

Buried in the small print, however, was Spitzer's now-official change of view: "Like most psychiatrists," says Dr. Spitzer, "I thought that homosexual behavior could be resisted—but that no one could really change their sexual orientation. I now believe that's untrue—some people can and do change" (Nicolosi, 2001). The story here is obviously Spitzer's change of heart. But did he actually change his mind?

It seems unlikely since, in 1973, it was Spitzer's suggestion that the *DSM-II* (American Psychiatric Association, 1968) replace homosexuality with a new diagnosis, sexual orientation disturbance (SOD). According to SOD criteria, only those "bothered by," "in conflict with," or who "wished to change" their homosexuality had a mental disorder. SOD, however, had two conceptual problems. First, the diagnosis could apply to heterosexuals, although there were no reported cases of unhappy heterosexuals seeking psychiatric treatment to become gay. In 1980, with Spitzer chairing the Task Force on Nomenclature and Statistics, SOD was modified in the *DSM-III* and replaced by ego-dystonic homosexuality (EDH). This new diagnosis, however, did not resolve the second, thornier issue of making patients' subjective distress about homosexuality the determining factor in making a diagnosis. Although SOD and EDH were a compromise in the 1973 debate, they were incongruous with an evidence-based approach to psychiatric diagnosis. In 1987, with Spitzer's reluctant approval, EDH was removed from the *DSM-III-R* (American Psychiatric Association, 1987; Krajeski, 1996; Spitzer, personal communication, January 23, 2003).

If Spitzer did not previously believe in the possibility of changing homosexuality, why did he invent the DSM disorders of SOD and EDH? In 1984, I heard Spitzer speak at a New York conference on homosexuality where he defended the still-extant EDH diagnosis, saying "If a guy comes to me and says he wants to change his homosexuality, I believe he should have the right to try and change." Thus, despite what the conversion therapy publicists would have the media and the public believe, it seems unlikely that Spitzer himself has undergone the conversion he now claims. Clearly, he has always supported trying to change same-sex attractions.

In 1965, songwriter Tom Lehrer wrote, "Once, the rockets are up who cares where they come down/that's not my department." Anecdotal reports of harm done to patients is the reason the American Psychiatric Association (2000) deemed conversion therapies unethical. However, Spitzer dismissed this issue, stating he did not interview anyone who was harmed (cf. Shidlo & Schroeder, 2002). However, the question has been raised whether researchers should consider any potential social harm which might arise from their scientific research (Byne,

Schuklenk, Lasco, & Drescher, 2002). To his credit, Spitzer has been willing to speak out against political misuse of his study. In September 2001, the Finnish Parliament debated a bill intended to grant same-sex couples the right to civil unions. With opponents of the bill citing Spitzer's study as "proof" that homosexuality could be changed, Spitzer's letter to the Finnish parliament was published in a major Finnish newspaper. Spitzer explained that while his report was "based on a very unique sample," such results "are probably quite rare, even for highly motivated homosexuals" (Hausman, 2001). He added in his letter to the parliament member that "it would be a serious mistake to conclude" from his research that homosexuality is a "choice." He emphasized that he is concerned with "scientific issues" related to sexual orientation, and that he "personally favor[s] antidiscrimination laws and civil unions for homosexuals" (Hausman, 2001).

After Spitzer's intervention, the Finnish civil unions bill passed (Stålström & Nissinen, in press). With the publication of his study, one can only hope that when Spitzer's "rockets" land elsewhere, he will find ample time and opportunity to respond to those situations as well.

Sexual Orientation Change: A Study of Atypical Cases

Richard C. Friedman, M.D.

225 Central Park West, #103, New York, New York 10024;
e-mail: rcf2@columbia.edu.

This study must be understood in historical and sociocultural context.

Antihomosexual Bias

Although antihomosexual bias has recently diminished, much work remains to be done in order to eliminate it entirely. The mental health professions have been helpful in combating discrimination. However, for many years they were unfortunately responsible for adding fuel to the prejudicial fires. In the first edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM; American Psychiatric Association, 1952), homosexuality was included in the category of Sociopathic Personality Disorders. At that time, the view of the psychiatric establishment was that a person who was homosexual inevitably had a defective conscience. The second edition of the DSM (American Psychiatric Association, 1968) included it with the sexual perversions, such as pedophilia, sexual sadism, and fetishism. Public policy decisions were made on the basis of these clinical judgments. These decisions adversely influenced the lives of gay/lesbian people and contributed to negative stereotypes depicted in the media (Gonsiorek & Weinrich, 1991).

During the decades following World War II, homosexual desires were believed to be symptoms motivated by unconscious irrational anxiety about heterosexuality. It was thought that psychotherapy would cause these fantasies to melt away and the patient would become heterosexual. Universal heterosexuality was seen as biologically based and normative (Bieber et al., 1962; Socarides, 1978). This model rested on a scant data base, but was accepted not only by most psychoanalysts, but by most psychiatrists, psychologists, and other mental health professionals. Hooker's (1957) well known study of socially well-adjusted homosexual men demonstrated that unconscious conflicts attributed by most psychotherapists to homosexuality per se were, in fact, not demonstrable among *nonpathological* homosexual men. This research dramatized the necessity to distinguish between clinical and nonclinical samples in conceptualizing sexual orientation.

Perhaps more to the point of the Spitzer study, data about the frequency of change of sexual orientation as a result of psychotherapy were also lacking. In his article, Spitzer cites Bieber et al.'s (1962) outcome data. There are two aspects of the study by Bieber et al. that warrant commentary. The first is that the investigators studied overt sexual behavior and not fantasy; hence, the outcome data refer to heterosexual competency but not heterosexual/homosexual desire. Secondly, the majority of patients in the Bieber et al. study who were predominantly or exclusively homosexual did not, in fact, become predominantly or exclusively heterosexual. Interestingly, Freund (1963, 1971) also observed that in a laboratory setting some homosexual men could voluntarily alter penile responses to respond to heterosexual stimuli. Both Bieber et al.'s and Freund's data suggested that a minority of men may have some degree of plasticity of response to an erotic stimulus. Although the entire body of literature prior to the Spitzer study has many defects, it suggests that for *most* men, homosexual orientation is more or less fixed, but that for some—almost certainly a small minority—it seems more plastic. More women appear to be plastic with respect to erotic stimuli than men (Baumeister, 2000). Hence, more women than men would be likely to have the capacity to alter sexual orientation in response to some type of intervention.

Reparative Therapy

Nicolosi (1991) hypothesized that homosexuality was a reaction to a defect in the masculine self. Nicolosi's clinical experience was based on patients who were frequently devout Christians and who sought to change their sexual orientation either for religious reasons or because they disapproved of a "gay" lifestyle. Like the orthodox psychoan-

alysts of the 1950s and 1960s, Nicolosi used clinical samples to make generalizations about all homosexual people. By the 1990s, however, ideas about homosexuality generally accepted by mainstream mental health professionals, including psychoanalysts, had changed (Friedman, 1988; Isay, 1989; Marmor, 1980). The pathological model of homosexual orientation had been or was soon about to be repudiated by the vast majority of psychotherapists. Moreover, it had become apparent that many patients had suffered harm because of misguided efforts to alter their fixed sexual orientations (Duberman, 1991). I have seen many such patients in consultation over the years. The idea that homosexuality generally is a product of a masculine self-defect was abhorrent to many and reparative therapy was strongly criticized by mental health professionals (American Psychiatric Association, 2000). A belief became increasingly popular among therapists that a homosexual orientation should always be considered normal and that attempts to change it ill-considered and even unethical.

Homophobia and Internalized Homophobia

Patients who seek reparative therapy have a conflict between their erotic desires and conscience/value systems. In order to understand this group from a clinical perspective, it is necessary to have a sociocultural and historical grasp of homophobia, and a psychodynamically informed understanding of "internalized homophobia." The latter term refers to negative internalizations about being homosexual that become part of the self concept during development as a consequence of interactions with homophobic/heterosexist others (Malyon, 1982). Limitations of space interdict extensive discussion of these topics here, and we refer interested readers to Friedman and Downey (2002) and Herek (1996). Suffice it to say that for many nonheterosexual people, the primary psychopathological problem is not with their sexual orientations, but rather with rigid, irrationally punitive superegos formed during childhood which undermine the well-being of the older person. Most such people can be helped by gay affirmative psychotherapy and some by more exploratory dynamic psychotherapy. During therapy, sexual orientation does not change, but the person's pathological conscience structure is modified to be compatible with his or her present life philosophy. A different clinical subgroup, however, consists of people—often religious fundamentalists—whose value systems are not compatible with a homosexual orientation. These people reject the suggestion that their values should be modified, and insist on their right to personal/religious values that are not gay affirmative—or are even antigay affirmative. It is primarily from a *subgroup* (e.g., positive responders)

of these individuals that Spitzer found volunteers for his investigation.

The Spitzer Study

In order to appreciate the contribution of this investigation, it is necessary to have a clear idea of its limitations. The study did not assess the techniques of reparative therapy itself. The particular sample reported on was not representative of those who seek such interventions. The research was not designed to ascertain the effectiveness of reparative therapy nor did it assess complications resulting from such intervention. It is possible, for example, that most people who requested the intervention were either not helped by it or actually harmed in some fashion. The design of the study was such that these issues were intentionally not addressed. As a single point study of people selected to have benefited from the treatment, the sample was obviously highly biased. The data base reported on in the study therefore does not support any generalizations about reparative therapy per se. Spitzer cites estimates of success in sexual orientation change by Socarides and Nicolosi, but their global impressions do not meet scientific standards for acceptable data.

The Usefulness of the Study

This is an investigation of sexual histories taken in a detailed and systematic manner of an unusual sample. It has three major strengths. First, the structured interview used is comprehensive and carefully constructed. Second, the data are available and open to inspection by others. This type of transparency and sharing of information is a welcome advance, supporting scholarly values at a time when political correctness often dominates academic discourse. Finally, the data support inferences already available to therapists and scientists but obscured by controversy. Some degree of plasticity with respect to the object of sexual desire appears possible for some people. This was already known by the scientists and clinicians, but because the possibilities for abuse of the majority through misguided application of “reparative” principles has been so great, this point has recently been obscured. Scientific and clinical judgment suggest that even among a delimited universe of highly religious men, meaningful change is probably impossible for most. The small minority for whom such change is possible, however, have rights and the subgroup of that minority who have psychiatric disabilities also have clinical needs which must be appropriately responded to by therapists. The needs and attributes of this minority, however, must

not be taken as applicable to those of most gay/lesbian people.

Conclusion

Systematic investigation of unusual cases has always been an integral part of academic—clinical work. The findings of the Spitzer study are part of this tradition. The fact that this research was carried out is even more important than its findings. It is necessary for reasoned inquiry to proceed during periods of social unrest when pressures towards censorship are particularly great.

The Politics of Sexual Choices

John H. Gagnon, Ph.D.

122, blvd. Carnot, Nice 06300, France; e-mail: jgagnon@bigplanet.com.

The decision, recorded in the article by Spitzer, for people who have a well established history of sex with persons of the same gender to seek professional help and religious encouragement to start a life of having sex with persons of the other gender, becomes remarkable only in particular political and scientific circumstances. I will not discuss the methodology or substance of the article in any detail. This will undoubtedly be the topic of a number of other commentaries. My concern is how the political and scientific contexts shape the way in which individual changes in gender preference in erotic relationships are understood. Only two comments about the changers—the folks who made the change seem to have done so for reasons that have to do with becoming more conventional in their social performances rather than for a more satisfying “sexual,” in the narrow sense, life. And it may well be that the amount of “*sturm und drang*” involved is a function of the moral condition (which is a consequence of its political status) of their prior sexual lives—sinners always proclaim the difficulty of giving up their sins as they return to the moral community, in this case the moral community of straightness.

Let me first address the problem of politics. There are those who believe that it is possible to study “homosexuality” without addressing the political context of their research, but I am not one of them. Although there is survey evidence that antigay prejudice is less than it once was, there still remains a substantial number of persons who are actively antigay and a still larger number whose latent antigay sentiments can be mobilized by provocative political campaigns. At the present time, important positions in the U.S. federal government are occupied by persons of these antigay persuasions.