

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”<sup>1</sup>

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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.

The primary difference between my studies and Spitzer's study is that my research was designed to analyze the meanings of participants' experiences and understand the context of their struggles and how they cognitively or behaviorally resolved their conflicts. Spitzer used his participants' self-reports, however, to prove the efficacy of reparative therapy. Because of my research focus and methodology, I learned that a variety of alternate reasons exist, besides the efficacy of reorientation treatments, as to why and how such participants claim success. I learned foremost that participants could identify as heterosexual because they were provided in the course of therapy with causal theories and interventions that helped them dissociate from a gay or lesbian identity. Such techniques included teaching participants that they were heterosexuals who had sexualized their emotional needs to be close to the same sex. Participants could then reframe their same-sex sexual fantasies as "admiration" rather than eroticism and believe they were heterosexual by eliminating their homosexual behaviors and maintaining their commitments to their family and religion.

Participants described being successful in reducing homosexual thoughts and behaviors; however, my results demonstrated ambiguity and inconsistencies in participants' reports of their sexual orientation. For example, some participants indicated they were "exclusively heterosexual" but specified experiencing limited heterosexual attractions. Some would describe themselves as "heterosexuals with a homosexual past," or as no longer having homosexual attractions, but only because they now avoided certain situations, such as "cruising" areas or being alone with same-sex individuals. These same inconsistencies may also be found in Spitzer's findings when some could not answer the question regarding labeling their sexual identity. Successful reports of reorientation in my studies were also in contrast to participants' journal entries, which monitored their attractions and motivations throughout their therapy experience. Several wrote about homosexual and heterosexual longings but later denied or disregarded them, which seemed to depend upon their current thinking process and circumstance. Because of these discrepancies in self-reports, it was difficult to say exactly how many participants experienced an increase in heterosexual attraction following therapy.

It became apparent during my analysis as well that participants' sexuality could not be measured on a unidimensional scale, as Spitzer used, because their homosexual attractions seemed mutually exclusive to their heterosexual attractions. That is, if a participant described himself or herself as "less homosexual," it would not necessarily mean she or he was "more heterosexual." Spitzer claimed that my definition was arbitrary of what constitutes

a significant increase in heterosexual arousal. However, I conceptualized sexual orientation by using Freund's (1974) definition as "the erotic preference for the body of one sex over that of the other" (p. 26). Participants in my studies reported that, at the end of therapy, they could still be aroused erotically to the body shape of same-sex individuals and, indeed, that this arousal pattern exceeded that toward opposite-sex individuals *despite calling themselves heterosexuals*. Participants reported that therapy helped them change their thinking about and expression of homosexuality and sexuality but not their actual sexual orientation. As well, even those participants who reported having an increase in heterosexual attraction described those attractions as oriented only to their spouse and different from their homosexual arousal. This difference in attraction and intimacy was described by one "converted" participant in this way:

I use the comparison of a campfire versus a forest fire. That maybe my emotional response to men would be like a forest fire and that it's very . . . it's been very intense and dangerous and out of control and perhaps damaging or hurtful. But my relationship with my wife is more like the campfire. It's warm and comfortable and happy and reassuring and protective and although it probably doesn't have the same emotional intensity that the physical relationship with a man might bring, you know, I think maybe it's good.

Some participants enjoyed sexual intercourse with the opposite sex; some stated that sexual intercourse with the opposite sex felt unnatural. Additionally, participants reported that their same-sex attractions and conflicts became a non-issue because they became less focused on their sexuality and more focused on careers and relationships.

Several other reasons exist concerning why we should not accept these clients' self-reports uncritically. As Spitzer noted, self-reports are unreliable measures. Freund (1960, 1977) and Conrad and Wincze (1976), for example, found that clients' self-reports of favorable reorientation outcomes tended to be imprecise, deny certain facts, and were not supported by objective data. Spitzer seemed to believe that he has assessed sexual attraction; yet, he has only measured participants' subjective experiences of their attractions. Phallometry would be a more reliable and valid measurement of sexual orientation because it distinguishes erotic arousal patterns in men. In addition, men can suppress responses in such assessments but not produce false ones (Kuban, Barbaree, & Blanchard, 1999; see also Chivers, 2000). A person who is primarily attracted to children and who wants to avoid punishment would more than likely tell others that he has changed, but measuring the degree of his arousal may indicate otherwise.

Demand characteristics and social and cognitive dissonance theories suggest that participants in my research and in Spitzer's would also need to tell themselves and others that they were not failures. Given the extreme internal and external motivations and the amount of time and energy they have invested, participants would want to feel successful.

To illustrate this, I talked with an individual, "Steven" (personal communication, January 26, 2003), who participated in a study conducted by Shidlo and Schroeder (2002), which was similar to mine and to Spitzer's. Steven stated that he was asked by his therapist to participate in this study and "give a good report." Steven stated that he felt confident at the time of his interview that he was doing the right thing and was making progress. Therefore, he told the interviewer that he had made significant improvements in his pre and post ratings. Steven also stated, however, that, in retrospect, his report was "inflated" and based on his need for approval and validation:

I wanted to be NARTH's poster child. I wanted to fit in and there was so much at stake. I wanted to boost my morale and tell others that I was doing well. . . . I downplayed my sexuality. I lied enough so it would be believable to myself and the researcher. I also believed I could become [heterosexual], and I saw a glimmer that it was true. I convinced myself because I sometimes felt it, and there was enough hope that it was or could be true.

Steven stated that because he was behaving heterosexually, could be aroused with stimulation, was delaying the times between ejaculations, and loved his wife, he felt heterosexual. He also described sex with his wife as satisfying because it kept his family together, met religious and societal standards, and was preferable to the extreme guilt associated with the brief sexual encounters he had with men. He also stated that he struggled with labels: "I've slept with 1 woman 100 times and 100 men 1 time. Am I bisexual?" Steven stated that although he stopped sexualizing his thoughts about men, his dreams manifested erotic preferences for them. Furthermore, Steven stated that his self-report was political: "Gay-affirmative research was taking away our right to our beliefs. I needed to defeat these people and stand up for our beliefs and for the crusade." Steven's experiences are similar to those described by my participants and suggest that Spitzer's data collection may be invalid, ignoring important contextual factors and the shifts these individuals may make in perspectives and individual development.

An additional limitation of Spitzer's study is his selective reporting of clients' experiences. His research fails to describe the experiences of those individuals for whom reparative therapy does not work. By contrast, my research included the significant harms that occurred when hopes

and assurances of a lasting cure turned false and the person continued to be "plagued" by same-sex attractions after sincere efforts to change had failed. These failures were internalized and reported to increase self-hatred, hopelessness, and fear, even leading some participants to attempt suicide. Additionally, reparative therapy tended to reinforce extreme, negative stereotypes of the lives of lesbian, bisexual, and gay individuals, which seemed to cause still more self-hatred, discrimination, and difficulties in intimacy. Spouses and families also blamed themselves or the client for not changing enough and further pain, separation, and depression followed. These harms are not superficial ones. They require clarification and accuracy in portraying how the underpinnings and current practice of such therapy have the potential for serious negative consequences. Spitzer espouses reparative therapy, but missed the larger picture because he limited his focus on a highly self-selected, nonrepresentative portion of the population who may seek out such treatments.

Spitzer's data are important, however, in that they demonstrate that a subset of same-sex attracted individuals can adapt successfully to live in a heterosexual relationship. Spitzer is inaccurate when he wrote that I would consider these individuals as therapy failures. In fact, I have advocated and developed a broader-based treatment plan where such clients can explore a wide range of options and develop individualized solutions to integrate their sexual and social selves in a healthy manner. My biggest concern is that Spitzer's description of his data is misleading. Policy makers, religious leaders, families, and individuals in conflict may believe that all homosexual or bisexual individuals could (and therefore should) be heterosexual if they just tried hard enough. In fact, Spitzer's study has been widely cited as proof that gay men and lesbians can change their sexual orientation. A more accurate interpretation of his results would suggest, however, that only a rare proportion of same-sex attracted individuals can find ways to live satisfactorily in a heterosexual relationship.

### **The Malleability of Homosexuality: A Debate Long Overdue**

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Is homosexuality innate and immutable? Or can a person with a homosexual sexual orientation make significant changes in the direction of becoming heterosexual? Are the official statements issued by the major national mental health associations—which declare that there is