminine on the outside, but those internal characteristics that actually make us feminine beings. For example, I was always comfortable wearing dresses, getting my nails done, and wearing lots of jewelry, so I didn't see those as contemptible qualities in my mother. But when I saw her let herself be a victim of my father's verbal assaults, I vowed that I would never be like my mother. I'd never be under the control of a man, never be dependent on a man, never be weak or admit my vulnerability. Psychologists call such feelings of children toward their parents "defensive detachment." In not allowing my mother to influence me, I walled myself off, not just from anything negative she could have instilled in me, but also from anything good she could have imparted to me as a woman.

Of course, misogyny doesn't always lead to lesbianism. In my case it fostered same-sex attraction because it cut me off from men, from women, from God, and even from myself. I hated men. I hated women. I hated myself for being a woman. I had no more value for women than any women-hating man does, and yet no one was more surprised to discover that I, too, was a misogynist. And I've had to confess that sin to God. My detachment from men and women left me walled off from being able to receive anything good from either men or women.

The first time I noticed I was attracted to women was when I was in the sixth grade, but I didn't

act on any of those feelings until well after I completed high school. I did have a number of boyfriends growing up, and I hate to admit that I was very promiscuous. With each relationship, I hoped that he would be "the one." I would have done almost anything to feel accepted, but each relationship ended either with my boyfriend cheating on me or with him telling me in one way or another that he wanted to move on. Each ending left me feeling less and less like I was able to please a man.

My first encounter with a woman gave me the most intense sense of belonging and connection I have ever felt. It is hard to explain just how enveloped I felt during that first encounter. I felt a sense of relief I had never felt before. I felt like I had finally found that sense of home within my soul I had been missing.

What I really had fallen into was an emotionally dependent relationship that had nothing at all to do with love. I was trying to fill my need for connection on my own terms. If love means honoring people, then is it loving to have them participate in what the Bible says alienates them from God? I realized that if I truly loved a woman, I could not sleep with her.

Aborted Femininity

Perhaps one of the most significant manifestations of misogyny I know of came at my own hands. I've already said that I had been promiscuous with men. One of those relationships led to an unplanned pregnancy. I was dating a guy, and we had been together for a few months and I thought we were getting along fairly well. That is, until I got pregnant. When I told him about it, he told me to do whatever I wanted, keep it or have an abortion, and then walked out. I never saw him or talked with him again. When I telephoned him, he hung up on me, and when I stopped by his house, he didn't come to the door. I ended that pregnancy with an abortion.

I honestly don't know what the commitment level is supposed to look like in a situation like that, but I'm quite sure that it shouldn't have been abandonment. Abortion is one of the ways we, as women, assault our femininity, and it is a sign that says, loud and clear, that our society is not meeting the needs of women.

I wish I could say that I've been able to free myself from the effects of misogyny with my determined self-effort, but quite the opposite is true. The most I could ever hope to do in my own strength was to keep myself walled off from further hurt. Left to my own efforts, I would have had to settle for existing instead of living. And I wanted to live.

I've had to surrender those past hurts to God. I've had to confess my weakness, self-hatred, and my hatred of women. I've had to choose to keep myself present to the larger body of Christ and be willing to enter into transparent relationships with people. Healing comes in community and by being in fellowship with other believers. Isolation is one of the greatest enemies of the soul. We kid ourselves into believing that we can meet our own needs, but the truth is, we don't have that much power. My healing continues, but the healing that's already occurred has come through inner-healing prayer, professional Christian counseling, and participation in a program called Living Waters, by Desert Stream Ministries, and run by Regeneration of Northern Virginia, an Exodus International-affiliated ministry. I have put off the labels of victim and lesbian and betrayed. I have had to be willing to let God define me as a woman and to show me how to be comfortable with my true femininity. Whereas once I dreaded women's fellowship

groups for fear that everyone could see the little girl I felt I was in a grownup body, I am now learning to participate confidently, as a woman. I've had to ask God to break the power of those vows I made to protect myself. I've had to grieve a lot of what happened in my past. I've had to let God into some deep places of pain.

While divulging some of my past makes me feel like I've just been on the Jerry Springer show, I know there are women reading this who want to believe that they are not hopeless cases or damaged goods. There are women who want to find another path than lesbianism and emotionally harmful relationships. To them, I say there is hope.

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http://www.christianitytoday.com/ct/2005/february/36.62.html

Great Expectations
By Michael Newman

As the first male grandchild for my doting paternal grandmother, I was born into a world of great expectations. My grandmother had divorced early in life and raised two sons as a single mother. Now she could do things for her grandson--me--that she had been unable to do for her own sons. I always loved going to her house, where I played with my own special toys.

When I was three, however, my world changed drastically. We moved from the Midwest to the South for better job opportunities for my father. Grandmother was far away and soon afterward my baby sister was born.

My mother spent much time looking after the needs of a demanding newborn and my father worked long hours at the local factory, so I learned to entertain myself. I had an active imagination and amused myself by retreating into a fantasy world.

From my limited perspective, I envied all the attention that girls received. I did not identify with boys' rough-and-tumble sports, so always felt alienated from male playmates.

Taunts and teases began in kindergarten. I hated being called "sissy," but felt helpless to change the perceptions of other boys. So I put more effort into being the perfect child by getting top grades in school.

My parents were nominal churchgoers, although I went to Sunday School. Then, at age 13, I went with a friend to a special youth week and accepted Jesus Christ as my Savior. My faith had become personal.

I continued to feel uncomfortable around other guys, and began to admire them from afar for their looks and personalities. I heard about homosexuality, but I thought, That's not me. I'm a good Christian boy! I was not interested in having sex with other males, although I had already experienced same-sex adolescent "crushes" and was painfully aware of my attraction to other male bodies.

Outwardly, things seemed tranquil during the rest of my teen years. I did well academically, my best friend filled the role of being my "girlfriend," and I made preparations to enter college.

After one year of college, I persuaded my parents to let me attend a large university in another state. During my first year away from home, I had my first homosexual experience. My friend, Mikel, had just entered into homosexual activities himself. While we were out drinking, he revealed that he was gay and that he knew I was, too. After all those years of painful labeling, I felt someone understood me, but did not condemn me.

Mikel and I began a tempestuous six-month sexual relationship in which I was constantly dealing with guilt because of my Christian beliefs.

Then God brought a godly man into my life. Sam was a strong Christian who befriended me, got me involved in student Bible studies, and later became my roommate. I admired Sam, but I was afraid to tell him of my struggles. After four months as roommates, I dared to share my secret--

and discovered that God had already prepared his heart. He sat down with me and we prayed together about the whole situation.

"Lord," Sam said, "even if Mike is struggling with homosexuality, I know that he does have a relationship with You, and it is not by accident that we met. I don't understand homosexuality, but I trust You to help him. In the meantime, I will just be his friend."

I was overwhelmed by Sam's acceptance and his openness for God to use him as my friend. Although I still struggled with same-sex attractions and even fell into some sexual encounters, he never preached at me and was a wonderful Christian brother.

After finishing my undergraduate studies, I moved to a graduate school in the southwestern USA and rededicated my life to the Lord. I sought out Christian fellowship through university ministries and finally confessed my past struggles to a new Christian friend. Wally found a Christian psychologist for me to talk with. I needed to know more about God's promises for me, and what He had actually done for me on the Cross. I had to deal with a lot of shame and guilt. Through counseling, I started to grow in my faith through being more firmly rooted in God's Word.

After obtaining my master's degree in Romance Languages (Spanish and French), I returned home. But I sorely missed the Christian fellowship that I had enjoyed during college, and my homosexual thoughts and feelings re-emerged.

I moved to Houston in search of a job. I sought out friendships in a large church and threw myself into various activities to escape my inner loneliness. Then I met a man who, after seven years of marriage, had decided to pursue a gay lifestyle. I befriended him with good intentions, but soon became entrapped: first, emotionally, and then sexually.

I was devastated to find myself ensnared again in a gay relationship, but felt powerless to escape. As I agonized over the situation, I asked God why I had fallen again into homosexuality. The quiet voice of the Holy Spirit spoke to my heart: I will have no other idols before Me.

God was showing me that my Christianity had largely been external. My performance orientation and deep need for approval from people had finally been unmasked! All my life, I had struggled to perform, to be the best, to make my family proud. So this was the bigger issue that had hidden behind my homosexual struggles.

I heard about Exodus International through a local ministry, and attended my first Exodus conference in 1984. What an overwhelming experience to be among hundreds of men and women who were also overcoming homosexuality!

A class on emotional dependency hit me right between the eyes. Elizabeth Moberly's theory of thwarted same-sex affirmation needs as an underlying "root" of homosexuality was another breakthrough for me. Previously, I had been ashamed of my emotional neediness, so I had tried to hide it. What a release to know that God knew my real needs for male affirmation, and there were healthy ways to have them met!

Inner healing and deliverance were foreign ideas to me; I felt they were just emotional experiences with no spiritual depth. God began breaking down my misconceptions and prejudices, but it was

a slow process.

With high hopes and great vision for Houston to have a ministry for those struggling with homosexuality, three of us brainstormed ideas, then joined forces to establish Christian Coalition for Reconciliation (CCR) in 1985. We began receiving phone calls and I began counseling men seeking help.

I met people seeking freedom from a wide variety of problems, including sexual abuse, alcohol and drug addiction, and obsessive/compulsive disorders.

An increasing number of men came to us who were HIV-positive. Some clients made progress, some stagnated, some wavered and eventually left the ministry.

My Messiah complex eroded as I saw more of my own human and spiritual limitations. I had to trust God in even greater ways as ministry challenges drew me closer to Him for answers. I was compelled to re-examine my own relationship with Christ for a deeper understanding of His provision for healing on all levels: emotional, physical, sexual and spiritual.

The annual Exodus conferences helped me learn and grow. I also took advantage of other Christian seminars and courses to amplify my knowledge.

I was further stretched personally when I became full-time director of CCR in 1987. The next year, I joined a charismatic Baptist church. Gradually I was opened up to new discoveries about my relationship with God.

A major turning point occurred during a time of worship at the 1990 Exodus conference. I had a mental image of myself as a three-year-old, afraid of the outstretched arms of a male figure kneeling in front of me. The words, “Daddy, I’m scared,” flashed into my head as pain stabbed my heart.

I exploded into loud sobbing as several people prayed over me. I saw that, as the perfectionist who had accepted Christ at age 13, I had never fully allowed myself to feel some perceived emotional hurts of childhood. But in those moments, I felt flooded by the love of God my Father. When I returned home, I sought out a Christian counselor to explore these issues in more depth.

Now, as I minister to others, I am reminded that the journey out of homosexuality is an ongoing process. It’s easy to despair when an old struggle, supposedly gone forever, rears its ugly head again. But I’ve learned that this happens so the Holy Spirit can do a deeper work in that area of our lives.

I don’t have to live under the burden of others’ “great expectations.” I’m at peace as God works in my life daily to make me more like Him.

God Restored My Marriage
Beth Babb

It was on a Rhode Island beach in June of 1985 that I finally admitted to myself that my husband, Mike, and I had a serious problem. My feelings were in turmoil as I wandered alone down the sand, looking for seashells.

I watched the silvery waves wash starfish onto the beach, as the spiny creatures were ripped from their rocky perches. Like those starfish, my world had been solid and secure--but now I was being pulled by forces beyond my control. My life was out of control in a way I didn't understand. I felt vulnerable and scared.

God, I know my marriage is in trouble, I thought. I can't ignore it any longer--but what should I do?

Drastic Changes
Occasionally I looked back at Mike, sitting in a chair on the beach, staring sullenly at the waves. *What is wrong with him, anyway?* I sighed, thinking of my numerous half-hearted attempts to discover the reason behind my husband's drastic change in behavior. Mike had been generous, fun-loving, always making jokes. Now he was a brooding, unpredictable stranger. The changes frightened and threatened me.

Later, I stood near Mike's chair with our friends, Julie and Jack, who had invited our family to visit them and take a special trip to the beach. I noticed Julie looking at Mike in a questioning way, but we all tried to carry on as normal.

Fearful Questions
Then, all too soon, the day ended and we made preparations to drive back to our friends' home in nearby Massachusetts. The men and boys traveled in one car; I went in another car with Julie and her daughter. On the drive home, Julie probed my fearful heart. My emotions came tumbling out in a crazy fashion; I was so confused by this strange direction my life was taking.

Julie listened for a long time, then finally spoke. "I think I know what is wrong with Mike."

"Don't tell me," I wanted to scream, "I don't want to know!" But another part of me wanted to identify the problem, whatever it was.

Julie spoke with difficulty. "When I pray about Mike, two words keep getting impressed on my heart." She glanced over at me. "One is suicide--and the other is homosexuality."

Wanting to Run Away
I knew she was right, and suddenly I wanted to run away--from her, from Mike, from everything. How I longed to escape from the searing pain that tore through my heart! I was in tears as we talked the remainder of the trip back to Julie's home. I knew that, as Mike's wife, I was too emotionally wounded to confront him. Finally, Julie agreed to speak to Mike.

But during the remaining days of our visit, no opportunity presented itself for Julie and Mike to

talk alone. At the airport, she hugged me and whispered that she would be praying for us. With a heavy, bewildered heart, I flew back to Kansas beside a man I no longer understood.

Mike and I had met at a small Bible school in Kansas. At the time, I'd just left another unpleasant relationship, and wasn't interested in any man. But when Mike asked me for dinner, for some reason I said yes. He was very kind and I liked him. Three-and-a-half months later, we were engaged. We married on June 12, 1975. *How have things changed so much since then?* I wondered.

Intense Warfare

Back home in Kansas, life went on. Depression, sadness, and fear were my constant companions. Then the spiritual warfare grew even more intense.

In the kitchen one evening, I felt something like a black cloud suddenly descend over my head. Tears sprang to my eyes as a heavy presence seemed to settle on my back. Not wanting the children to see me, I groped my way to the bathroom, fell to the floor, and began weeping. "Oh God, oh God!" I moaned repeatedly. The black presence was so strong that I wondered if I would ever get up again--I thought I might die.

Finally, I lay down upon the floor, totally exhausted. The dark presence lifted and then was gone. Although I feared its return, the blackness never did come back.

I don't completely understand what happened on that bathroom floor. But I know that spiritual warfare was fought and great spiritual strides were taken toward freeing both Mike and myself from the enemy's grip.

Confrontation

A few days later, Julie called on a Sunday morning. "Beth, the Holy Spirit won't leave me alone. I have to confront Mike. Are you ready?"

"Yes," I replied, "it couldn't be any worse."

We agreed to pray the rest of the day and then Julie would call back. That evening, she spoke to Mike on the phone. "I think I know what is troubling you."

"Oh, really?"

"Yes." Julie reminded Mike of her love, then said the two words which were by this time imbedded in my heart like poisoned arrows. "You are struggling with homosexuality--and suicide."

Mike began crying.

After their conversation, I entered the room and looked at Mike. "Don't you think it's time you told me?" Those were difficult words. Part of me still wanted to pretend that nothing was wrong. Mike looked up from our bed. "I'm gay," he said calmly. Those two words ripped through me like bullets.

Turmoil and Pain

A few minutes later, the doorbell rang. Two women--one of them an old friend--needed a place to spend the night. I quickly "put on my happy face," acting as if nothing was wrong as we prepared a room for them. Somehow, through a blur of frozen emotions, we made it through the night.

The next morning after Mike left for work, I suddenly realized that I was scheduled to speak at a meeting several hours away. I felt like an open wound, but resolved to carry through on my commitment.

I don't remember much of the trip. I cried as I drove, wondering what I could possibly say to a room full of women. Maybe, I thought, the emotional agony will overpower me and I'll just die.

I wondered whether Mike would still be there when I returned home. I grieved over my children as I pondered what all of this would do to them. Then, somehow, I was standing before the group, silently pleading with God to send the Holy Spirit to take over completely.

My notes were a blur as I opened my mouth. "God is faithful, reliable, trustworthy, ever true to His promises. We can depend on Him." As I spoke, a powerful anointing fell upon me. My deep pain temporarily vanished as the Holy Spirit pled with people to be cleansed.

"My people shall not be ashamed," God said to us all through my lips. "Give up your secret sins. I love you." His message was a healing balm.

I knew that God was calling me to extend His love to Mike. "Don't desert him," the Lord whispered in my heart. "My grace is sufficient for you."

The trip back to Wichita was both wonderful and awful: Wonderful because Jesus was my close companion, assuring me that He would take care of Mike. Awful because I knew a long, hard struggle lay ahead of us. *How will we survive?* I wondered.

Asking Hard Questions

Back in Wichita, I immediately phoned Mike at work and asked him to go out to dinner. That evening at our favorite restaurant, I asked him the question that had been on my mind all day: "Mike, what direction do you want to go?"

His deep brown eyes were sad. "I want my marriage, my family. I don't want homosexuality, but I can't make it on my own. I need a miracle from God."

I remembered what the Lord had shown me earlier in the day, and told Mike that I would never reject him. "I'm ready to stand with you. I'll support you in every way possible."

We were like children groping in the dark. We had no earthly resources; we only knew to hang on to Jesus. I had never heard of anyone being delivered from homosexuality. It seemed a forbidden topic in our Christian circles.

A New Start
A few weeks later, Mike resigned at work and took a different job 150 miles away in Oklahoma City. He had been deeply attracted to another man at work, and was eager to move far away from Wichita. We put our house up for sale, and I expected to join him as soon as possible.

Little did we know the plans God had for us. Mike lived in Oklahoma City for the next one-and-a-half years, while the children and I lived in Wichita. We saw each other only on weekends.

In Oklahoma City, Mike found The First Stone, an Exodus ministry dedicated to helping homosexuals find freedom. He attended regularly and earnestly sought God's healing. In the coming months, his growth was phenomenal. He had been depressed and hopeless, but became happy and full of hope. He regained a genuine desire to read his Bible and attend church, rather than simply "going through the motions" of being a Christian.

A Changed Man
When Mike eventually returned to Wichita, God sent him back a changed man, with a dream in his heart to establish a similar ministry to help others.

But there was a problem. Unfortunately, Mike returned to a weary, resentful wife. The enemy had been hacking away at me, and I was too emotionally exhausted to support Mike's new ministry. Rather than celebrating his return, I felt angry and repulsed by his vision to help other homosexuals.

Desperately I turned to Jesus, my faithful friend, for cleansing, for strength, for a desire to understand and love Mike. The Faithful One proved Himself steadfast once again as He began healing my heart.

It was difficult to face the truth: I was not the loving wife I should be. And I had no love or tolerance for needy homosexuals. Daily, I persevered in turning to Jesus for healing and restoration.

That was over ten years ago--and the healing process continues in my life. God has brought me farther than I ever believed possible. Recently, I spoke to Mike's ministry group. As I looked at the faces of those precious men, I saw friends whom I now dearly love. Yes, God is doing a miracle in my wounded heart--a heart once full of stony places with no room for hurting homosexuals. Respect for my husband has returned. God has also given me both a willingness to help Mike in ministry, and the desire to see my life continually healed and changed.

I know with complete confidence that my Heavenly Father will finish the work that He has begun in me. I've seen Him restore my husband and my marriage. There is nothing too hard for Him.

Bob's Story

Unwanted! Yes, unwanted. That was my experience even before conception. My dear mother had birthed five of my dad's kids while he was out there making babies elsewhere. You can be sure my mother didn't want to bring another one of his into the world!

Doctors, four in total, attended my birth and told her it was her or me – not both would make it. Well, we both did, but she wasn't happy. Neither was my Dad. Another mouth to feed.

I grew up knowing I was unwanted and even my siblings treated me that way. Never do I remember sitting on my father's knee. In fact, I received a lot of abuse from him – both physical and emotional.

Unhealthy masculinity can have major effects on a young boy, and for me it did. Feeling alone and finding my way wasn't easy. At the age of thirteen I was sexually abused by my sister's boyfriend. Even though I felt dirty and embarrassed by the incident, some false identities came out. I got satisfaction from a male (figure) for the first time and it had a major effect on me. I even began to seek it out.

After a couple months the opportunities ceased. I eventually was able to put it aside or under the rug. I told no one.

In time, I started dating girls and found the one and only and got married. I never discussed my boyhood experiences with my wife. There is a true saying in life: If you don't deal with it, it will deal with you.

After being married for a little over two years we had a son. My wife was an amazing mother and wife.

Work for me was very demanding and took me away from home for days at a time. One day, I picked up a hitchhiker and he just so happened to be gay and made advances toward me. Boy, did that bring back memories! He asked me where I was staying and wanted to come back to my motel and tell me more, plus more and more. The experiences I had as a boy came rushing back and all the urges came with it.

He told me about downtown Toronto and all of its appeal. I wanted it! And, I sought it out for a year, unbeknownst to my wife. Eventually, I told her I'd been living a lie. She wanted us to get help, but I refused, thinking I could deal with it on my own.

For a year I was able to sweep it under the rug again. It was hard! Then I broke down and went back and after a month told my wife that she and our son needed to go back to her mom and I would try to find myself.

To say this was a selfish move is an understatement! The appeal of downtown Toronto engulfed me. I had no intention to return to my wife and boy. I was hooked "line and sinker." I took to the

lifestyle like a fish to water and it didn't take long for me to fit in. I did everything I could to deal with the resulting guilt and memories.

All the gay ghettos were calling me. I went to Fire Island, New York; Provincetown, Massachusetts; and even Key West, Florida.

My boss was told by one of my staff that I was seen coming out of a gay bar in downtown Toronto. He fired me the following Monday. This was the 70's; it wouldn't happen today. But it was a good thing as far as I was concerned. I was free to do my thing.

"Europe, here I come!" I lived in London, Amsterdam and West Berlin for about a year and indulged myself in the gay lifestyle.

Upon returning to Toronto, I immersed myself bigtime in the gay community – managed a gay bar, played in the gay World Series in New York, became president of the Gay Business Council to name a few.

For over twenty-five years I was heavily involved in gay life.

Then, out of the blue, my son called saying he wanted to visit me. He'd only known about my being gay for about a week. He'd just visited his mom and she told him about me. Like I said, she was an amazing woman, never wanting to taint my son's image of me.

When he got off the plane, we were actually able to identify each other and we headed to downtown Toronto to my apartment. That reunion and encounter was life changing. He called me dad (first time, wow!) and told me he loved me. He also told me God loved me unconditionally. All I could think about was what I'd missed out on. I also thought about change – was it possible?

I wanted two things out of that encounter, one, a relationship with God and two, a new relationship with my son. Yes, and one more. Change. To be free of my homosexual desires and establish healthy relationships with men.

The ball started rolling. I sought good counsel. I dealt with the issues I'd put under the carpet years before. Even my past relationship with my father was dealt with. I strongly believe this was a learned lifestyle and for me it needed to be unlearned.

I realize it's different for many individuals, especially today. But I believe it's very important for those who want to change back there should be opportunity to have access to reparative therapy. I don't condemn those who choose to stay, but I do advocate provision for those who want to be free.

Change is possible and freedom is possible, by the grace of God. I've experienced both for twenty-five years.

The gay community has the freedom of expression they've long wanted. But now the gay community is preventing those who want to leave from doing so. Is this not a double standard?

Coming out works both ways. It should be a two-way street!!

Bob Fife

Flight from Pain: Journey into and out of Transexuality through Christ
By Susan Takata

Bio: Susan Takata is the youngest of three girls born and still resides in the eastside of Vancouver, British Columbia. Gender Identity Confusion began when she was a toddler, continuing even when she made Jesus Saviour of her life in 1980. In the early 90's she enrolled in Another Chance Ministries (Marjorie Hopper - Director) as Steve. During this programme, Jesus became Lord of her life and with the power of God beside her began her healing journey. Susan was a pastor for a short time, volunteered in various committees such as Another Chance Ministries. She has been helping in many organizations such as 100 Huntley Street, Vancouver Challenge (Teen Challenge), and various street missions. She is an itinerate evangelist (Philippines, Indonesia, Canada, Caribbean) and itinerate worship leader.

After taking a sabbatical from ex-gay ministry she began being connected with Exodus Global Alliance in Canada and she is now being used by the Lord to show that though going through the journey to understand Gender Identity Confusion and walk in truth of who she is may come through overcoming some painful steps, it is worth it. And now walks in freedom.

* * * * *

I accepted the Lord as Saviour in July 1980 @ 16 yrs old. He knew where I was but He was waiting for me to see Him. Though born a girl, most of my childhood was filled with my mother implying that I was not a typical Japanese girl & didn't belong. I didn't like what girls were supposed to like, etc. This started my self-identification as "I must be a boy" starting in toddler ages. Meanwhile there was always a nagging feeling that my father was missing out because he didn't have a son. The words I chose to embrace from my mother were, "if you were a boy," etc. or "you're just like your father." I tried to ignore the words & feelings given from my mother.

When I was 5 our family, except for my dad, went on a trip to Japan from Canada. At that time people who were in the plane's boarding area could see their loved ones waiting for takeoff. I remember seeing my father hanging his head and looking so lonely. It was then that I decided that I was going to be the son he never had. I was sad to go but relieved too because there was some molestation happening. But the trip to Japan confirmed that I wasn't feminine. I did not fit in.

When we returned home to Canada, I kept getting worse because the Canadian families I was exposed to (next-door neighbours, TV, etc.) all regularly said "I love you" to each other but my family did not. I did not realize that in the Japanese culture they say I love you by providing for you, taking care of family members, etc. I didn't understand so I felt totally unloved by my real family. By the age of eight I came very close to stabbing myself a few times but, even though I was a Buddhist, I heard God say ``don`t do it.

At age 10 (March 11, 1974), I was raped. At this point disassociation started occurring. While the rape was happening to me the sensation was akin to me going out of my body and the experience was happening to someone else. This started my coping mechanism for flight from pain. I`m a boy -- all that ugly stuff happening to me is because of that body on the outside. As a result at the age of 12 I contemplated more heavily the thought of suicide. I remember I was in

my bedroom, placed a knife to my stomach and just as I was about to plunge The Spirit spoke to me and said He loved me which made me stop.

When I was thirteen, CKVU (Channel 13) began airing soft-core porn (geared more for men with sexuality from a man`s perspective) after midnight, starting a 25 year habit for me. At this time I was aspiring to be a male rock singer like BTO and The Guess Who which led me to have long hair. Nobody suspected my problem because I didn`t look butch. My father and I started having physical fights (but we are pretty good father & daughter now). And my mother began blaming me for the problems between her and Dad. I began to look into the Occult.

The Lord really protected me at this time – any relationships with women didn`t last when I told them I was becoming a male (straight or lesbian). On the other hand, men interested in me were all dedicated Christian boys but even during the date I was preoccupied with finding them good Christian women because I saw me dating a male as being a homosexual and I wasn`t a homosexual.

During this time every rejection I felt, every time I wasn't included in group activities, every failure, etc. I accounted to being a failure as a female. I began internally calling myself Steve while still answering to Sue. I decided to be the male. I decided to pursue a normal family where I would be the husband to a normal wife with kids.

I pursued relationships with normal women but they were short-lived because I felt as a Christian I loved them too much to be deceptive (I told them I wasn't physically a male). The lesbians didn't want me because I told them I was pursuing a sex-change operation. The lesbians were all after me until I told them I was having the operation to become a man. The local lesbian (women's) club advised me that I could attend their meetings only until I had my operation. Also my Father in Heaven kept reminding me if I really loved these women I wouldn't lead them to do anything that would jeopardize their relationship with Him. So my love for these people was bitter-sweet cause deep down I knew He was saying truth.

After a while I notified my sisters and sought out my general practitioner. The doctor said she would approve the operation and that I needed to get further approval from a psychiatrist at a Gender Dysphoria Clinic. I had already been passing as a male for a long time even without the hormones. (You had to be living as a male at that time for one year). My non-Christian friends were calling me Steve. I was a rock'n roll musician so having long hair was a norm.

During this time I started going to Christian Life Assembly. I wanted to stop the pain by becoming a male but I also didn't want to lose my relationship with the Lord. After seeing the doctor many times and getting ready to go to the clinic, the time for disclosure was at hand. We were in the chapel and I exclaimed to some of the congregation, "Don't call me Sue, call me Steve. Sue will be no more." Thank God for a pastor who was growing in the Lord. He began speaking life to me. A conversation I remember is when I stated I felt inferior because I wasn't a pastor, he stated that he thought I had gone farther because I was the first Christian in my family. At this point many of my friends in the church began to really minister to me.

Many of my guy friends took me aside and let me still be one of the guys but I'm sure they prayed for me every day. I got together with 3 guys and we prayed with each other. My Christian friends also let me know about their own personal struggles so I didn't feel like they treated me as inferior or like a project. By their actions my friends began to instill in me a desire to know The Truth and to live in the Truth. The truth is always the truth no matter how much we try to lie to ourselves. No matter how deceived we are in our gender we can never run away from what came out originally.

My prayer now became 'Lord Change Me to who You want me to be.' Either I believe that God will do it or I don't believe in God at all. Either God is Truth (and all His decisions) or He is a liar. My pastor who was humble enough to admit that his 12 pastor staff didn't have the resources to "fix" me referred me to Another Chance Ministries with Marjorie Hopper. Because she was also a struggler of trans-gender issues Marjorie knew better than to call me a lesbian. But I was perplexed as to why I was put in this ex-gay ministry when my being attracted to women was quite heterosexual because I thought of myself as a male. I was indignant when she insisted I join the women's group instead of the men's group. I kept wondering what I was doing there. But this was the hand of God.

My small group leader Ruth took the brunt of my "I don't belong in this women's group" mentality and patiently started talking to me. Ruth never had lesbian issues but she ministered to me better than someone who had been in the lifestyle. She ministered God. As we went through the 32 week programme, she did not put me in a box but uniquely asked the Lord to speak to me. I stayed in the women's group. It would be another 3 years (I was a small group leader) when Marjorie associated me with the L word.

The road to Wholeness in Christ means a break from the flight from pain. When we receive Christ we are broken vessels. As we continue to grow in Him, He takes these broken pieces and makes an object for His pleasure as He heals the pieces. In order to create the object the pieces have to be moved -- they have to submit to the Potter even if it means they go through the fire again. Most importantly they don't react in the same way they did before. As we desire the Lord to set us free we must realize that whatever coping mechanisms we used for our suffering must be submitted to Christ. Continuous surrender. Wholeness in Christ means to give God the final say. He is the only One who can be our all in all. He has big shoulders and just as a raging wound may have to hurt for awhile to properly heal The Lord is with us to walk us through but walking through is imperative. He may do things like corner us to uncomfortable situations to help us get set free

This began the journey of discovering the lies I believed about myself, lies I believed about others, the damaging effect of labels, inner vows, the importance of understanding inter-cultural practices and communication between generations, the importance of being a team player, that no business is new business (1st Cor. 10:13) – the thought that no one can minister to me because no one has gone through what I went through – is a lie.

BE PATIENT – BE WILLING TO CHANGE IN GOD'S TIME – NOT YOURS. I am no longer a transsexual and have no desire to be a man. I am happy as the female I was born to be.

Visit www.oncegay.com for many more testimonies.