

Peer Commentaries on Spitzer (2003)

Can Sexual Orientation Change? A Long-Running Saga

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The issue of whether people can change their sexual orientation has been obscured by moral controversy ever since homosexual orientation was “constructed” in the late nineteenth century (Bancroft, 1989, 1994). On the one hand, any evidence that such change has occurred has been used by those who condemn homosexuality as evidence of its “acquired” nature which, they would argue, is consistent with it being sinful; on the other hand, those who defend the homosexual reject evidence of such change on the grounds that those changed cannot have been true homosexuals in the first place (e.g., Ellis, 1915). Rational debate about the extent to which people can change, and what characteristics might predict the potential for such change, therefore becomes rapidly buried.

I am more than familiar with this long-running controversy. In the 1960s, early in my career as a budding behaviorist, I carried out research to assess whether behavioral techniques, such as aversion therapy or systematic desensitization, could modify sexual preference in men (no women presented themselves for such treatment). My experiences fairly quickly led me to conclude that such interventions were ineffective. But in reporting my findings (Bancroft, 1974), I came under attack from members of the Gay Rights Movement for attempting to impose societal norms on those with a homosexual orientation, and in the process reinforcing the social stigma. Thus, somewhat unwittingly, I found myself in the midst of this moral controversy. This, needless to say, caused me to reflect (Bancroft, 1975). In no way had I rejected homosexuality as a sexual lifestyle nor had I regarded it as pathological. In my innocence, I was responding to the requests of some homosexual men to help them to change and escape from

the social stigma their sexuality brought upon them. Also, as a researcher, I wanted to know whether the claims of “reorientation” that were being made by other behavior therapists, in particular MacCulloch and Feldman (1967), could be substantiated. The use of such interventions did not imply that homosexuality was a pathology, but rather an aspect of behavioral responsiveness that might be modifiable with these new behavioral techniques that were based on so-called “modern learning theory.”

Times were different then. The Gay Rights Movement was early in its development and it was much more likely than it is today that individuals would seek such change. But on reflection, I realized that, whereas I was genuinely trying to help the individual, in the process I was aligning myself with those who reinforced homophobic attitudes and all the consequences of the stigma that ensued. It did not continue to be a dilemma for me, as my own results gave me no reason to continue to use such simplistic interventions.

Then, in 1973, the American Psychiatric Association (APA) removed homosexuality from the DSM, in the process rejecting the notion that it was inherently pathological (Bayer, 1981). Although revealing considerable division of opinion within the psychiatric profession on this issue, this step could be regarded as the official end of the medicalization of homosexuality, which up to that time had been pursued steadfastly by the medical profession. As if to reinforce this “demedicalization,” the APA has since periodically issued statements about the immutability of sexual orientation, and that it is unethical for clinicians to attempt to change it with therapy (American Psychiatric Association, 2000). What has happened since 1973 is that “the Church,” in many of its manifestations, has stepped into the breach, reviving religious opposition to homosexuality in terms of immorality rather than pathology. Given that Spitzer played a key role in the APA’s demedicalization of homosexuality in the 1970s, it is interesting that he has recently paused to reconsider, if not the pathology of homosexuality, at least its immutability.

What can we learn from Spitzer's study? Its principal strength is the substantial size of his sample, much larger than most comparable studies. I also have no reason to doubt Spitzer's sincerity in carrying out this study. But there are some major limitations.

First and foremost, the sample consists of men and women who principally sought treatment because of their religious beliefs and who were presenting themselves as evidence that such change was both possible and desirable for others (for 93%, religion was extremely or very important, and 78% had spoken in public about their "conversion," in many cases in their churches). Assessment of change was entirely based on their recall of how things were before treatment. Given their powerful agenda of promoting such treatment, it would be surprising if they did not overestimate the amount of change. A similar problem exists with the evaluation of any treatment for which the patient has a vested interest in proving its worth. Spitzer addresses this issue by pointing out that simple bias of this kind would have produced a more clear-cut picture of re-orientation and no gender difference. He is partially right, but he cannot justifiably conclude that because there was not maximum distortion, that distortion did not occur.

Secondly, it is very difficult to discern from this study just what the "reparative therapy" had involved. At best, it had been a long process, with a substantial minority still continuing in ongoing therapy after many years. There were a few hints at specific interventions, mainly of the "self-control" variety (e.g., "thought stopping," "avoiding tempting situations"), and an intriguing passing reference, at least for homosexual men, to "the demystification of the male and maleness," resulting in a decrease of romanticization and eroticization of men. But for the most part, there seemed to be a more general process involving group pressure and therapist reinforcement of the determination to be different and, as a result, less immoral.

It was not clear how these subjects were recruited, although unquestionably they constitute a highly unrepresentative sample of those who had come under the influence of religion-driven "reparative therapy." I could also take issue with Spitzer's criteria of change, and his title, which states that 200 subjects reported a change from homosexual to heterosexual orientation, when the article reports a less substantial change for many, if not most, of them.

So where does this leave us? Let me put aside, for one moment, the politics and ethics of "reparative therapy." There are good grounds, apart from this study, for concluding that sexual orientation is not always fixed early and immutable. Whereas the large majority of us identify as homosexual or heterosexual at a relatively early age, never change, and have no inclination to attempt to

change, there is a minority of unknown size whose sexual behavior is less bound by an "orientation" or who are less certain about their sexual identity and who may go through processes of change without any involvement in "reparative therapy" or the like. It is noteworthy that Kinsey (Kinsey, Pomeroy, & Martin, 1948) proposed his scales to capture the variability of sexual preference, not only across individuals, but also within the same individual over time. As the Gay Rights Movement gathered momentum, Kinsey's view was rejected, in favor of a clear dichotomy of "straight or gay," with those who identified as bisexual regarded as deceiving themselves (e.g., Robinson, 1976). In the past 15 years, the flexibility of sexual identity has again been acknowledged. In the AIDS era, the concept of "men who have sex with men" is used as a more general descriptor than "homosexual."

Every now and then, I see someone in my clinic who presents himself (and, more occasionally, herself) as confused or conflicted about sexual identity. Sometimes they are struggling with the idea of bisexuality. "Does bisexuality exist?" they might ask. In some cases, their sexuality is compartmentalized (e.g., "I find certain types of men very sexually arousing, but I can't imagine being in a loving sexual relationship with another man")—what might be described as a failure to incorporate one's sexuality into one's capacity for a close dyadic relationship, a problem by no means confined to those with homosexual orientation. How do I react to such patients after a career of reflection on this issue? I now have no doubts about how to respond and this involves some crucial sequential steps:

- Step 1. Make it absolutely clear that, whatever the patient's values or beliefs might be, I have no difficulty whatsoever in accepting and valuing either a homosexual or a heterosexual or a bisexual identity. The issue is which is right for that person. In so far as I have personal values, they apply to issues of responsibility and the use of sex to foster intimacy in a close ongoing relationship. Neither is dependent on the gender of those involved. It behooves the therapist to be explicit about her or his moral values as they impact on the treatment process so that the patient can choose whether to work with that therapist or not.
- Step 2. Make it clear that in order to find out what type of sexual relationship works best, it may be necessary to experience more than one type of relationship, involving partners of either gender. Furthermore, during a lifetime, more than one successful relationship may occur, involving same sex and opposite sex partners at different times.
- Step 3. Emphasize the need to take time to work out what is right. The therapist, who is better designated as a

counselor in this context, facilitates this process of search and discovery as appropriate. This may involve helping the patient to identify the different “compartments” of his or her sexuality, and how to incorporate them into a sexually rewarding, intimate, and loving relationship. This is more education than therapy.

Some of the subjects in Spitzer’s study may have gone through some comparable process, except that it is clear that at no time was the acceptability of a homosexual or bisexual solution ever on the agenda. Others sound as though they are still battling with the conflict between what feels sexually right for them and what is morally acceptable to them (and their therapist).

The concept of “reparative therapy,” as described, raises some key ethical issues, the most fundamental being the distinction between medical treatment for a pathological condition and the imposition of moral values under the guise of medical treatment. If there were any grounds for regarding homosexual orientation as a pathology rather than a variant of human sexual expression, then treating the pathology might be justified. I would assert that there are no such grounds, and hence providing treatment on that basis is professionally unethical and, according to my value system, immoral. There is a long and disturbing history of medical practitioners imposing their moral values through their professional practice. The imposition of moral values, explicitly or implicitly, that is, urging someone to undergo change because their current sexual orientation is immoral, should not be regarded as “therapy,” and in any case raises other ethical and moral issues. I would strongly advocate Surgeon General David Satcher’s *The Surgeon General’s Call to Action to Promote Sexual Health and Responsible Sexual Behavior* (U.S. Department of Health and Human Services, 2001). This calls for responsibility in our sexual lives (responsibility towards ourselves and our sexual partners), coupled with a respect for diversity. Thus, someone who believes that homosexuality is wrong is entitled to that opinion, but is not entitled to impose it on others, particularly if those others exercise responsibility in their sexual lives. Thus, the principle of responsibility facilitates the acceptance of diversity.

Spitzer’s findings are consistent with the idea that some people do change their sexual orientation in some respects during the course of their lives, but his findings do not justify the existence of “reparative therapy.” As defined, this constitutes vigorous reinforcement of homophobia and the social stigma experienced by those with homosexual identities in our society. Together, this results in widespread suffering for homosexual minorities and, no doubt, for many who are pressured into attempting such change, considerable conflict and unhappiness.

Understanding the Self-Reports of Reparative Therapy “Successes”¹

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It should not be surprising that individuals who identify as “ex-gay” would report positive results when invited to participate in a study designed to support their position. It would be more informative, however, to understand how and why they came to those conclusions. My commentary on Spitzer’s study will involve reinterpreting his data in light of my research regarding individuals who reported successful experiences and those who reported harms from sexual reorientation therapy. My commentary will also clarify several misunderstandings that Spitzer made regarding my research.

My article that Spitzer cited (Beckstead, 2001a) was not meant to be a comprehensive summary of my findings or methodology but was written to describe the variety of agendas involved in sexual reorientation therapy. The methods I used in my investigations have been detailed in Beckstead (1999, 2001b) and Beckstead and Morrow (2003). Briefly, the whole of my research in this area includes two qualitative investigations involving 45 men and 5 women who held a wide-range of perspectives regarding sexual reorientation. Participants described their experiences at different points between 1997 and 2001 through interviews, prospective personal journals written during their therapy, four focus groups, and a multidimensional assessment (Coleman, 1987) of past, present, and intended future sexual orientations. Participants verified and also influenced my analysis of their experiences by reading preliminary results and correcting misinterpretations. Throughout these multiple interactions, participants described when they first discovered their attractions, how they dealt with these attractions while growing up, what motivated them to seek reorientation therapy, what their experiences were of such therapy, how therapy had affected them, how they currently managed their attractions, and what changes had occurred since the beginning of the study. Unlike Spitzer’s investigation, my studies also asked participants about their reasons for being involved with this type of research. All participants were asked the same questions during the interviews but were allowed to describe their experiences without any leading questions or direction. Similar to a structured interview, this method allowed for consistency and comparability among participants but also permitted exploration and the opportunity for participants to respond in their own terms.