

in penile volume responses following it could not be an effect of therapy and were considered due to the men consciously or unconsciously modifying their penile volume responses to conform with their wishes to be more heterosexual. As the changes in the men's penile volume responses following the aversive therapy were no greater than those following the conditioning procedure, it was concluded they also were not specific effects of the treatment, but due to similar attempts by the men to modify their responses.

Freund (1971) found that 20% of homosexual men when requested could produce penile volume responses which indicated they were predominantly heterosexual. In the four studies reported above, of the men assessed prior to treatment, 117 showed penile volume responses indicating predominant homosexual and 33 predominantly heterosexual orientation. Following treatment, 53 showed predominantly heterosexual orientation. Hence, 17% of men showed the change to predominant heterosexuality, less than the 20% of homosexual men Freund showed could produce this change voluntarily. It was concluded that aversive therapy produced a reduction in men's homosexual feelings and behaviors without altering their physiologically assessed sexual arousal to women as compared to men. An alternative theory was advanced that aversive therapies acted not by modifying physiological sexual arousal, but by reducing compulsive homosexual urges and behaviors. These changes were experienced as reduction in homosexual feelings, allowing some subjects to be more aware of and express their heterosexual feelings.

It is possible that the subjects investigated by Spitzer experienced similar changes without change in the core item of physiological sexual arousal to men as compared to women. Though he found much stronger changes than those in the men in the four studies reported, it is possible that men and women with strong changes were more likely to have volunteered for Spitzer's study. A number of men and women, presumably at times without treatment, can change what Spitzer termed core features of sexual orientation. The representative sample of the United States population investigated by Laumann et al. (1994) showed a steady reduction in homosexual behavior with age. It was reported respectively by 6.4% of men and 3.5% of women in their adolescence, 4.1% of men and 2.2% of women in the past 5 years, and 2.7% of men and 1.3% of women in the previous year. About 1% of men and 0.3% of women were aware of equal bisexual or predominant homosexual feelings but identified as heterosexual, as did 16% of the 2.4% of men who were exclusively attracted to the same sex. Exclusive homosexual activity was rare, reported by only 0.2% of women and 0.6% of men since puberty. Hence, less than a quarter of the 1.4%

of women and 2.7% of men who identified as homosexual or bisexual had never had sexual activity with members of the opposite sex. Dunne, Bailey, Kirk, and Martin (2000) found that 20% of male and female twins reported homosexual behavior or awareness of some homosexual feelings; 97% of all the men and 96% of all the women had been sexually attracted to someone of the opposite sex at some time in their life. Hence, an ability to identify as heterosexual, to experience heterosexual attraction, and to have heterosexual activity is present in a significant percentage of men and women with homosexual feelings or behaviors.

On the basis of the theory that aversive therapies acted to reduce compulsions, an alternative nonaversive therapy, imaginal desensitization, was developed and shown in a randomized control trial to reduce men's compulsive sexual feelings and activity to a greater extent than an aversive procedure (McConaghy, Armstrong, & Blaszczyński, 1985). Imaginal desensitization was recommended to reduce preoccupations with homosexual fantasies and compulsive homosexual behaviors, in men and women unable to accept a homosexual adjustment (McConaghy, 1993). Behavioral therapy for anxiety concerning heterosexual activity, and where appropriate, referral to a trained opposite-sex surrogate therapist, were recommended to increase heterosexual interest and activity. The book containing these recommendations was reviewed in a number of psychiatry and sexuality journals. No reviewers objected to the recommendations. It is possible that the majority of psychiatrists are not opposed to the use of therapies aimed at changing what Spitzer termed core features of sexual orientation of men and women who cannot accept a homosexual life-style. It could be argued that physiological arousal to members of one's own sex versus the opposite sex is the core feature of sexual orientation, particularly when the evidence presently available indicates that such arousal cannot be modified with therapy. However, this would seem a semantic issue, irrelevant to whether or not therapies aimed at modifying homosexual feelings and behaviors produce changes experienced positively by the men and women treated. The evidence from studies carried out over the past 40 years indicates that they do. Spitzer's concurrence with the recommendation to evaluate the risks versus the benefits of such therapies may be shared by many colleagues.

Finally, Recognition of a Long-Neglected Population *Joseph Nicolosi, Ph.D.*

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As a clinical psychologist who has worked almost exclusively with homosexual men for over 15 years, and as the originator of the term “reparative therapy,” I am very grateful to Spitzer for giving a voice to ex-gays. Although this client population remains little recognized, there are hundreds of ex-gay men and women whose quiet and heroic struggles have been assisted by the clinicians associated with the National Association of Research and Therapy of Homosexuality (NARTH). Some NARTH clinicians see same-sex attraction as a developmental disorder; others do not. But whether or not they hold to the “disorder” theory, all of these clinicians have agreed to support clients who choose to diminish their unwanted homosexuality and develop their heterosexual potential.

Who, then, is this client that seeks out “reparative” or “reorientation” therapy? Is he a self-hating person whose problem is rooted in internalized homophobia? It is essential to understand that there are radically different understandings of the term “homophobia.” Some see it as self-hatred and rejection of one’s core identity while others define it as the recognition that there is something disordered about one’s sense of self and way of relating to others with respect to gender.

Recently, Rosik (2003) noted that there is usually a difference in beliefs about the source of moral value that separates clients who seek sexual reorientation from those who seek gay-affirming therapy. Clients who seek gay-affirming therapy tend to emphasize a sexual morality that sees the individual as his own autonomous source of moral truth. This is the “ethic of autonomy,” which envisions sex as being moral as long as it is consensual. By contrast, argues Rosik, those who seek reorientation therapy tend to approach the subject more from a moral domain emphasizing the “ethic of divinity” and/or “ethic of community,” both of which assume a universal moral order grounded in religious values given by God or community. The act of giving one’s consent, for those who hold to this ethic, does not make a sexual act moral. Some expressions of sexuality, according to this view, convey an intrinsic harm to personhood—whether or not this harm is measurable by psychology or actually perceived by the person.

There is a considerable body of psychodynamic theory—supported by empirical evidence—to buttress reparative-drive theory and reparative therapy. Reparative theory views homosexual attractions as generated by unmet same-sex attachment needs (Moberly, 1983; Nicolosi, 1991, 1993). In fact, in the 30 years since the removal of homosexuality from the DSM, there has yet to emerge any alternative, credible, nontraumatic model of development that results in homosexuality. The only serious attempt to formulate a developmental model is that which

was offered by Bem (1996) and I elsewhere have listed my objections to Bem’s “Exotic Becomes Erotic” model (Nicolosi & Byrd, 2002).

Are there other, purely practical reasons for leaving a gay lifestyle? Male eroticism—which is by its very nature promiscuous—seems to pose an inevitable problem of infidelity. McWhirter and Mattison (1984) conducted an in-depth study of the quality and stability of 156 long-term homosexual couplings which had lasted from one to 37 years. Two thirds of the respondents had entered the relationship with the expectation of faithfulness. But not one of those couples was able to maintain sexual fidelity for more than five years. For this and other reasons, it is not so surprising that many of Spitzer’s subjects reported a deep dissatisfaction with gay life. I believe that the deficit-driven nature of homosexual attraction limits two men to constant cycles of intense infatuation which never have the chance to ripen beyond good friendship into mature, sexually faithful love.

One of my clients who has had over 2,000 anonymous contacts admits gay sex is “incredibly intense—no doubt the most pleasurable thing in my life.” Yet, this man confesses that afterwards he is “wiped out, depressed, sad, and discouraged.” Another former client (who married and now has grown children) explains why he left a gay lifestyle:

The sexual experience with a man is like taking an opium drug. It’s soothing, it’s anesthetizing, and it’s a “quick fix.” This can make it very difficult to leave homosexuality. When we have sexualized those emotional needs—when we have already learned to get those needs temporarily met in a sexual way—we’ve taken a normal, legitimate, God-given need [same-sex bonding and affection] and met it with a “drug.” That’s one of the things that I’ve had to recognize and admit to myself; a same-sex relationship wasn’t meant to have that kind of zing. The “zing” is artificial, but it is very compelling—and it is what keeps a lot of men in the gay life.

So, if it is true that for many people, gay relationships simply don’t “work,” then the next question must be: Is change possible? As Spitzer astutely notes, change should be viewed not in terms of erasing all unwanted desires, but as a matter of diminishing homosexual attractions and increasing heterosexual responsiveness.

Spitzer is not the only recent researcher who has observed the potential fluidity of sexuality. Diamond (2000) found that “for sexual-minority women, nonexclusivity in attraction is the norm, rather than the exception” (p. 247). Half of the lesbian, bisexual, and “unlabeled” women in her study reported at 2-year follow-up that they had changed sexual identities more than once. Haldeman (2000), who has been critical of reorientation therapy

because he sees homosexuality as part of a person's core nature, has stated that "the categories of homosexual, heterosexual, and bisexual, considered by many researchers as fixed are in reality very fluid for many."

Typically, with men who have left a gay lifestyle and developed heterosexual attractions, we almost always see that these newly developing attractions are of lesser intensity than their former homosexual feelings. For many years, I was unable to understand why, nor did I know why ex-gay men typically say they are sexually attracted to their wives, but much less so to other women (good news, of course, for the wives). I came to realize that this was not so much a problem of arousal, as of trust. Male homosexuality is often associated with the boy's narcissistic emotional enmeshment with the mother, where the son feels responsible for the mother's feelings (Socarides, 2002). The resulting fear and anger is projected onto all women, whom he expects will be manipulative and engulfing, and will take away his masculine power. The challenge for the ex-gay man is to enter into a relationship with a woman while maintaining a sense of self-possession. As he gets closer to a woman, this anxiety manifests itself as a fear of sexual performance. Therefore, almost without exception, the ex-gay man cannot develop a sexual relationship with a woman unless he first develops a friendship. Only when he knows he can trust the woman with his vulnerability will his latent heterosexual feelings become manifest.

Almost all the clients I have known who transition away from homosexuality describe a more subtle heterosexual response, one which has, as my former client says, less "zing." But even though they are of less intensity, these experiences are richer, fuller, and more emotionally satisfying. These men describe a feeling of "rightness" and a natural compatibility. As one ex-gay and now-married client said, "When I compare my intimate experiences with my wife to my homosexual experiences, it seems like we were little boys playing in the sandbox." Rather than feeling depleted, he is renewed, feels good about himself, and experiences himself as an integral part of the heterosexual world.

Wyler (2002) captures an experience of sexual reorientation similar to many of the individuals interviewed in Spitzer's study:

Where once we felt sexual lust [for other men], today we feel brotherly love. Where once we felt fear of heterosexual men and estrangement from them, today we feel trust and authentic connection. Where once we felt self-hate and a feeling of never being "man enough," today we feel self acceptance and a strong and confident masculine identity. We experienced this profound change by uncovering and healing the underlying pain and alienation from men, masculinity and God that, we found, had caused so much of our homosexual symptoms. . . .

We can only speak for ourselves—about our own experience, about what was right for us, about what brought about change in our lives . . . and what brought us joy.

There is no doubt that reorientation therapy is not for everybody. Many clients choose to live out their same-sex attractions—and respect for client diversity and autonomy require that gay-affirming therapy be available. But reorientation therapy must be offered for those who do believe that gay is not who they really are. This group—the population Spitzer studied—are the men and women who seek to live out a different understanding of the meaning of gender and wholeness.

Sexual Orientation Change and Informed Consent in Reparative Therapy

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Spitzer concluded that reparative therapy can sometimes change homosexuals to heterosexuals and, therefore, the movement towards banning this type of therapy is wrong-headed. He argued that using this therapy should be the patient's choice. Such choice, when based on informed consent, should be seen as fundamental to client self-determination. In this commentary, I examine the validity of his claim for *actual* change in sexual orientation and then evaluate his arguments concerning informed consent.

Spitzer's assertion that his study is a significant improvement over previous research in this area is correct. His measures of sexual orientation were more diverse, including not just surface aspects (e.g., overt behavior, self-labeling), but features that appear to get to the core (e.g., feelings, yearnings, fantasies). His sample size was impressive, his interview schedule was well designed, and his offer to share all his data, including audio recordings, with the research community was very much in the scientific spirit. His results are clear in indicating that his subjects did change in important ways. For instance, extending his report to an effect size analysis, change in self-reported sexual attraction from before to after therapy was 3.40 *SDs* for men and 4.04 for women, values that are enormous compared to average psychotherapy effects, which Smith and Glass (1977) estimated to be 0.68 *SDs* in their seminal meta-analysis. Effect sizes were similarly huge for other measures in Spitzer's study. Thus, on its surface, the study appears to show dramatic effects of therapy in changing sexual orientation. The key issue, as Spitzer himself noted, is the credibility of the self-reports.