

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

Paula C. Rodríguez Rust, Ph.D.

Department of Sociology, Hamilton College, 198 College Hill Rd., Clinton, New York 13323; e-mail: paularust@world.oberlin.edu.

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

et al., 1994; Rust, 1996a; Weinberg, Williams, & Pryor, 1994, 2001). Most research on coming out, situational homosexuality, and sexual multidimensionality involves the same methodological weaknesses as Spitzer's research, including reliance on retrospective self reports (cf. Diamond, 2000; Weinberg et al., 1994, 2001). With one exception that I will discuss below, I find Spitzer's acknowledgment of, and efforts to minimize, methodological bias thorough and fair. These biases must be considered, but they do not uniquely discredit Spitzer's findings.

Spitzer found greater changes among women than men. Numerous researchers have found greater variability in sexual feelings, identities, and behaviors over the life course among women than among men (e.g., Laumann et al., 1994; Weinberg et al., 1994) and less consistency among the dimensions of sexuality among women, particularly a tendency for women to identify themselves in ways inconsistent with their sexual attractions and behaviors (e.g., Diamond, 2000; Rust, 1992). It has been suggested that the greater variability and inconsistency in women's sexualities reflect greater social restrictions placed on their sexual behavior, greater dependence of sexual feelings on situational factors, and the importance of social relationships in defining women's identities (e.g., Pillard, 1990; Rust 2000b; Schwartz & Blumstein, 1998). Whereas men might base their sexual identities primarily on their sexual feelings and experiences, women are socialized to subject their attractions to social considerations and to define themselves in terms of their relationships to others, resulting in greater socially induced changes in women's experiences of their sexualities and more frequent changes in their self identities.

Although social influences might be stronger for women, I (Rust, 1996b) have argued that both men and women develop situationally dependent attractions to others, derive identity from their social circumstances, and change their identities as social circumstances change (Rust, 2001). Cass (1996) argued that sociocultural settings have "indigenous psychologies" such that "psychological functioning and human behavior is specific to the sociocultural environment in which people live" (p. 229). Spitzer's findings that both men and women, but particularly women, experience changes in their sexual feelings, behaviors, and identities during reparative therapy is entirely consistent with these social constructive arguments. Religious teachings, social support from ex-gay organizations and other-sex spouses, and cultural encouragement of heterosexual relationships are circumstances that might influence individuals' sexualities.

Some of Spitzer's own findings appear to undermine his conclusions. For example, Spitzer reported that 85% of male and 70% of female respondents "did not find life as a

gay man or lesbian emotionally satisfying." Although this could be interpreted as evidence that these individuals' pretherapy core sexual orientations were not homosexual, and that the shift toward heterosexual functioning is not, therefore, a shift in core orientation, I believe this would be a misinterpretation. The finding is not a lack of emotional satisfaction with a same-sex partner, but with life as a gay man or lesbian. I see this as evidence of the social malleability of sexual feelings; life as a gay man or lesbian might be unsatisfying for Spitzer's respondents because same-sex relationships lack social recognition and do not fit the family image they covet. The lack of emotional satisfaction is social in origin, but leads to a perception of one's same-sex attractions as ego-dystonic, which motivates a reconstruction of the self as heterosexual. One might be attracted to one's own sex, but also to a heterosexual lifestyle, and one might generalize one's attraction to a heterosexual lifestyle into an attraction to an other-sex person.

The distinguishing feature of Spitzer's research is not the finding that changes occur, but the argument that they reflect changes in core sexual orientation. Researchers who document changes in sexuality generally do not infer changes in core sexual orientation. For example, coming out is usually described as a rejection of a false heterosexual identity in favor of a LGB identity that reflects one's true sexual orientation, rather than a change in core sexual orientation (cf. Dixon, 1984). The term "situational homosexuality" was developed to protect the notion of an immutable core sexual orientation. Researchers who document sexual multidimensionality typically critique dichotomous constructions of sexuality, a deconstructionist approach that rejects the notion of a "core" homo- or heterosexuality. As Spitzer notes, even other researchers who study reparative therapy stop short of claiming changes in core sexual orientation. The real challenge Spitzer poses, therefore, is not the assertion that changes in sexual identity, feelings, and behavior occur, but the assertion of a core sexual orientation that is, although core, amenable to change. If a core orientation can change, what defining characteristic renders it "core"? The proposition that a malleable core sexual orientation exists is untestable. Its function is not scientific, but psychological; it allows individuals undergoing reparative therapy to hope that they will, ultimately, be able to live without fear that their same-sex desires will resurface.

Spitzer acknowledges his respondents' high motivation to demonstrate the efficacy of "reparative therapy," but asserts that he found their claims credible. He points out that his respondents did not report rapid or complete change, that some admitted using gay pornography, and that findings for women and men differed. I agree that these findings would be unlikely if respondents were

lying, but I find them entirely consistent with the argument that subjects were deceiving themselves or, as I believe, reconstructing themselves. Both self-deceptive processes and reconstructive processes can be lengthy, and reconstructive processes can be gendered. The change must be credible to the respondent as well as to observers; otherwise, the self-deception, or reconstruction, cannot be successful.

Spitzer notes the possibility of interviewer bias, but underestimates other methodological biases. Recruitment via ex-gay ministries and the National Association for Research and Therapy of Homosexuality ensured respondents with personal interests in the success of reparative therapy. Given the impossibility of randomly assigning individuals to treatment and control groups, this bias is probably unavoidable. Many had obvious vested interests. Spitzer reports that 78% had spoken publicly in favor of reparative therapy. More important, however, is the fact that subjects self-selected in response to "repeated notices of the study" sent to them by organizations upon which they relied for their "recovery." Endorsement of the research by these organizations would have suggested to potential respondents an organizational interest in the study's outcome, thus heightening both self-selection and response biases.

Spitzer's lack of criticism for the term "reparative therapy" and his equation of sexual addiction with homosexuality are disturbing. In all fairness, Spitzer does not advocate the use of reparative therapy to treat homosexuality in general. Spitzer's respondents underwent therapy because they desired to function heterosexually. These desires undoubtedly stem from social disapproval of homosexuality, and I would prefer to change the attitudes, not the individual; however, this choice belongs to the individual. Although Spitzer does not explicitly advocate reparative therapy in general, his failure to critique it speaks loudly. As social scientists, we cannot be held responsible for others' use of our findings, but I do believe we have a responsibility to consider the political circumstances within which we choose our research questions and present our findings. Social responsibility is particularly important when our research touches on areas of sexuality in which social prejudices have caused so much suffering for so many for so long.

A Candle in the Wind: Spitzer's Study of Reparative Therapy

Donald S. Strassberg, Ph.D.

Department of Psychology, 390 S 1530 E., Room 502, University of Utah, Salt Lake City, Utah 84112; e-mail: donald.strassberg@psych.utah.edu.

Spitzer is to be congratulated on tackling a difficult research question in a manner that, in some ways, is superior to many of the previous research efforts in this important area. He asked more, and often better, questions of more people who have "successfully" undergone reparative therapy than anyone else. However, his study has some serious methodological limitations. Although he acknowledges most of these limitations, he may be too willing to minimize or deny their impact on the meaningfulness of his results.

The acknowledged major limitations of this study are the manner in which participants were recruited and its reliance on self-report measures of change. Beyond the fact that there was no control group and no random assignment to treatment, interviewees were self- and therapist-selected because they believed that they had changed as a result of reparative therapy. This, obviously, creates several important limits. For example, we have no idea how typical these self-reported changes are. Spitzer admits that these are likely exceptional cases, but how exceptional? Do they represent the top 25%, 10%, 1%? This is not a trivial matter, especially as one is trying to weigh the relative benefits and risks associated with reparative therapy. Of course, a related limit to this recruitment strategy is that we have absolutely no idea about how many reparative therapy patients might have been harmed by their participation, or in what ways.

The sole reliance on self-reports of this select group is also problematic. I agree with Spitzer's belief that few of his participants consciously misrepresented themselves on the pre- and postmeasures. However, it seems likely to me that he may have underestimated the degree to which, for religious and self-esteem reasons, his participants may have been highly motivated to see themselves as having changed more than was really the case. Further, we have the cognitive dissonance that would have been created had these men and women seen their years of work as unsuccessful and ineffective. Spitzer is more convinced than I by the "evidence" of the reality of these reports (i.e., that most reported less than complete change on all dimensions). These were educated people who, as a result of their own experiences and the experiences of others like them, knew that absolute change in orientation was unlikely, even for those "successful" in treatment. They could have been easily unrealistically positive in their appraisals while reporting less than complete "cures."

Where does that leave us? It is unlikely that many practitioners or theorists currently believe that sexual orientation is completely fixed and unalterable for all people, in all ways, throughout the lifespan. There are a number of