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Conversion Therapy in the Southern United States: Prevalence and Experiences of the Survivors

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ABSTRACT
Numerous studies have determined that conversion therapy, a practice meant to change one's sexual orientation to heterosexual or gender identity to cisgender, can be ineffective and severely harmful. However, few studies have documented the prevalence or characteristics of its survivors. This study is a quantitative analysis of the LGBTQ Institute Southern Survey that estimates the prevalence of conversion therapy (specifically SOCE) in the Southern United States and documents its significant association with negative mental health outcomes. Conversion therapy survivors comprised 7.6% of the sample (11.6% after listwise deletion). Respondents who were younger and reported being a gender minority; lesbian, gay, or some other sexual orientation; Hispanic; less educated; and less religious were more likely to have experienced it. Findings support previous studies which report a strong correlation between conversion therapy and poor mental health outcomes. Results regarding the prevalence and demographics of survivors offer new insights for further research.

KEYWORDS
Conversion therapy; reparative therapy; LGBTQ youth; sexual orientation change efforts (SOCE); gender identity change efforts (GICE); mental health; same-sex attractions; gender nonconformity

Introduction and literature review

Conversion therapy (also referred to as reparative therapy, sexual reorientation therapy [SRT], sexual orientation change efforts [SOCE], ex-gay therapy, or gender identity change efforts [GICE] when directed toward gender minority individuals) occurs when a formal group of people, usually religious or mental health professionals, attempts to change someone's sexual orientation to "heterosexual" or their gender identity to "cisgender" (American Medical Association, 2019). Homosexuality has not been considered a mental disorder in the *Diagnostic and Statistical Manual of Mental Disorders* since 1973, and in 2013 gender nonconformity underwent a similar transition from "gender identity disorder" to "gender dysphoria," indicating that being transgender or non-binary does not constitute a mental disorder (American Psychiatric Association, 2013; Anton, 2010). Yet, conversion therapy continues to be

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utilized by religious leaders and mental health practitioners as a form of social control (Anton, 2010).

Conversion therapy efforts can include various painful forms of aversion therapy ranging from hypnosis to inducing vomiting or paralysis or administering electric shocks while showing the individual homoerotic images (American Medical Association, 2019; Hein & Matthews, 2010). "In extreme cases, they may also include surgical and hormonal interventions, or so-called 'corrective' rape" (National LGBT Survey Research Report, 2018, p. 83). However, more commonly conversion therapy focuses on prayer, talk, and behavioral therapy that attempts to diminish the individual's same-sex attractions or gender expression through shame and forced adherence to strict gender roles (Flentje, Heck., & Cochran, 2013). Parents and family members can also play a role in initiating and enforcing some of the latter approaches, particularly those based on promoting conformity, such as rewarding or punishing their child through token economies based on whether they play with toys gendered as feminine or masculine (Rekers & Lovaas, 1974). Ryan, Toomey, Diaz, and Russell (2018) found that over half of their sample experienced conversion therapy between ages 13 and 19 from a parent or caregiver, compared to 34% experiencing the practice from a therapist or religious leader, and Green, Price-Feeney, Dorison, and Pick (2020) found that while only 5% of their sample experienced formal conversion therapy, 67% had someone attempt to change their sexual orientation or gender identity.

There is a scientific consensus that conversion therapy is ineffective and can result in significant, long-term psychological harm (Ending Conversion Therapy: Supporting and Affirming LGBTQ Youth, 2015). Many pro-conversion therapy studies utilize biased samples that only include clients who have recently undergone conversion therapy, thus distorting the purported success rates and failing to analyze whether conversion therapy remains effective in the long term (Shidlo & Schroeder, 2002). Further, even the most scientifically rigorous studies report success rates of no more than 30% (Haldeman, 2002). Through the lens of queer theory and activism, the debate around whether conversion therapy is an effective practice is inconsequential because the very existence of conversion therapy is rooted in societal and religious homophobia, transphobia, and cisheteropatriarchy (Haldeman, 2002).

A wide variety of U.S. scientific organizations condemn conversion therapy, including the American Psychological Association and the American Medical Association (American Medical Association, 2019; Anton, 2010). In 2015, under the Obama administration, the Substance Abuse and Mental Health Services Administration released a report reiterating the professional consensus that conversion therapy should be condemned as psychologically harmful and replaced with more accepting, supportive, and scientifically sound therapeutic practices.

As of the writing of this manuscript, in the United States conversion therapy for people under 18 has been banned in 20 states (not including a partial ban in North Carolina), the District of Columbia, and various smaller jurisdictions (Movement Advancement Project, n.d.). Unfortunately, the state bans in Illinois and California fail to cover gender identity change efforts experienced by gender minority youth (Movement Advancement Project, n.d.). In addition, according to a study from the Williams Institute, state bans on conversion therapy primarily focus on how professionally licensed mental health practitioners may deceive their patients by representing conversion therapy as an effective treatment (Mallory, Brown, & Conron, 2018). Mallory et al. (2018) further claim that these bans still allow religious leaders and advisors to continue practicing conversion therapy with people under 18 with no consequences, likely due to first amendment concerns.

Limitations in the available literature

The majority of research on the effects of conversion therapy reviewed for this manuscript focuses on its efficacy and impact on psychological well-being. Further, there are several limitations when analyzing the demographics of study samples, such as smaller sample sizes, qualitative data, and a tendency to focus more on Christians (especially Church of Jesus Christ and Latter Day Saints members) and gay men, in part because those groups tend to be especially likely to undergo conversion therapy (Beckstead & Morrow, 2004; Bradshaw, Dehlin, Crowell, Galliher, & Bradshaw, 2015; Dehlin, Galliher, Bradshaw, Hyde, & Crowell 2015; Flentje, Heck, & Cochran, 2014; Shidlo & Schroeder, 2002). In particular, lesbian, bisexual, and transgender experiences tend to be underrepresented in samples (Bradshaw et al., 2015). In fact, studies that include or focus on transgender experiences of conversion therapy tend to find that transgender respondents are significantly more likely to have undergone the practice than cisgender respondents (Mallory et al., 2018; National LGBT Survey Research Report, 2018; Turban, Beckwith, Reisner, & Keuroghlian, 2019).

Prevalence of conversion therapy

Most studies have not attempted to estimate the prevalence of conversion therapy, and the results of those that have vary somewhat in scope. A 2018 study from the Williams Institute "estimates that 698,000 adults (age 18–59) in the U.S. have received conversion therapy, including about 350,000 LGBT adults who received treatment as adolescents (p. 1)." The Trevor Project's 2019 National Survey on LGBTQ Youth Mental Health, a pioneering cross-sectional study of over 34,000 LGBTQ youth, found that two thirds of LGBTQ youth had someone try to convince them to change their sexual

orientation or gender identity and 5% of youth experienced a more structured version of conversion therapy (The Trevor Project, 2019). One study in the United Kingdom found that 5% of their respondents reported being offered conversion therapy, and 2% reported undergoing the practice (National LGBT Survey Research Report, 2018). A study focusing exclusively on transgender adults found that 14% of their respondents reported exposure to gender identity conversion efforts (Turban et al., 2019). The amount of variation around how many LGBT Americans have gone through conversion therapy demonstrates that more research is needed to conduct truly accurate estimates.

Previous findings on survivor characteristics

Across the studies analyzing conversion therapy, various demographic variables were considered when theorizing what might impact one's likelihood of experiencing conversion therapy. However, only a few studies analyzing the demographics of conversion therapy survivors exist. Some of the individuals more likely to have experienced conversion therapy include people who identify as gay or lesbian, gender minority people, nonwhite people and Hispanic/Latinx individuals in particular, people not born in the United States, people who reported more gender nonconformity during adolescence, people from the Southern United States, and people who grew up in rural rather than urban or suburban communities (Dehlin et al., 2015; Green et al., 2020; Maccio, 2010; National LGBT Survey Research Report, 2018; Ryan et al., 2018).

Religion appears to play a particularly strong role in the likelihood that someone experiences conversion therapy. Anti-LGBTQ family reactions and high levels of religious fundamentalism are associated with participation in conversion therapy, and young adults raised in highly religious families are more likely to have experienced it (Maccio, 2010; Ryan et al., 2018). Indeed, religiously motivated conversion therapy appears to be more common than conversion therapy conducted by mental health practitioners (Dehlin et al., 2015; Maccio, 2010). In fact, in two different studies on survivors of conversion therapy, every respondent reported growing up in a religious community with extremely negative views toward homosexuality (Beckstead & Morrow, 2004; Flentje et al., 2014).

Previous findings on mental health effects

The professional consensus that conversion therapy is ineffective and psychologically harmful appears throughout the available literature. In one study, none of the participants indicated changing their sexual orientation to heterosexuality, and most participants reported feeling ashamed that, in spite of their best efforts, they continued to experience same-sex attractions (Fjelstrom, 2013). According to another study, both parental attempts to change sexual

orientation and external forms of conversion therapy correlated with negative mental health issues among adolescent respondents (Ryan et al., 2018). Another study found that 80% of respondents who experienced conversion therapy considered the practice "not at all effective," "moderately harmful," or "severely harmful" (Bradshaw et al., 2015).

A study of LDS (Church of Jesus Christ of Latter Day Saints) members concluded that there were a variety of negative effects resulting from conversion therapy, including: "decreased self-esteem, increased self-shame, increased depression and anxiety, the wasting of time and money, increased distance from God and the church, worsening of family relationships, and increased suicidality" (Dehlin et al., 2015, p. 8). Indeed, these researchers theorized that when participants in religiously motivated conversion therapy realized that it was not working, it likely negatively affected their beliefs in God and their religious community. This theory is reinforced by the finding that church counseling was one of the most "severely damaging (p. 9)" practices for LDS members who underwent conversion therapy, and respondents who participated in SOCE experienced much higher levels of sexual identity distress and low self-esteem (Dehlin et al., 2015).

Gender minority individuals, who already tend to experience conversion therapy at higher rates than cisgender individuals, report similar consequences for their mental health from the practice (Mallory et al., 2018; Turban et al., 2019). Turban et al. (2019) found that "lifetime exposure to GICE was significantly associated with multiple adverse outcomes, including severe psychological distress during the previous month and lifetime suicide attempts" (p. 73). Another study found that gender minority respondents who "had a professional try to stop them from being transgender" were significantly more likely to experience serious psychological distress, have attempted suicide, have ever experienced homelessness, have ever done sex work, and almost three times as likely to have run away from home compared to respondents who did not experience GICE (James et al., 2016, p. 110).

Those who have undergone conversion therapy tend to report more shame, poor self-esteem, lower life satisfaction, depression and other mental health issues, social withdrawal, sexual dysfunction, suicidal ideation and attempts, lower educational attainment, and lower weekly income than those who have not been exposed to the practice (Flentje et al., 2014; Haldeman, 2001; Ryan et al., 2018; Shidlo & Schroeder, 2002). Indeed, the Trevor Project found that youth who underwent conversion therapy were "more than twice as likely to attempt suicide as those who did not" (The Trevor Project, 2019, p. 1). Severe negative mental health outcomes appear to be a staple of conversion therapy experiences.

Methods

The current study is a secondary analysis of the LGBTQ Institute Southern Survey (hereafter "the Southern Survey"), a project jointly conducted by the LGBTQ Institute at the National Center for Civil and Human Rights and Georgia State University (Wright, Roemerman et al., 2018a; Wright, Simpkins et al., 2018b). The purpose of the current study is exploratory and poses three key questions:

(1) What is the prevalence of conversion therapy in the Southern United States?

(2) What demographic factors are correlated with the probability that someone under 18 undergoes conversion therapy?

(3) How does conversion therapy impact the mental health of those who experienced it before turning 18?

The Southern Survey (Wright, Roemerman et al., 2018a; Wright, Simpkins et al., 2018b) was created and implemented to combat a substantial lack of data from the LGBTQ community in the South. Data were collected through an online, anonymous, approximately 30-minute survey of LGBTQ-identifying individuals living among 14 southern states.[1] The Southern Survey had three main areas of interest: education and employment, public health and wellness, and criminal justice and safety. Questions were modeled after national random surveys such as the General Social Survey, American Community Survey, and a Pew Research Center national survey of LGBT Americans, and they ranged from institutional experiences of discrimination to respondents' attitudes about political climates and their own local LGBTQ communities (National Opinion Research Center, n.d.; Pew Research Center, 2013; US Census Bureau, n.d.). After receiving IRB approval, the survey was advertised through social and print media with the collaboration of 146 organizational partners contacted during the data collection process, and the final sample size of respondents who met the study's criteria was 6,502.

The Southern Survey included two questions about conversion therapy that were composed by the first author. The first question asked participants "During adolescence, were you ever sent to a therapist/mental health practitioner, clergy/religious leader, or some other individual or organization in an effort to change your sexual orientation?" Respondents who answered "yes" to the first question could also answer a check-all-that-apply question asking whether they had experienced conversion therapy from a religious leader/clergy member, mental health practitioner, or someone else. These subcategories of conversion therapy are somewhat similar to the subcategories in two studies by Elaine Maccio where she asked respondents whether the treatment they received was religious or nonreligious and professional or

nonprofessional (Maccio, 2010, 2011). The question failed to ask about gender identity change efforts, thus obscuring whether gender minority respondents who answered "yes" experienced sexual orientation change efforts, gender identity change efforts, or both. 475 out of 4,096 respondents answered yes to having gone through conversion therapy before the age of 18, demonstrating that our sample of interest is about 11.6% of the overall sample size.[2]

For the current study on conversion therapy, we used this data to create descriptive tables of the demographic information of the total sample of respondents, the demographic information of respondents who went through conversion therapy, and the responses to questions on conversion therapy, and tables that report on our logistic regression analyses of the likelihood that someone experienced conversion therapy and the impact of conversion therapy on respondents' overall mental health. Each of these tables includes specific data on cisgender respondents, gender minority respondents, and all respondents aggregated together in order to showcase findings unique to the cisgender and gender minority subsamples. We decided to run binomial logistic regressions because the dependent variable for our second and third research questions is nominal and binary. We recoded all variables that were not interval/ratio into binary dummy variables to meet the assumptions of the logistic regressions. For our second research question, demographics are the independent variables, while whether the respondent experienced conversion therapy is the binomial dependent variable. Below is the first logistic regression equation:

$$\begin{aligned} log\ (p/1-p) \ = \ & b0 \ + \ b1 * Age + \ B2 * Gender + \ B3 \\ & * Sexual\ Orientation + \ B4 * Race/Ethnicity + \ B5 \\ & * Educational\ Attainment + \ B6 * Religiosity \end{aligned}$$

We originally ran three different models for this logistic regression. The first model controlled for race/ethnicity, educational attainment and religiosity, the second model just controlled for educational attainment and religiosity, and the third model only controlled for educational attainment. The three models demonstrated that although we do not have an issue of overfitting our variables due to small N's, we do have a slight problem of multicollinearity between race/ethnicity and education: we lose the ability to analyze the effects of education when race/ethnicity is included. We decided not to include the second and third models in Table 4, and instead focused on comparing the total sample, cisgender subsample, and gender minority subsample results.

For our third research question, whether the respondent experienced conversion therapy is the independent variable, while the respondent's mental health is the dependent variable. Below is the second logistic regression equation:

$$log\ (p/1-p) = b0 + b1 * Mental\ Health + B2 * Age + B3 * Gender + B3 * Sexual\ Orientation + B4 * Race/Ethnicity + B5 * Educational\ Attainment + B6 * Religiosity$$

Although the current study's dataset includes measures of sexual attraction and behavior in addition to sexual orientation labels, we chose to only include sexual orientation in our analysis because the other variables often measure individuals who identify as heterosexual but engage in same-sex sexual activity rather than individuals with a solidified LGBQ+ sexual identity. Experiences of same-sex attraction and same-sex sexual activity tend to include substantially higher percentages of the general population than LGBQ+ self-identification (Copen, Chandra, & Febo-Vasquiz, 2016; Geary et al., 2018). Additionally, including all variables together would create issues of multicollinearity.

Gender identity was measured by several different questions, including: asking about assigned sex at birth; whether respondents are or were a transgender person; if so, which identity label fits them best (with the response categories including "Transgender," "Transgender MtF (Male-to-Female)," "Transgender FtM (Female-to-Male)," "Transsexual," "Woman with a transsexual past," "Man with a transsexual past," "Gender variant," "Cross dresser," "Queer," "Genderqueer," and "Some other Gender Identity, please specify"); how the respondent thinks of their gender now (with the response categories "Man," "Woman," "Genderqueer," and "Other"); and Likert-type questions about how masculine or feminine the respondent feels, looks, and wishes they were. For the purpose of this study, the data on gender identity was then aggregated into four gender categories: cisgender man, cisgender woman, transgender man or woman, and non-binary. The two latter categories also fall under the umbrella term "gender minority" respondents and will hereafter be referred to as such for the purpose of this manuscript.

Our dataset used the Kessler six-item psychological distress scale (K6) to measure mental health. The K6 is well-known as an internally valid and reliable screening tool for "discriminating between cases and non-cases of serious mental illness" (Khan, Chien, & Burton, 2014). It includes six different questions asking respondents how often they felt nervous, hopeless, restless, depressed, that everything was an effort, or worthless within the past 30 days. Each question includes Likert-type response categories ranging from "None of the time" to "All of the time."

The K6 is an especially useful tool in large surveys because it can be self-administered by respondents speedily and without difficulty and can screen for mental illness in both clinical and community studies (Kessler et al., 2002). Its successful screening is easily replicated across studies and good for estimating the prevalence of particular disorders as well as overall psychological distress (Sunderland, Slade, Stewart, & Andrews, 2011). For the purpose of this study, these six questions were recoded into a scale variable that measures the sum of

all of the Kessler 6 Mental Health Scale questions, excludes any missing values, and can be utilized in regression equations. The final version of the variable used in our second regression was recoded into a binary where 0 means that the respondent has a significantly lower probability of experiencing a serious mental illness and 1 means that the respondent has a significantly higher probability of experiencing a serious mental illness (the original scale ranged from 0 to 24, with a cutoff point of 13 to identify respondents with a serious mental illness).

Results

Table 1 includes the descriptive statistics of demographic independent variables for the total sample (N = 4,096), the subsample of cisgender respondents (N = 3,219), and the subsample of gender minority respondents (N = 877): age, gender, sexual orientation, race/ethnicity, educational attainment, and religiosity. People ages 18 to 29 comprise the largest age group in the total sample (33.7%) and both subsamples, and respondents in this age group make up over half (51%) of the gender minority subsample. Cisgender respondents are the majority of the total sample (78.6%) and include slightly more cisgender

Table 1. Sociodemographic characteristics by gender.

	Total Sample (*n* = 4096)		Cisgender Sample (*n* = 3219)		Gender Minority Sample (*n* = 877)	
	n	%	*n*	%	*n*	%
Age						
18 to 29	1382	33.7	935	29.0	447	51.0
30 to 39	961	23.5	781	24.3	180	20.5
40 to 49	682	16.7	573	17.8	109	12.4
50 and over	1071	26.1	930	28.9	141	16.1
Gender						
Cisgender Man	1484	36.2	1484	46.1		
Cisgender Woman	1735	42.4	1735	53.9		
Transgender Man/Woman	697	17.0			697	79.5
Non-Binary	180	4.4			180	20.5
Sexual Orientation						
Heterosexual	199	4.9	111	3.4	88	10.0
Lesbian	1011	24.7	865	26.9	146	16.6
Gay	1410	34.4	1315	40.9	95	10.8
Bisexual	839	20.5	636	19.8	203	23.1
Other	637	15.6	292	9.1	345	39.3
Race/Ethnicity						
Non-Hispanic White	3349	81.8	2666	82.8	683	77.9
Black/African American	252	6.2	207	6.4	45	5.1
Hispanic	237	5.8	174	5.4	63	7.2
Other	258	6.3	172	5.3	86	9.8
Educational Attainment						
Less than a 4-year degree	1338	32.7	951	29.5	387	44.1
4-year degree or higher	2758	67.3	2268	70.5	490	55.9
Religiosity (How important is religion in your life?)						
Very important	736	18.0	588	18.3	148	16.9
Somewhat important	896	21.9	717	22.3	179	20.4
Not too important	831	20.3	653	20.3	178	20.3
Not at all important	1633	39.9	1261	39.2	372	42.4

women (53.9%) than men (46.1%), while binary transgender women and men comprise most of the gender minority subsample (79.5%). While a majority of cisgender respondents are gay (40.9%), a majority of gender minority respondents are some other sexual orientation (39.3%). Additionally, 3.4% of cisgender respondents and 10% of gender minority respondents are heterosexual. The respondents are overwhelmingly non-Hispanic white in the total sample (81.8%) and both subsamples. While over two thirds (70.5%) of cisgender respondents have a 4-year degree or higher, only 55.9% of gender minority respondents have the same level of educational attainment. Religiosity levels are relatively equally stratified among cisgender and gender minority respondents, and in the total sample the majority of respondents (39.9%) consider religion "Not at all important" in their lives.

Table 2 includes the same descriptive statistics of demographic independent variables as Table 1 for the total sample of respondents who answered "yes" to the first conversion therapy question (N = 475), the subsample of cisgender respondents (N = 332), and the subsample of gender minority respondents (N = 143). Most of the findings are stratified similarly to those in Table 1, with a few exceptions. Among cisgender respondents, more respondents are men (57.8%) than women (42.2%), while women comprise the majority of respondents in Table 1's cisgender subsample. Significantly fewer respondents who underwent conversion therapy are bisexual (12.2%), especially among cisgender respondents (9.3%), and the number of Hispanic respondents nearly doubled (10.1%) compared to the amount in Table 1. Gender minority respondents who underwent conversion therapy were also most likely to state that religion is "Somewhat important" in their lives (28.7%) rather than "Not at all important," unlike in Table 1.

Table 3 contains the descriptive statistics for our second research question's dependent variable and our third research question's independent variable, the two questions about conversion therapy. 11.6% of total respondents, 10.3% of cisgender respondents, and 16.3% of gender minority respondents have experienced conversion therapy before the age of 18. Respondents are more likely to experience conversion therapy from a religious leader or clergy member (6.9%) than a mental health practitioner (6.5%) or some other method. Respondents are more likely to experience one type of conversion therapy (8.4%) than two types (3.1%) as well, and gender minority respondents experienced all forms of conversion therapy at higher rates as shown throughout Table 3. A chi square analysis of the relationship between different types of conversion therapy and gender was highly significant, X^2 (1, N = 4,096) = 24.1, $p < .001$. An additional chi square analysis of the relationship between number of different types of conversion therapy and gender was highly significant as well, X^2 (2, N = 4,096) = 25.4, $p < .001$. Regarding the prevalence of conversion therapy by state (not included in Table 3),

Table 2. Sociodemographic characteristics of respondents who underwent conversion therapy by gender.

	Total Sample (n = 475)		Cisgender Sample (n = 332)		Gender Minority Sample (n = 143)	
	n	%	*n*	%	*n*	%
Age						
18 to 29	178	37.5	108	32.5	70	48.9
30 to 39	104	21.9	70	21.1	34	23.8
40 to 49	84	17.7	57	17.2	27	18.9
50 and over	109	22.9	97	29.2	12	8.4
Gender						
Cisgender Man	192	40.4	192	57.8		
Cisgender Woman	140	29.5	140	42.2		
Transgender Man/Woman	109	22.9			109	76.2
Non-Binary	34	7.2			34	23.8
Sexual Orientation						
Heterosexual	21	4.4	3	0.9	18	12.6
Lesbian	122	25.7	92	27.7	30	20.9
Gay	201	42.3	181	54.5	20	14.0
Bisexual	58	12.2	31	9.3	27	18.9
Other	73	15.4	25	7.5	48	33.6
Race/Ethnicity						
Non-Hispanic White	357	75.2	261	78.6	96	67.1
Black/African American	31	6.5	21	6.3	10	7.0
Hispanic	48	10.1	27	8.1	21	14.7
Other	39	8.2	23	6.9	16	11.2
Educational Attainment						
Less than a 4-year degree	188	39.6	129	38.9	59	41.3
4-year degree or higher	287	60.4	203	61.1	84	58.7
Religiosity (How important is religion in your life?)						
Very important	120	25.3	84	25.3	36	25.2
Somewhat important	107	22.5	66	19.9	41	28.7
Not too important	96	20.2	70	21.1	26	18.2
Not at all important	152	32.0	112	33.7	40	27.9

Table 3. Descriptive statistics of conversion therapy types.

	Total Sample (n = 4096)		Cisgender Sample (n = 3219)		Gender Minority Sample (n = 877)		x^2
Different Types	*n*	%	*n*	%	*n*	%	24.1***
Any Conversion Therapy	475	11.6	332	10.3	143	16.3	
Mental Health Practitioner	265	6.5	185	5.7	80	9.1	
Religious Leader/Clergy	282	6.9	194	6.0	88	10.0	
Other	76	1.9	49	1.5	27	3.1	
Number of Different Types	*n*	%	*n*	%	*n*	%	25.4***
No Conversion Therapy	3624	88.5	2890	89.8	734	83.7	
One Type	345	8.4	243	7.5	102	11.6	
Two Types	127	3.1	86	2.7	41	4.7	

*p <.05, **p <.01, ***p <.001

Mississippi had the highest prevalence at 17.8% and West Virginia had the lowest prevalence at 4.4%.

Table 4 demonstrates several significant relationships between demographic variables and the likelihood that a respondent underwent conversion therapy before the age of 18. Younger respondents are significantly more likely than older respondents to report having experienced any form of conversion therapy (−.012, $p < .01$), and this finding remains significant among both

Table 4. Logistic regression results by gender: predictors of undergoing conversion therapy before age 18.

Independent Variable	Total Sample			Cisgender Sample			Gender Minority Sample		
	B	S.E.	Exp(B)	B	S.E.	Exp(B)	B	S.E.	Exp(B)
Age	−.012**	.004	.989	−.011*	.004	.990	−.019*	.008	.981
Cis Woman	−.386	.213	.680	−.439	.286	.645			
Transgender Man/Woman	.418*	.199	1.520						
Non-Binary	.595*	.249	1.813						
Lesbian	.560*	.268	1.750	1.716**	.615	5.561	.098	.347	1.103
Gay	.537	.279	1.710	1.616**	.608	5.030	−.025	.384	.975
Bisexual	−.298	.277	.742	.682	.622	1.977	−.519	.353	.595
Other Sexual Orientation	.046	.272	1.047	1.311*	.634	3.711	−.459	.330	.632
Black/A.A.	−.013	.205	.987	−.159	.245	.853	.463	.391	1.589
Hispanic	.633***	.176	1.884	.405	.225	1.499	1.059***	.298	2.883
Other Race-Ethnicity	.291	.188	1.338	.322	.239	1.380	.330	.307	1.391
Educational Attainment	−.229*	.107	.795	−.436***	.125	.647	.324	.203	1.383
Religiosity	−.219***	.044	.803	−.166**	.052	.847	−.362***	.083	.697
Nagelkerke R Square	.061			.057			.085		

*p <.05, **p <.01, ***p <.001

cisgender (−.011, $p < .05$) and gender minority (−.019, $p < .05$) respondents. Respondents who identify as transgender men or women (.418, $p < .05$) or non-binary (.595, $p < .05$) are significantly more likely to report having gone through conversion therapy than cisgender respondents. Lesbian respondents are also significantly more likely to report having gone through conversion therapy (.560, $p < .05$), and although this pattern is significant among cisgender respondents (1.716, $p < .01$), it is not significant among gender minority respondents. Within the cisgender subsample, respondents who are gay (1.616, $p < .01$) or had some other sexual orientation (1.311, $p < .05$) are significantly more likely to report having gone through conversion therapy, however these findings lose significance in the total sample and gender minority subsample.

In regard to race, Hispanic respondents were significantly more likely to report having gone through conversion therapy than white respondents in the total sample (.633, $p < .001$) and gender minority subsample (1.059, $p < .001$), but not in the cisgender subsample. Respondents who received less than a 4-year degree are significantly more likely to report having experienced conversion therapy than respondents who received a 4-year degree or higher in the total sample (−.229, $p < .05$) and cisgender subsample (−.436, $p < .001$), but not in the gender minority subsample. Lower levels of religiosity at the time of taking the survey also yielded highly significant values in the total sample (−.219, $p < .001$), cisgender subsample (−.166, $p < .01$), and gender minority subsample (−.362, $p < .001$). This finding implies that respondents who had gone through conversion therapy in their youth were less likely to consider religion important in their lives at the time of taking the survey. The Nagelkerke R Square yields a score of .061 among the total sample, a score of

Table 5. Logistic regression results by gender: predictors of a probable SMI (serious mental illness).

	Total Sample			Cisgender Sample			Gender Minority Sample		
	B	S.E.	Exp(B)	B	S.E.	Exp(B)	B	S.E.	Exp(B)
Age	−.035***	.003	.965	−.036***	.004	.964	−.032***	.007	.968
Cis Woman	.120	.157	1.127	.084	.184	1.088			
Transgender Man/Woman	.744***	.157	2.104						
Non-Binary	.758***	.203	2.134						
Lesbian	.476*	.236	1.610	.562	.360	1.754	.571	.334	1.770
Gay	.571*	.247	1.770	.660	.364	1.935	.584	.357	1.792
Bisexual	1.064***	.229	2.897	1.142**	.353	3.132	1.096***	.315	2.993
Other Sexual Orientation	.962***	.230	2.617	1.189**	.367	3.284	.861**	.304	2.365
Black/A.A.	−.124	.171	.883	−.089	.197	.915	−.217	.335	.805
Hispanic	.092	.159	1.097	−.165	.205	.848	.580*	.285	1.785
Other Race-Ethnicity	.075	.155	1.078	.249	.193	1.283	−.212	.253	.809
Educational Attainment	−.486***	.083	.615	−.525***	.099	.592	−.417**	.153	.659
Religiosity	.031	.036	1.031	.023	.043	1.023	.070	.068	1.072
Exposed to Conversion Therapy	.540***	.115	1.716	.421**	.145	1.524	.720***	.200	2.054
Nagelkerke R Square	.171			.125			.138		

*p <.05, **p <.01, ***p <.001

.057 among cisgender respondents, and a score of .085 among gender minority respondents.

Table 5 demonstrates that respondents who experienced conversion therapy as an adolescent have a significantly higher probability of experiencing a serious mental illness or SMI (.540, $p < .001$). This finding remains significant when the sample is stratified by cisgender (.421, $p < .01$) and gender minority (.720, $p < .001$) respondents. The Nagelkerke R Square yields a score of .172 among the total sample, a score of .125 among cisgender respondents, and a score of .138 among gender minority respondents.

Discussion

The above findings demonstrate both similarities to previous studies showing relationships between conversion therapy and negative mental health and new insights that suggest a need for further study. In particular, this study found that respondents who are younger, transgender, non-binary, Hispanic, less educated, and less religious at the time of taking the survey are more likely to have experienced conversion therapy in their youth. Among cisgender respondents, those who identify as lesbians, gay, or some other sexual orientation are also more likely to have experienced the practice before age 18. The finding that respondents who undergo conversion therapy before age 18 are significantly more likely to experience serious mental illness further substantiates the scientific consensus around conversion therapy as a psychologically harmful practice. This study also provides data on conversion therapy within the unique political and social contexts of the South, a region known for its religious and conservative values.

The findings regarding age indicate that newer generations of young people may be more likely to recognize and report their experiences with sexual orientation or gender identity change efforts such as conversion therapy. We theorize that older generations of LGBTQ people who grew up in a more hostile social climate may have realized their sexual orientation or gender identity later in life or learned to hide same-sex attractions and gender non-conformity from a young age and may, as a result, have been more successful in avoiding conversion therapy before age 18 altogether. However, further cohort research is required to determine the actual social contexts that may be behind our finding that contemporary LGBTQ young adults are more likely than those in previous generations to have endured conversion therapy before the age of 18. It is especially noteworthy that gender minority and lesbian individuals in the sample were more likely to have experienced conversion therapy because in general, these groups appear to be severely underrepresented in most existing research on this topic.

The finding that transgender and non-binary respondents also are more likely to report having experienced conversion therapy is consistent with previous studies supporting the finding that gender minority individuals are more likely to undergo the practice than cisgender individuals (Turban et al., 2019). Indeed, this finding is especially timely because societal efforts to control gender also may be growing. According to the Human Rights Campaign (2016), increased public awareness of transgender people and issues propagated by activists and the media have led to "an increased level of anti-transgender violence, particularly targeting transgender women of color (p. 1)." This same report found that between 2015, the year same-sex marriage was legalized in the United States, and 2016, 44 anti-transgender bills were introduced across the country, the largest amount "state legislatures had ever seen" (Human Rights Campaign, 2016, p. 2). However, because the first question on conversion therapy only asks if anyone attempted to change the respondent's sexual orientation and did not ask about attempted changes to gender identity, it is unclear whether gender minority respondents went through conversion therapy due to their sexual orientation, gender identity, or both.

Perhaps cisgender gay and lesbian respondents are more likely to report having experienced conversion therapy than bisexual respondents because of the nature of the practice; it makes sense that individuals able to maintain opposite-sex attractions are less likely to be exposed to sexual orientation change efforts. The finding that cisgender respondents with some other sexual orientation also are more likely to have experienced conversion therapy requires further study with a more fine-grained disaggregation of other sexual orientation categories in order to more fully analyze this correlation. Although we found no other studies analyzing significant results around the relationship between race and conversion therapy, it is possible that Hispanic respondents

are more likely to have gone through conversion therapy due to being raised in more religiously conservative environments with higher expectations related to masculinity and machismo. Indeed, according to one study, "the strong emphasis on religion, and especially Catholicism, in Latino culture was a key reason (p. 207)" that Latinx LGBTQ individuals feel disconnected from their community, and "machismo was explicitly mentioned by all but one of the participants as an expectation or value that produced difficulties (p. 207)" (Gray, Mendelsohn, & Omoto, 2015).

The finding that lower educational attainment correlates with a higher likelihood of experiencing conversion therapy reinforces prior research findings that conversion therapy is negatively associated with less education and lower overall socioeconomic status (Ryan et al., 2018). Respondents who have undergone conversion therapy may be less likely to identify as religious at the time of taking the survey in part because nearly half of them experienced conversion therapy from a religious leader in their community in their youth. Their families may have felt religiously justified in forcing them to experience such an ineffective form of treatment, as demonstrated by research outcomes that young LGBTQ people raised by more religious parents (particularly families with high levels of religious fundamentalism) are more likely to be exposed to conversion therapy (Maccio, 2010; Ryan et al., 2018). These experiences likely led respondents to lose trust in the positive elements of religion; one study supports this notion with the findings that when religion-based conversion therapy did not work, it damaged many participants' beliefs in God and the institutions and leaders contiguous to their faith (Dehlin et al., 2015).

Limitations

The design and methods of the LGBTQ Institute Southern Survey have both significant strengths and limitations. Strengths consist of the following: the survey was created with substantial and regular community feedback; the sample size is large; the sample was collected with the assistance of 146 partner LGBTQ community organizations throughout 14 states; there are many questions on a wide range of topics; and there are very few representative surveys of LGBTQ people and no targeted surveys in the South. Thus, this survey yields a diverse set of respondents across the Southern states and asks a wide variety of questions able to cover issues ranging from discrimination in various social institutions to political views.

The survey's limitations consist of the following: the survey is a convenience sample, thus it may not be truly representative of all LGBTQ people in the South or their intersectional experiences; and the survey particularly underrepresents the experiences of nonwhite respondents (Wright, Roemerman et al., 2018a.). A random sample would be ideal, however when studying a marginalized population such as LGBTQ individuals a random sample

cannot easily be achieved. In addition, while the survey design facilitated the collection of data from a much larger sample, it fails to encompass the wealth of information that could be obtained through more qualitative studies, such as in-depth interviews or observation.

Regarding limitations for the current study, only two questions on the Southern Survey focus on conversion therapy, the first question only asks about sexual orientation change efforts and fails to ask about gender identity change efforts, and neither question is open-ended. Thus, unlike more qualitative studies of conversion therapy, the current study is unable to provide more comprehensive data about respondents' experiences with the practice, such as their personal emotions surrounding it and what forms of therapy they underwent (e.g. aversive therapy versus talk therapy versus gender roles training). Gender minority respondents in particular were unable to specify whether the conversion therapy they experienced was meant to change their sexual orientation, gender identity, or both. If an entire subsection of the Southern Survey had been devoted to respondents who experienced the practice, we could have measured how effective or harmful each respondent rated conversion therapy, examined the prevalence of various conversion therapy techniques such as aversion therapy and "gender role training," analyzed experiences of conversion therapy unique to gender minority respondents, and gathered rich data from open-ended questions where respondents described their experiences in-depth.

To eliminate small N's, we recoded age from six ten-year categories by collapsing the last three categories (although in the logistic regressions, age is coded as an interval/ratio variable) and we have recoded educational attainment into a binary of less than a four-year degree and four-year degree and over. We left gender, sexual orientation, race/ethnicity, and religiosity as they are currently coded because we believe that each category within those variables is unique from the others and important to keep separate. We have taken the small N's of these variables into account by running three different regression models for our second research question.

We created a listwise deletion filter in SPSS that put the total sample size at 4,096 and the sample size for those who had experienced conversion therapy at 475 respondents. The first model included all independent variables in Table 1, the second model included all variables except race/ethnicity, and the third model included all variables except race/ethnicity and religiosity. The three models demonstrated no issues with overfitting variables due to small N's. However, we did find a slight issue of multicollinearity between race/ethnicity and education: we cannot fully analyze the effects of education when race/ethnicity is included. We decided to exclude the second and third models from Table 4, and instead analyze discrepancies between the total sample, cisgender subsample, and gender minority subsample.

Conclusion

This study reiterates the negative consequences of conversion therapy that various other studies have substantiated, and thus supports legal actions against the practice, especially when conducted on people under 18. The prevalence of conversion therapy in our sample (7.6% of the total sample) suggests that a significant number of people in the South endure the practice. The findings that respondents who are younger, transgender, non-binary, lesbian, gay, some other sexual orientation, Hispanic, less educated, and less religious at the time of taking the survey are more likely to experience conversion therapy may display a shift in who bears the brunt of the practice within the LGBTQ community. Indeed, many of the demographic findings could be studied further, in particular how younger respondents, cisgender respondents with some other sexual orientation, Hispanic respondents, less educated respondents, and less religious respondents are all more likely to have experienced conversion therapy. Perhaps newer generations of queer and transgender youth experience conversion therapy at higher rates as a result of the anti-LGBTQ backlash that has permeated politics in the South since the nationwide legalization of same-sex marriage (Barber, 2019).

Notes

1. The states include Alabama, Arkansas, Florida, Georgia, Kentucky, Louisiana, Mississippi, North Carolina, Oklahoma, South Carolina, Tennessee, Texas, Virginia, and West Virginia.
2. Prior to listwise deletion, 495 of 6,502 (7.6%) respondents reported experiencing conversion therapy before age 18.

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Disclosure statement

The author reports that there is no potential conflict of interest.

Data availability statement

The data that support the findings of this study are available upon reasonable request by contacting the corresponding author, Dr. Eric Wright, via email at: ewright28@gsu.edu.

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