

sexual experiences for both sexes (Brown & Sinclair, 1999; Meston et al., 1998).

Given the possibility of distortion and the demand for attitude-behavior consistency, issues related to sampling and control should be elevated to the highest level. Simply locating people who claim to have changed does not provide convincing data. It would be possible to locate people who claim and sincerely believe any number of phenomena that are not easily verifiable empirically and about which many professionals are skeptical. All participants were obtained from organizations or therapists who are extremely committed to the efficacy of reparative therapy and only people who contacted the researcher were included in the study. These people are by definition those who believe in the effectiveness of the reparative techniques and earnestly need the technique to be effective both from a spiritual and an emotional perspective. Moreover, basic to any behavior change research is the inclusion of persons who attempted behavior change and failed.

Effort to employ the highest degree of control is incumbent upon researchers of such sensitive topics. Assignment of participants to experimental conditions is not the only means of enhancing control. Because of the problems with a hypothesis-biased population, it is critical to establish the nature of the sample obtained in terms of theoretically relevant characteristics; it is important as well to compare these individuals to other samples of lesbians and gay men to determine exactly the ways in which they are similar or different. Such critical characteristics should include homophobia, erotophobia, sex guilt, emotional stability, psychological disorders, self-esteem, social functioning, and religious guilt, to name but a few.

A comparison could involve matching therapy participants with nontherapy participants to determine the extent to which nontherapy participants had attempted sexual orientation changes in the past. With only one group purporting to experience change and with no comparison group, little confidence can be placed in claims that change occurred specifically due to therapeutic intervention and not due to some other factor. Moreover, change based on retrospective reports related to therapeutic progress are highly suspect in terms of validity, again especially given the incredible demand for change inherent in the life situation of these respondents, and given the fact that the pretherapy period was on average 12 years prior to the data collection period.

In addition to emotionally-based cognitive distortions, the issue of bias in assessment of current heterosexual relationships must be considered. When an individual who desperately wants to be heterosexual is finally involved in a heterosexual relationship and is asked, "Are you emotionally satisfied with your relationship?," what

the researcher may actually be measuring is relief at achieving this greatly desired goal and not necessarily what most individuals mean by satisfaction with a relationship. The same can be said for the question about physical satisfaction. What is not investigated is the effort that goes into becoming physically aroused, because anecdotal reports suggest that "ex-lesbians" or "ex-gays" often must spend a great deal of effort achieving levels of arousal sufficient to engage in heterosexual sexual behavior.

The only conclusion that is indisputable in Spitzer's study is that he has identified a subset of lesbians and gay men (who in fact may actually be more appropriately considered bisexual) who claim to have changed their overt sexual behavior; the nature of the change, and the process through which it occurred, has not been convincingly established. Given the importance of this issue for individuals struggling with their sexual orientation, to claim otherwise is misleading and dangerous.

Initiating Treatment Evaluations

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Spitzer presents face valid evidence that changes in homosexual behavior and feelings of desire and satisfaction can be achieved by some, to varying degrees, via "reparative therapy."

These reports, which Spitzer quite logically argues are convincing, are necessary preliminaries to an open trial, which enrolls a series of appropriate subjects, treats them all and records the results. This allows an estimate of the proportion of good outcomes, although it does not establish that the therapy caused the benefit since patients may improve in spite of their treatment. Volunteers who claim successful outcomes do not yield an estimate of the proportion benefited. Also, just how common such reported successes are remains obscure.

Spitzer calls for a consecutive series who perceive homosexuality as a problem of theirs they wish fixed, who have been evaluated before and after treatment. I agree this is the correct next step. Apparently, Nicolosi and Byrd claim to have such data. If this is more than therapist self-serving, they have an obligation to present their data or to stop making such important claims. Such strictures also apply to the range of official groups that assert the uselessness and damaging effects of "reparative therapy" for homosexuality. Where are their data? If it is nothing but anecdotes and presumptions, how can they claim they are being professionally responsible? Relevant observations are needed to raise hopes that a treatment is worth

evaluating. Spitzer provides the level of evidence appropriate to the initial stages of therapeutic evaluation with regard to a heuristically important issue.

Spitzer, pessimistically, but perhaps accurately, states that this methodologically correct next step, the evaluation of the treatment of a well defined consecutive series of homosexual patients, is unlikely to occur. However, cost and duration are really not to the point, considering other trials that have received NIMH funding. Concerns about patient safety may be more to the point but apparently these concerns are more theory driven than data substantiated. A data safety monitoring board would provide an adequate safeguard.

The trepidation in this area may arise from concern about the "repathologization" of homosexuality. This is fostered by the term "reparative therapy," which is both vague and presumptuous. However, if it was renamed, say, "role modification," would that help? Effective change techniques do not necessarily imply illness (e.g., cosmetic surgery).

The American Psychiatric Association (APA) states that it supports such research, but ethical practitioners should refrain from attempts to change individual's sexual orientation until the research findings are at hand. Such a data based orientation with regard to psychotherapeutic efforts can only be welcomed. Of course, if this criterion was consistently applied, the APA would have to be substantially more critical about other more favored psychotherapies.

Treatment evaluation aspires to demonstrate specific benefits through determinate causes. Spitzer suggests that the causal efficacy of reparative therapy may never be shown because it is extremely unlikely that patients would enter a long placebo controlled trial. However, the point of a placebo controlled trial is to address the null hypothesis that the entire effect of the treatment is due to the nonspecific combined effects of being in treatment, having one's hopeful expectations raised in a congenial environment, and the natural history of the condition.

However, there are controlled dismantling comparisons that allow causal inferences. Behavioral activation, which may account for the benefits of cognitive behavior therapy, is a reasonable comparison. Reparative therapy might be compared to its components, such as incremental heterosexual pleasures, avoidance of exposure to homosexual pleasures, or any other credible component of the currently ill-defined reparative therapies. If it turns out that complex reparative therapy was more effective than its credible components, and if it were unlikely that the components were toxic, this suggests causal efficacy for reparative therapy, even though specific causal agents remain obscure.

To engage in such meticulous research would require a very convincing body of data from the simpler longitudinal, complete, series of treated and evaluated subjects. Those who claim therapeutic success have the responsibility for providing the supportive data. Spitzer's study provides the necessary minimum for future studies to be considered feasible and perhaps fruitful.

Some claim that they know that the mere publication of this report will cause grievous social, political, and personal harms. This amounts to a call for censorship, rather than meeting the issues on factual and logical grounds. History is replete with often successful attempts to quash questions about the conventional wisdom. This accounts for their infrequency. Initiating questions, in the framework of fostering objective studies, rather than asserting prior knowledge of the truth, has an honored place in science.

A Positive View of Spitzer's Research and an Argument for Further Research

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Spitzer demonstrates that some individuals who have undergone "reparative" therapy report that they have changed their sexual orientation from homosexual to heterosexual for at least a 5-year period. His study obviously has many limitations, being retrospective, relying on telephone interviewing, and without any objective measurements of sexual arousal, such as penile plethysmography or vaginal photoplethysmography, which he fully discusses.

Arguably, one's fantasies, including masturbatory fantasies, are the best reflection of one's sexual arousal pattern compared with questions involving one's history of sexual interest or behavior. It is notable that in this study, among those who masturbate posttherapy, 68% of males and 41% of females still report same sex fantasies on 20% or more of masturbatory occasions and only 31% of males and 72% of females report opposite sex fantasies on 20% or more of masturbatory occasions. This masturbatory data suggest that change in one's sexual arousal pattern is difficult.

Spitzer, as well as the various national organizations cited in his article, suggests that more research could be done to further determine "reparative" therapy's risks versus its benefits. However, he then says that, realistically, it is unlikely, given the costs of such a study, that such research will be conducted in the future. Although "reparative" therapy concerns itself with change in sexual orientation, other therapies, such as cognitive behavioral therapy, concern themselves with the control or