A Research Review of *Parent-Initiated Sexual Orientation Change Efforts with LGBT Adolescents: Implications for Young Adult Mental Health and Adjustment*[1]

by Ryan et al.

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This study no doubt is intended to fill the void that has heretofore existed regarding research on adolescents who have undergone sexual orientation change efforts (SOCE). The 2009 APA Task Force's report acknowledged that there was no empirical literature to evaluate adolescent change efforts, which always should have been somewhat of an embarrassment to proponents of therapy bans for minors. Hence, the Ryan et al. study was enthusiastically welcomed by ban proponents and quickly adopted in the legislative efforts to prohibit SOCE among minors, including minors who have a self-determined goal to

[1] Ryan, C., Toomey, R. B., Diaz, R. M., & Russell, S. T. (2018). Parent-initiated sexual orientation change efforts with LGBT adolescents: Implications for young adult mental health and adjustment. *Journal of Homosexuality*. Advance online publication, pp. 1–15. http://dx.doi.org/10.1080/00918369.2018.1538407

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explore their sexual attraction and behavior fluidity. Because this research has clear political advocacy aims, great caution should have been taken by the authors to exercise restraint in order to not overstate the scientific implications of their work. Unfortunately, there are some worrisome signs that such caution has not been sufficiently exercised.

Ryan et al. conducted a cross-sectional study of 245 LGBT White and Latino young adults ages 21–25. They asked participants (1) *Between ages 13 and 19, how often did any of your parents/caregivers try to change your sexual orientation (i.e., to make you straight)?* And (2) *Between ages 13 and 19, how often did any of your parents/caregivers take you to a therapist or religious leader to cure, treat, or change your sexual orientation?* For question 1, 53% of participants responded this had occurred at least once, and for question 2, 34% reported having been taken to a therapist/religious leader for attempted orientation change. Participants also were assessed for mental health and adjustment, including measures of suicidal ideation, lifetime suicide attempts, depression, self-esteem, and life satisfaction.

The authors reported findings that certainly pleased ban proponents:

> With the exception of high-risk sexual behavior and substance abuse, attempts to change sexual orientation during adolescence were associated with elevated young adult depressive symptoms and suicidal behavior, and with lower levels of young adult life satisfaction, social support, and socioeconomic status. Thus, SOCE is associated with multiple domains of functioning that affect self-care, wellbeing, and adjustment. (p. 10)

I concur with Ryan et al.'s discussion regarding the critical need for education of the conservatively religious community on matters pertaining to sexual orientation, particularly the need for acceptance and love of children experiencing same-sex attractions by their parents. This is the most appropriate "take home" lesson from their study. Other observations and conclusions made by these researchers, however, suggest their advocacy interests have colored their scientific objectivity.

First, the authors indicate that Spitzer "retracted" his study (Spitzer, 2003). This gives the impression that the study was retracted from the scholarly literature—something that never happened. The journal's editor, Kenneth Zucker, Ph.D., refused to retract the article, commenting to one interviewer,

> You can retract data incorrectly analyzed; to do that, you publish an erratum. You can retract an article if the data were falsified—or the journal retracts it if the editor knows of it. As I understand it, he's [Spitzer] just saying ten years later that he wants to retract his interpretation of the data. Well, we'd probably have to retract hundreds of scientific papers with regard to interpretation, and we don't do that. (Dreger, 2012)

So perhaps it can be said that Spitzer "retracted" his interpretation of the data, but the findings such as they were still stand. We are left to decide which interpretation is more plausible—whether all of Spitzer's participants were either lying or self-deluded or whether some if not many were in fact reporting their actual experience of change (Armelli, Moose, Paulk & Phelan, 2013). It is also worth noting that studies Ryan et al. view with favor have been conducted with essentially the same design and a similar recruitment strategy used by Spitzer (e.g., Shidlo and Schroeder, 2002). Hence,

overgeneralizing in any direction (harm or benefit) from these studies is likely to be a scientifically dubious practice.

Second, Ryan et al. imply their research supports legislative and professional regulatory efforts to prohibit licensed therapists from assisting some religiously devout sexual minority clients in their self-determined goal of exploring sexual attraction and behavior fluidity. This is problematic on a number of fronts. Ryan et al. did not disentangle participants' perceptions of the effects of licensed therapists from that of unregulated and unaccountable religious leaders, so it is impossible to rule out the common-sense suspicion that negative effects were an outcome far more attributable to the practices of the latter group (see Dehlin, Galliher, Bradshaw, Hyde, and Crowell, 2015, for evidence supporting this concern). The concept of "cure, treat, or change" is also quite nebulous. This language may not only have served as a prompt for more negative responding, but presumably was elastic enough in participants' minds to include anything from simple prayers for healing ubiquitous in conservative religious circles to much rarer and harmful practices like exorcisms that everyone should oppose.

Third, the authors state, "we acknowledge that we did not include young people whose sexual orientation may be more fluid" (p. 12). By limiting their sample to LGBT-identified young adults who self- identified in adolescence and who did not report experiencing any sexual orientation fluidity, the sample excludes by definition those sexual minorities who may have felt some benefit from religious and professional experiences that could be viewed as non-affirming. Adolescents who may have experienced therapy-assisted meaningful shifts or changes in same-sex attraction or behavior are less likely as young adults to self-identify as LGBT and go to LGBT bars, clubs, or service agencies where they could be recruited for research. Thus, the nature of the sample likely overestimates harm.

There is growing evidence that constructs and conclusions derived from LGBT-identified samples may not be easily transferrable to non-LGBT identified sexual minorities with primary religious identities (Hallman, Yarhouse, & Suarez, 2018; Lefevor, Sorrell, Kappers, Plunk, Schow & Rosik, 2019; Rosik, 2007b). This raises serious questions regarding the validity of the already limited empirical basis for therapy bans impacting religiously identified sexual minority clients and their therapists when these bans are overwhelmingly based on research with LGBT-identified samples.

For example, ideological confounds are quite possible in the authors' choice to measure self-esteem in part through utilizing Rosenberg's (1965) measure of self-esteem. As is always a methodological concern when surveying conservatively religious individuals, some scales define their construct in a manner that is inherently biased against religious values (e.g., Rosik, 2007a, 2007b). Consequently, scores may reflect differences between humanistic values and theistic beliefs (e.g., elevation of the self versus the virtues of humility and self-negation) more than the construct purportedly assessed by the instrument, which in the present case was self-esteem. Such appears to be the case with this measure of self-esteem, where research has suggested that when antireligious humanistic dimensions of the Rosenberg scale were statistically controlled, the self-esteem ratings of conservatively religious persons were significantly improved (Watson, Morris, & Hood, 1987). The implication for the Ryan et al. (2018) study is the distinct possibility that self-esteem levels were suppressed and might actually have been higher than indicated for participants who were more highly and conservatively

religious and therefore more likely to have experienced SOCE as adolescents.

Ryan et al. fail to acknowledge the very real potential downsides of therapy bans. The potential unintended consequences of banning therapies conducted by licensed therapists include, as noted by Sandley (2014), an erosion of the mature minor doctrine (for adolescents), an increased reliance by parents and adult consumers on unlicensed and faith-based providers, and the establishment of a very weak standard of scientific support that could come to be used in the courts against other progressive causes such as women's reproductive rights (i.e., purported psychological harms attributed to abortion).

Schumm (2015) has suggested some aspirational standards that would justify the use of empirical data in advocacy for public policy and judicial decision-making in controversial arenas. These ideals include utilizing only studies that (1) have findings with effect sizes of 0.20 or greater (even when results are not statistically significant), (2) use random samples from known populations (if the results are being generalized for policy or law purposes), and (3) employ reliable and valid independent variables. Ryan et al. and other researchers in this field would be well advised to exhibit heightened circumspection in their advocacy when such standards are not met (Rosik, 2017).

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