

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.

Spitzer stated that he believed his subjects' self-reports, claiming these did not appear to be lies or self-deceptions. Most likely the subjects did believe what they reported (so they were not lying), but what about self-deception? Spitzer argued that if self-deception obtained, then one would have expected findings such as reports of complete or near complete change, rapid change, and similar change in men and women. Since these did not hold, he rejected self-deception. These arguments are unconvincing. Why must self-deception produce the perception of only complete and rapid change rather than partial and gradual change? Cannot men and women self-deceive differently to reach different perceptions of change, given that they are known to think differently about many sexual and nonsexual issues? More importantly, what about social psychological research on cognitive dissonance and social cognition (Festinger, 1957; Myers, 2000), which shows that self-deception frequently occurs in situations of conflict? Festinger (1957) described cognitive dissonance as a state of negative arousal resulting from conflict between important beliefs, which motivates attempts at dissonance reduction through means such as altering and even distorting the conflicting beliefs to make them consonant. Much experimental research has supported his theory. Social cognition research similarly has demonstrated multifarious routes to self-deception as a means of adapting to current needs and pressures (Myers, 2000).

Patients in Spitzer's study fit classically into the cognitive dissonance dilemma. On the one hand, their sexual attractions were homosexual. On the other, their religious beliefs were antihomosexual. Religion was core to their identities (93% said religion was very or extremely important in their lives) and its tenets caused serious conflicts with their sexual orientation (79% said that this conflict was a major motivation for wanting to change their sexual orientation). Resolving conflicts between such powerful forces is difficult, but subjugating homosexual expression to religion in some cases should not be seen as surprising. Volumes could be written on the power of religion to overcome one's basic nature. Suffice it to say that because of religious beliefs, men have frequently overcome survival instincts (e.g., Muslim suicide hijackings and bombings). In sexuality, men have frequently yielded to antibody, antisex religious philosophies (e.g., Christian priests and monks, including the three most conspicuous early theorists: Origen, who cut off his testicles with a rock to destroy his sexual urge; Augustine, who abandoned sexual pleasure completely despite having enjoyed it so much previously; and Chrysostom, who lived as an ascetic hermit in the desert to avoid all temptation). In short, beliefs about the value of one's life and one's sexuality can readily become subservient to strong religious beliefs. Such

yielding, however, does not alter one's biological nature; it just suppresses it. In this sense, strongly religious patients who accept their religion's antihomosexual view, and then under therapy change their attractions and fantasies, may be merely suppressing their true nature rather than altering it.

The alternative explanation then is that Spitzer's subjects, clearly in conflict, resolved their cognitive dissonance (and thus felt happier after the therapy) by rejecting homosexual feelings, thoughts, and behavior, while embracing heterosexual ones. But this rejection represented an effortful suppression rather than an alteration of their basic core nature. Let us examine the therapy itself and some of Spitzer's measures in this regard. We are told that three of the most important elements of the therapy that helped produce change were linking childhood experiences to later sexual feelings, thought stopping, and avoiding tempting situations. The first of these likely reinforced the religious motive to change and added credibility to the therapy, teaching patients that their true nature is heterosexual just as their religions have insisted, that their diversion to homosexual "pathology" is attributable to their having been "victims" of abuse or neglect, and that now they can finally be "healed." The second and third provided the cognitive and behavioral controls to suppress homosexual yearnings and avoid them. Maintaining these controls and behaving heterosexually were then fueled by the relief provided by ending the decades-long cognitive dissonance.

A gay man sees another male who previously would have excited him; he rejects feeling aroused and acknowledging that the male is sexually attractive. He thinks about the other male when alone; he stops this thinking before it becomes a fantasy. He is alone and begins to yearn for homosexual sex, but stops himself, feeling resolutely now that this is intolerable. He sees a woman and tells himself she is attractive, and feels a rush of self-esteem for living up to Christian virtue. The problem is that these apparently involuntary reactions are actually under conscious, cognitive control. The man is playing out a role rather than expressing his true nature, which is suppressed (cf. Goffman, 1959). In short, these measures, it seems, assess surface rather than core change. The man's beliefs are tied to the surface, to the role he feels compelled to play, and to the extent that the core differs, his self-reports are self-deception. What is needed are measures of involuntary response to various actual stimuli, rather than just self-reports that reflect essentially volitional behavior. Put the man back into tempting situations of the kind that formerly aroused him or expose him to gay pornography of the type that used to excite him. Measure his arousal with plethysmography. Expose him

to heterosexual situations that he claims attract him or expose him to heterosexual pornography and then measure the arousal in the same way. Have him self-report reactions to a researcher not in the reparative therapy camp. If he responds more like a homosexual, then his therapeutically induced beliefs are not genuine. If he responds more like a heterosexual, then reparative therapy may be seen as perhaps working.

Spitzer called for professionals to steer away from banning reparative therapy. The inconclusiveness of his measures, which could be reflecting self-deception, weakens this call. This aside, there is another problem with his recommendation, and that concerns whether patients truly are giving informed consent, as they should be according to Spitzer. Informed consent requires knowing the odds of success, a result not derivable from Spitzer's data. More importantly, psychotherapy patients generally put trust in their therapists as medical patients do in their doctors—they assume the treatment is scientifically valid. Reparative therapists teach their patients that homosexual orientation is the product of childhood seduction or negative family events. Such teaching is *not* based on scientific research but stems from theory (usually psychoanalytic) combined with unsystematic observation that dubiously claims to be scientific. But empirical research, as opposed to clinical anecdotes, does *not* support seduction or any family environment variables as causative (e.g., Bell, Weinberg, & Hammersmith, 1981). Patients provided with myth presented as scientific fact are not giving true informed consent.

Finally, there are important reasons to urge caution in mental health treatment of “deviant” sexuality, given the field's history of medicalizing sex based on morality rather than approaching it scientifically (Kinsey et al., 1948; Szasz, 1990). If it is important for homosexual patients to give true informed consent, then therapy from psychologists and psychiatrists should be informed by the full range of knowledge we have about homosexuality, which extends far beyond the clinic or pulpit. Historical, cross-cultural, and cross-species perspectives are essential. The first shows clearly that the Judeo-Christian condemnation of homosexuality is socially constructed, rather than divinely inspired, based on cultural and political events combined with idiosyncratic philosophy (Johansson, 1990). The first two perspectives show that homosexuality in certain forms has been accepted as normal and even functional rather than condemned as sinful and sick in a majority of human societies across time and place (Ford & Beach, 1951; Greenberg, 1988). The third perspective suggests that it has a natural if not genetic basis, as its expression increases systematically in the primate order as one moves from prosimians to New World

monkeys to Old World monkeys to apes and finally to humans (Vasey, 1995). In the conflict between the Judeo-Christian attitude and homosexuality, it appears, scientifically speaking, that it is the former, not the latter, that is out of sink with nature. Therapy should be informed by these perspectives so that patients can give true informed consent.

Reparative Science and Social Responsibility: The Concept of a Malleable Core as Theoretical Challenge and Psychological Comfort

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Spitzer's article is reminiscent of constructions of homosexuality as an illness, heterosexuality as normal and healthy, and “reparative therapy” as a treatment. Spitzer presents evidence that individuals' sexual attractions and sexual self identities, as well as sexual behaviors, can change over time, and interprets this as a change in core sexual orientation resulting from reparative therapy. In the current theoretical climate, it would be easy for critics to reject the findings on methodological grounds, to disagree with the conclusion that core sexual orientation changes occurred, or to dismiss Spitzer's argument for its complicity with outdated views of homosexuality. It is important, however, to distinguish methodological criticisms from criticism of Spitzer's underlying moral perspective, and to refrain from using the former to undercut the latter.

Although there are sources of bias in Spitzer's methods, the findings that individuals' sexual attractions, responses, self identities, and behaviors can change are consistent with findings of other contemporary researchers. Comparable research has been conducted under different theoretical guises, including research on coming out, “situational homosexuality,” and the multidimensionality of sexuality. Research on coming out documents shifts over the life course from heterosexual to lesbian, gay, or bisexual (LGB) self identities, feelings, and behaviors (e.g., Coleman, 1982; Rosario et al., 1996; Rust, 1993; Savin-Williams, 1995). Research on situational homosexuality explains same-sex activity among individuals otherwise cast as heterosexual, such as prison inmates (e.g., Giallombardo, 1966; Ward & Kassebaum, 1965; Wooden & Parker, 1982) and women in the sex trade (e.g., McCaghy & Skipper, 1969; see Rust, 2000a). Research on sexual multidimensionality documents imperfect and shifting correlations among sexual attraction, response, behavior, and identity (e.g., Blumstein & Schwartz, 1976a, 1976b, 1977; Diamond, 2000; Ekstrand