

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

(93%) of his subjects stated that religion was “very” or “extremely” important in their lives. We question whether it is reasonable to expect that “extremely” religious individuals will honestly answer explicit questions about details of their sexuality, let alone details that they find deeply reprehensible and that they are actively attempting to repress. The role of religion in fostering an atmosphere of lies and enabling the production of self-deceptive narratives has been well documented in the form of many first-person narratives from “ex-ex-gays” (Duberman, 1991; Maniaci & Rzeznik, 1993). These narratives demonstrate how gay men and lesbians can be motivated to believe what they *want* to believe or are *told* to believe in matters of sexual orientation that they find morally distasteful. Perhaps more of a concern, however, is the fact that 19% of Spitzer’s subjects were mental health professionals who espouse reparative therapy and directors of ex-gay ministries. In light of their personal and professional investment in such enterprises, it seems reasonable to assume that such individuals would be highly motivated to communicate the message that change in sexual orientation is not only possible, but desirable.

There are additional important conceptual problems with this study. Prior to “reparative” therapy, most of Spitzer’s subjects reported that they were predominantly attracted to same-sex individuals and experienced some attraction to opposite-sex individuals. Post-therapy, most subjects reported the opposite pattern. Spitzer points out that reports of complete change from homosexual to heterosexual were uncommon. Unfortunately, he does not elaborate on this point, so it is impossible to say how many of his homosexual subjects, if any, experienced such change. As such, we believe that the title of this paper is misleading because most of Spitzer’s subjects were bisexual, not homosexual. For such individuals, change, if it occurred, was on a continuum of bisexuality, and did not entail a binary shift from homosexual to heterosexual orientation. Spitzer obviously chose to categorize such individuals as gay or lesbian because they were predominantly attracted to same-sex sexual partners, but this reflects subjective decision-making processes on his part that ultimately mask the extent of bisexual variation that exists in the real world.

The existence of sexual diversity, or variation, is quickly becoming a growing area of inquiry in the biological and behavioral sciences. Humans are, if anything, a behaviorally diverse species and this diversity extends to sexual interactions. Given the extent to which behavioral diversity characterizes the expression of human sexuality, it does not seem particularly surprising to us that change in sexual orientation might be possible in *some* individuals without harmful effects on the individual. Such

change seems particularly plausible along a continuum of bisexuality, as appears to be the case for most of Spitzer’s subjects. In fact, a similar phenomenon has been observed among Japanese macaques (*Macaca fuscata*), a species of monkey endemic to Japan. In some populations of these monkeys, females engage in varying proportions of heterosexual and homosexual mounting, courtship, and sexual relationships from one annual mating season to the next (Vasey, 2002).

Thus, perhaps the most robust result of Spitzer’s study is that some individuals can change along a continuum of bisexuality. However, it is equally, if not more, important to point out that sexual orientation is unlikely to be amenable to change in many, if not most, individuals and that attempts to bring about such change are likely to cause harm to the individual (American Psychiatric Association, 2000; Haldeman, 2001; Friedman & Downey, 2002). Indeed, Spitzer’s study seems to support this conclusion. He noted that most of his subjects spent years, even decades, in therapy, attempting to change their sexual orientation. This time frame alone suggests that sexual orientation is, even in the most highly motivated individuals, remarkably resistant to change.

Some readers may interpret Spitzer’s study as evidence that homosexual and bisexual orientations are chosen. We believe that such an interpretation is unfounded. Spitzer’s study demonstrates individuals can choose to foster their latent heterosexual tendencies while repressing their overt homosexual tendencies. It does not provide evidence that individuals choose or learn to be homosexual. Change in sexual orientation over the lifespan does not indicate that one’s primary sexual orientation (i.e., that which is first expressed) is a learned choice. A left-handed individual might choose to use only their right hand because of social restrictions (Dawson, 1977; Payne, 1987) and may, with practice, become adept at doing so, but this does not imply that the initial use of their left hand for daily tasks reflected any sort of conscious choice.

We believe that the next steps in this program of research (if any) are to, first, identify what parameters differentiate individuals that *can* change their sexual orientation in the *absence* of harmful effects, from those that either can not or will not. Second, the nature of change must be clarified. Is the change truly from homosexual to heterosexual or vice-versa? Is the change from homosexual or heterosexual to bisexual, or vice-versa? Or, is the change merely along some continuum of bisexual desire? Third, the relation between reparative therapy and change in sexual orientation may simply be spurious and reflect a correlation between either of these variables with religiosity. As such, future research should employ appropriate control groups to identify whether change in sexual orientation

is contingent on participation in some form of reparative therapy. We should not assume, *a priori*, however, that participation in such therapy is a necessary prerequisite for change. Finally, if change is contingent on therapy, the next question is which types of reparative therapy facilitate change and which do not.

In conclusion, there seems to be a basic contradiction in the overall message of this work. The emphasis on the efficacy of reparative therapy in changing sexual orientation seems to hinge on the notion that sexual orientation is flexible to begin with. If not, change would be impossible. Clearly, in the minds of some, sexual flexibility is real and is a good thing, but only insofar as it operates in the service of promoting sexual inflexibility in the form of a heterosexual endpoint. Strangely lost in this line of reasoning is the potential normativeness of the original variability to begin with. Acknowledging this contradiction might shift the focus of attention to the arguably more relevant issue of why there is any perceived need for change. To this end, the foundational assumption inherent in much reparative therapy that same-sex attraction reflects a developmental disorder needs to be critically addressed, particularly in light of the American Psychiatric Association's (2000) formal position that homosexuality is not a disordered outcome.

### Science and the Nuremberg Code: A Question of Ethics and Harm

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This comment combines the perspectives of 14 researchers in the social and behavioral sciences from diverse backgrounds who have serious concerns about Spitzer's study on sexual orientation change through "reparative interventions." In his article, he reviewed research on sexual orientation change through reparative interventions, noting policies and position statements of key institutions, and deficiencies in previous studies. Spitzer recruited 143 men and 57 women based on their assertions that they had changed their homosexual orientation to a predominantly heterosexual orientation. Subjects were recruited through their therapists, pro-change religious ministries, and targeted advertising. He then assessed these

individuals about their pre- and postreparative intervention sexual interests using a structured telephone interview. The main study finding is self-fulfilling: Participants selected through this sampling strategy reported changes that were the basis of their recruitment into the study.

Designing a study using as a conceptual framework the assumption that the heterosexual/homosexual binary provides an accurate description of the organization of human sexual desire and expression is out of step with the field of sexuality research (Stein, 1999). Studies over the last 50 years have shown cross-cultural variations in sexual expression and relationships (Kumar & Ross, 1991; Naz Foundation, 2000), which suggest that the binary is not evidence of nature at work; rather, it is evidence of the historical forces that continue to shape our concept of relationships (Crawford, Kippax, Rodden, Donohoe, & Van de Ven, 1998).

In addition to conceptualizing sexual expression in a way that is inconsistent with the scientific literature, this study suffers from bias introduced via the recruitment strategy and other serious methodological flaws, rendering it problematic from a scientific point of view. Spitzer acknowledged some methodological limitations of his study, including involvement of an unblinded research interviewer and the potential fallibility of participants' self-reports that were not corroborated with any objective measures. However, Spitzer did not make use of other systematic, well-established scientific procedures that are crucial to obtaining valid scientific results nor addressed how his results may have been affected by the many design flaws in his study. Therefore, it is important to underscore scientific problems in the study, including (1) a recruitment strategy resulting in not only a sample of convenience but a sample invested in demonstrating change, potentially building in a strong bias; (2) lack of a comparison or control group, leaving the study unable to demonstrate the effects of a reparative intervention or determine that a reparative intervention is responsible for any reported changes; (3) many measurement problems, including lack of operational definitions of "homosexuality," "heterosexuality," or "bisexuality," use of nonneutral language in the measures, and noncomparable measurement of "heterosexuality" and "homosexuality"; (4) use of a telephone interview with an unvalidated instrument; (5) lack of interviewer selection and training to reduce reactivity and social desirability pressures; (6) statistical analysis that did not address any of the research questions, since all statistical tests concerned gender differences in the responses. These tests lend an appearance of scientific weight to the study, which is misleading because gender differences were not the point of the study; and (7) lack