

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

no published evidence demonstrating that homosexuals can significantly alter their sexual attractions—in fact, accurate? Such questions take center stage in any discussion of sexual orientation and change.

Studies published in some peer-reviewed journals have attempted to demonstrate that homosexuality is so strongly compelled by biological factors that it must be indelibly ingrained in a person's core identity. Therefore, such studies imply that sexual orientation is not amenable to change; however, critical reviews of those studies and subsequent acknowledgments by the researchers themselves yield only one conclusion: that biology alone is not sufficient to explain the development of homosexuality (Byne & Parsons, 1993; Friedman & Downey, 1993; Hamer & Copeland, 1994; LeVay, 1996). Rather, homosexuality—like most other complex attractions and behaviors—is almost certainly polygenic and multifactorial in origin. Given this likely genesis of homosexuality, what potential is there for change for those individuals who are motivated to seek such change?

Sexual plasticity in homosexual men is not a new or novel idea. More than 30 years ago, Freund (1963, 1971), using penile plethysmography, found that some homosexual men could voluntarily alter their penile responses to respond to heterosexual stimuli without ever receiving reorientation therapy. Although it would be erroneous to generalize from such a clinical sample to suggest that homosexual orientation is malleable in all people, still, historical and current research would suggest that it is equally erroneous to conclude that change in sexual orientation is not possible for *some* men.

In addition, the recent research by Diamond (2000) on lesbians has demonstrated that sexual orientation in females is far from fixed in those women who are not exclusively heterosexual. My own research and clinical experience for more than 30 years suggests that some homosexual men are able to make and sustain significant changes in core aspects of their homosexual orientation, including fantasy and sexual arousal—not just behavior. Such individuals are able to develop and then maintain heterosexual attractions (Byrd & Nicolosi, 2002; Nicolosi, Byrd, & Potts, 2000). Sexual plasticity in homosexual men and women has not received adequate attention within our profession. Indeed, a number of writers have decried the political activism that silences opposing viewpoints within the mental health arenas (Halpern, Gilbert, & Coren, 1996; Sarason, 1986). In a recent lead article in the *American Psychologist*, Redding (2001) made a strong case for the lack of sociopolitical diversity in psychology, the bias that results in research and publications, and the *de facto* discrimination that disfavors clinicians who hold unpopular

views (such as the belief that clients who seek sexual reorientation should be supported).

This confounding of politics, psychology, and therapeutics has occurred, I believe, because of antihomosexual bias in some cases and gay activism in others. In both instances, there has been a confusing co-mingling of facts and theories by anti- or prohomosexual political groups—both of which claim to have science on their side—and the ideas expressed do not appear to be representative of beliefs held by most therapists.

Frustrated with such activism, a former president of the American Psychological Association (APA), Robert Perloff, exclaimed “. . . listen to the client. . .” (Murray, 2001). Indeed, patient self-determination is the cornerstone of the mental health professions, and it must take priority over political activism. In fact, in a rare public expression of anger and frustration at the American Psychological Association meeting in 2001, Perloff condemned the APA's narrow politicism. Of reorientation therapy with homosexuals, he said: “It is considered unethical. . . . *That's all wrong*. First, the data are not fully in yet. Second, if the client wants a change, listen to the client. Third, you're barring research” (Murray, 2001, p. 20).

Listening to the client and respecting his or her choices are essential to the mental health professions, and Spitzer has concluded that some individuals who seek to diminish their homosexual attractions are motivated by a rational, self-directed goal. They are not simply seeking change to conform to external pressures or because of internalized homophobia.

The Spitzer study essentially reopens the debate over whether or not homosexuality is mutable. His research has ignited a heated discussion about the possibility of diminishing a homosexual orientation and developing heterosexual attractions. Indeed, Spitzer provides evidence that some gay men and lesbians are not only able to change self-identity, but are able to modify core features of sexual orientation, including fantasies. Thus, his research makes an important contribution to a plethora of other studies and case reports on change (Throckmorton, 2002).

Spitzer's sample size was larger than those of most in prior studies. He carefully considered the affective components of the homosexual experience and was considerably more detailed in his assessment than were other studies. His use of a structured interview demonstrates clearly how the subjects were evaluated. He limited his pool of participants to those who reporting at least 5 years of sustained change from a homosexual to a heterosexual orientation. Virtually any bias in the interview coding was eliminated by the near perfect interrater scores. A unique feature of his research is that the entire set of data is available to other researchers. And, finally, Spitzer has been and

continues to be supportive of gay affirmative therapy and gay rights.

Much of the criticism of Spitzer's study is likely to focus on sample bias because many of his subjects were referred by religiously conservative organizations which promote the possibility of change; however, as astutely noted by Rosik (2003), this may actually be a strength of the research given that the clear majority of the studies on homosexuality and change used convenience samples solicited through gay-affirming organizations and media. Rosik (2003) further notes that "this suggests a skew in the existing literature as a whole, the degree of which can only be determined through a closer examination of individuals such as those in Spitzer's study" (p. 18).

A substantial majority of the participants in the Spitzer study valued and agreed with their traditional religious faiths, which view homosexual relationships as non-life-giving and outside of the will of God. Such value systems should not be dismissed, judged by the therapist to be improper, or overridden through therapeutic manipulation. Haldeman (2000) offers an interesting perspective in this regard:

A corollary issue for many [clients] is a sense of religious or spiritual identity that is sometimes as deeply felt as is sexual orientation. For some it is easier, and less emotionally disruptive, to contemplate changing sexual orientation, than to disengage from a religious way of life that is seen as completely central to the individual's sense of self and purpose. However we may view this choice or the psychological underpinnings thereof, do we have the right to deny such an individual treatment that may help him to adapt in the way he has decided is right for him? I would say that we do not. (p. 3)

As LeVay (2000) explains it:

First, science itself cannot render judgments about human worth or about what constitutes normality or disease. These are value judgments that individuals must make for themselves, while possibly taking scientific findings into account. Second, I believe that we should as far as possible, respect people's personal autonomy, even if that includes what I would call misguided desires such as the desire to change one's sexual orientation. (p. 12)

Spitzer's research has demonstrated that, contrary to the prevailing climate, the data on homosexuality are far from complete. Ethicality would suggest that the suppression of data and discouragement of further scientific research should not be tolerated. With appropriate guidelines in place (institutional review boards), it is not only ethical but well within the purview of science to encourage the study of issues such as change from homosexuality. The well-intentioned caretakers of our national organiza-

tions slide down a slippery slope when advocating what amounts to a virtual censorship of scientific investigation of politically unpopular views. It is ironic that Spitzer—the original architect of the 1973 decision to remove homosexuality from the DSM—is once again, going against the prevailing winds of his time and advocating the avoidance of that slippery slope.

A Methodological Critique of Spitzer's Research on Reparative Therapy

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In Spitzer's study of the effectiveness of reparative therapy in changing sexual orientation, he reports that gay men and lesbians indicate that they have made major changes in their sexual orientation from homosexual to heterosexual. He also notes that even those who made only limited change in sexual orientation still found the therapy beneficial.

The criteria for acceptance into the study required subjects to have had a predominantly homosexual orientation before entering reparative therapy. They should be able to report that after reparative therapy they have sustained for at least 5 years some change toward a heterosexual orientation. The acceptance criteria also required participants to report in a telephone interview on their sexual behavior for the year before they entered reparative therapy and then also report on their behavior in the year before the current research interview. Spitzer reports that there was, on average, an interval of 12 years between the time of entry into reparative therapy and the telephone interview. This places a heavy burden on memory and Spitzer acknowledges there is greater fallibility in such long range memory.

Participants in the study come from a very narrow stratification of the population: 97% were Christian, 95% were Caucasian, the mean age for males was 42 years, the mean age for females was 44 years, 76% of the males were married, and 47% of the women were married. Some participants were directors of ex-gay ministries and some had publicly spoken favorably of efforts to change sexual orientation, often at their church. Thus, this is a population of highly religious, White, Protestant, middle aged, and middle class men and women. There is little evidence that they are representative of a diverse gay community.

Participants in this study were asked in a telephone interview to report on their sexual fantasies, masturbation fantasies, lustful looks, use of gay pornography, homosexual thoughts, and overt sexual behavior. A key question is the credibility of the participants' self-report. It should be