

qualitative studies documenting individuals, particularly women, who experienced significant transitions in many aspects of sexual orientation without the benefit of formal, or even informal, reparative therapy (e.g., Blumstein & Schwartz, 1976a, 1993; Charboneau & Lander, 1991; Diamond, 2000; Kinnish & Strassberg, 2002; Kitzinger & Wilkinson, 1995). If change in many aspects of sexual orientation is possible without therapy, sometimes without even intention, than certainly such change is possible for some of those who will invest years of concentrated effort toward bringing about such change.

Then what does this study tell us beyond that some people in reparative therapy can and do significantly change, or at least believe that they do, in some aspects of orientation? It tells us that among such self-identified changers, most were not exclusively same-sexed oriented before treatment and most, perhaps all, were not exclusively other-sexed oriented after treatment. Does this surprise anyone? Perhaps there is more change reported by more people here than many of us would have expected. But this is a highly select group of men and women. These are among the “best” the reparative therapy movement could offer—they are the poster adults for this movement. Even if we accept their self-reports as fact, what these data say is that some unknown (but likely small, perhaps very small) fraction of those who are motivated to spend years trying, were able to move, often to a substantial degree, along most dimensions of the sexual orientation continuum. This is not trivial, but not terribly surprising either.

Although Spitzer made some laudable methodological improvements in his approach to an important research question, the design of his survey does not really put it into the category of “scientific evidence supporting the efficacy of reparative therapy” for which so many seem to be looking. We need to know a lot more about those who may benefit and those who may be harmed by an approach that labels gay/lesbian/bisexuals as pathological and in need of repair (an issue, by the way, that Spitzer avoids discussing). I doubt any of us has yet to see, let alone conduct, the perfect study on virtually any psychological issue, and certainly not one as complex as sexual orientation. Spitzer is to be congratulated on trying to “light a candle” rather than continuing to “curse the darkness” when it comes to trying to understand what happens as a result of reparative therapy. However, the amount of illumination provided by this particular candle does not strike me as quite as bright as Spitzer seems to believe. More importantly, it does not tell of nearly as much about reparative therapy as the media or the religious right is likely to want to make of it.

Spitzer’s Oversight: Ethical-Philosophical Underpinnings of “Reparative Therapy”

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Spitzer introduces data from a self-selected sample who responded to requests for those who had “sustained some change in homosexual orientation” and concludes that “there was no evidence of harm” to these participants. Although Spitzer does not claim that this study provides any evidence that such interventions are harmless for all individuals who seek them, he suggests that further research be conducted. While Spitzer presents an ostensibly scientific call for further inquiry, the justification for changing sexual orientation is ultimately an ethical-philosophical one: “In fact, the ability to make such a choice should be considered fundamental to client autonomy and self-determination.”

Although I do not question Spitzer’s science, there is a glaring oversight in his article: a failure to examine the ethical and philosophical underpinnings of sexual orientation modification (SOM). I will refer to this as SOM instead of “reparative therapy,” because the latter phrase suggests a clinically indicated treatment for a disorder, a method of repairing something that is broken. While heterosexuality may be normative, it is no longer argued in the clinical literature that heterosexuality is inherently healthier than a nonheterosexual orientation nor that its absence is a defect in need of fixing. Even though sexual orientation is no longer thought of as a preference, the desire to change it most clearly *is* a preference, one that is deeply influenced by culture. Further, SOM is a directionally neutral term, whereas reparative therapy inherently suggests a unidirectional modality. If Spitzer or other advocates of SOM were really value-neutral and supportive of client autonomy, they would also be calling for research into changing heterosexual orientation to bisexual or homosexual.

The ultimate issues regarding SOM are ethical-philosophical ones and not empirical. It is not whether sexual orientation *can* be changed, but whether it *should* be changed. To the extent that we are organic and have an ever greater command and control over our biology, a great many changes to our biologically influenced makeup will one day be possible. The implication of Spitzer’s position is that on the basis of client autonomy and self-determination, any such change that is desired should be granted if it can be safely effected, but it is a glaring oversight to state this without examining the ramifications of such a position.

Since this is an ethical issue, I will follow the conventions of the philosophy of ethics and, rather than cite empirical research, will suggest three hypothetical cases that illustrate problems and inconsistencies with Spitzer's position. First, assume that in the near future a sequence of genes will be identified that contributes significantly to an individual's sexual orientation. Preimplantation genetic diagnosis (PGD) presently offers physicians and their patients the ability to screen embryos with certain sequences of DNA, such as those identified with genetically linked diseases. The same technology that already exists could easily be adapted to selectively decide which genetically influenced traits will be allowed to continue in future generations, as soon as specific genetic sequences are identified for such traits or predispositions. Thus, in this hypothetical example in which a sequence of genes has been identified, a much more effective SOM would be using PGD to screen out those embryos whose genetic inheritance predisposes them to a heightened probability of having a parentally unwanted sexual orientation. Spitzer's assumption about individual autonomy—do not deny the patient any available effective treatment for modifying sexual orientation—would surely extend to our hypothetical case, and this new, more efficacious method of SOM would be the free choice of prospective parents, perhaps even more for those living in a free market economy, where treatment providers insist on unrestricted trade in therapeutic interventions. A second example: consider the parallel with race. If an individual experiences discomfort because of racial prejudice, would one encourage the development of interventions that successfully altered skin tone if patients requested it, or would one abandon such "treatments" and instead undertake the harder work of changing societal attitudes and laws? A third example illustrates an inconsistency within Spitzer's position. Many primarily heterosexual individuals occasionally have same-sex attractions, and so one could suggest that SOM be pursued to aggressively encourage bisexuality and thus double the opportunity for finding a soulmate. Advocates of SOM generally assume without question that heterosexuality is the only change that should be pursued.

It could be argued that Spitzer's SOM does not involve such hypothetical cases, but is designed to deal with the reality of clients who are distressed by their nonheterosexuality and who genuinely wish to change themselves. Yet, consider this equally true reality: the mental health professions accept that healthy, happy sexual orientation is not confined to heterosexuality. It is further a reality that the desire for nonheterosexuals to change is not an inherent property of a nonheterosexual orientation, but a discomfort contributed to by certain cultural, religious, and social norms. Spitzer's response to this reality is to

turn aside from the sources of the discomfort, to treat the proximate rather than the ultimate cause of the distress.

If one strips away the empirical veneer, there are chiefly three ethical-philosophical underpinnings of reparative therapy: (1) proponents of SOM are interested in taking individuals whose naturally occurring, potentially nondysfunctional sexual orientation causes them discomfort because of the social and cultural norms of *others*, and they wish to "help" these individuals conform to these norms, rather than addressing the dysfunctional norms themselves; (2) for individuals who themselves have intensely unsatisfactory adjustment to their own sexual orientation, advocates of SOM are unwilling to recommend techniques such as gay-affirmative therapy that may question or change aspects of self which are very clearly a matter of belief rather than biology, deciding instead that clients' dysfunctional beliefs about sexual orientation enjoy a privileged status which should not be challenged—despite the fact that many forms of empirically supported psychotherapy are based on the ability to modify cognitive distortions and change irrational beliefs; (3) whether called "reparative therapy" or something else, by offering such "treatments" therapists implicitly deny that nonheterosexual orientation can be healthy, and they instead reinforce the cognitive distortion that nonheterosexual orientation is defective, inferior, and/or immoral. For all three possibilities, it is not really client autonomy that is the basis of reparative therapy, but therapist autonomy to change clients, based chiefly on a therapist preference for heterosexuality. This is ultimately a value judgment and not something that can be fruitfully addressed through further empirical research.

Sexual Diversity and Change Along a Continuum of Bisexual Desire

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Despite the unusual care with which this study was undertaken, we are not entirely convinced that most, if any, of Spitzer's subjects experienced a change in sexual orientation from homosexual to heterosexual. The overarching problems are twofold: one methodological, pertaining to sample selection, and the other conceptual. The manner in which Spitzer's sample was composed suggests that many of his subjects were apt to experience cognitive dissonance around issues pertaining to their sexual orientation and this may have prompted them to lie or engage in elaborate self-deceptive narratives when reporting change in sexual orientation. As Spitzer notes, the vast majority