

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

of expertise or experience on the part of the investigator in sexuality outcome studies.

Although veracity from research participants is a concern in any interview study, here the problem is greater than the typical wish to please the interviewer; these participants want or need to please *themselves*, to believe their self-assertions of heterosexuality. Spitzer declared that “the key question is judging the credibility of the[ir] self-reports.” Desire to avoid stigmatization by one’s community can be a source of motivation for reporting treatment success. Contrary to Spitzer’s contentions, studies whose outcomes depend on socially desirable responding never obtain absolute denial of undesirable behavior (Turner et al., 1998). It is an error to assume that a participant’s potential *under-reporting* of unwanted and socially undesirable feelings represents veracity (Turner et al., 1998).

Spitzer failed to provide evidence for his assertion that “changing sexual orientation can be a rational, self-directed goal.” In fact, he did not design a study that tests this hypothesis. Further, his statement that “change in sexual orientation seems plausible (again, at least to the author) as the participants used change strategies commonly effective in psychotherapy” is an unsupported inference. Referring to unmeasured psychotherapeutic techniques does not attest to change.

Our concerns go beyond the lack of rigor in this study’s scientific methodology—the scientific problems lead to serious ethical problems as well. According to the *Nuremberg Code* (Directive 4; Nuremberg Code, 1949), “The experiment should be so conducted as to avoid all unnecessary physical and mental suffering and injury.” Research ethics dictate that the harm associated with any treatment be the first thing to be evaluated. If substantial harm is found, then any degree of “change” is irrelevant. Spitzer asserted that his study “questions the current conventional view that desire for therapy to change sexual orientation is always succumbing to societal pressure and irrational internalized homophobia,” and that his findings demonstrated “no obvious harm.” Both assertions are unsupported by his work. There was no objective measurement of harm to participants in this study; moreover, there was no attempt to assess the harm accruing to individuals who attempted but failed “reorientation.” Harm from reparative interventions has been demonstrated (Shidlo & Schroeder, 2002) and there is a body of work on homophobia showing that health care providers’ attitudes can be hazardous to their patients (Baker, 1993; Brotman, Ryan, Jalbert, & Rowe, 2002; Garofalo & Katz, 2001; Plummer, 1995). When doing research, scientists have the responsibility not only to ensure protection of the research subjects but also to minimize the negative impact that the research

may have on the community the subjects represent. To disregard the potential for harm exposes populations that experience discrimination to additional risks. If the publication of this study makes psychotherapists more comfortable (perhaps in subtle ways) encouraging their homosexual patients to “change,” then the study will have done further harm.

To imply that “change” in sexual orientation is possible, without indicating how likely it is for a given individual to achieve any degree of “change,” suggests that most or all homosexuals can “change” orientation if sufficiently motivated and serves only to reinforce the false notion that homosexuality is a choice. Thus, creating an unsupported impression that reparative interventions are effective is unethical. There are social and cultural disincentives to being attracted to people of the same sex: violence, discrimination, marginalization, illegal status and imprisonment, individual and social abuse, and less than equal status in relation to public services (Bedard & Gertz, 2001; Hart, 2001; Ragins & Cornwell, 2001; Yomtoob, 2001). Being gay or lesbian is stigmatized in many workplaces, families, communities, and institutions (e.g., high schools), whereas there are significant social, cultural, and economic benefits available to those with a heterosexual orientation. Therefore, to be a gay man or a lesbian involves more than simply solving a question of sexual attraction or identity. Researchers conducting studies on sexual orientation have a responsibility to evaluate the potential implications of those studies. Feasibility does not justify poor science.

In hypothesizing that “same sex attractions . . . can be significantly diminished through development of stronger and more confident gender identification, possibly demystifying males and maleness,” reparative interventions confuse gender role, sexual orientation, and sexual identity (Stein, 1999). Reparative interventions assume homosexuality is sinful, wrong, and, as quoted by Spitzer “reflect[s] a developmental disorder,” making homosexuality pathological in the service of an agenda that aims at reinstitutionalizing homosexuality as a mental disorder. Harm will be done if this study is used to justify any attempt to relabel homosexuality as a mental disorder. Spitzer asserted that he began the study with a skeptical view of the outcome. This point is worth noting, as Spitzer (1981) has written “If there were a ‘treatment’ for homosexuality . . . that was available and effective in most cases, it is likely that there would be little objection to classifying it as a disorder” (p. 213).

We are troubled by the publication of work filled with scientific flaws that disregards harm and conveys a number of false impressions. It is likely that this study will attract considerable attention in the media, and that lay

audiences will not appreciate its lack of scientific rigor. Homophobic and heterosexist audiences will use it to further their agendas. Documented consequences of homophobia include suicide among young homosexual men and women (Cochran & Mays, 2000; Fergusson, Horwood, & Beautrais, 1999; Garofalo et al., 1999; Herrel et al., 1999; Hershberger & D'Augelli, 1995; McDaniel et al., 2001; Remafedi, 1998, 1999a, 1999b, 2002; Remafedi, French, Story, Resnick, & Blum, 1998). We fear the repercussions of this study, including an increase in suffering, prejudice, and discrimination (Stein, 1998; Suppe, 1984).

Sexual Reorientation Therapy: Is It Ever Ethical? Can It Ever Change Sexual Orientation?

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I address four questions—methodological, ethical, and conceptual/theoretical—raised by Spitzer's courageous report on 200 subjects claiming posttherapy changes in sexual orientation from homosexuality towards heterosexuality: (1) Are subjects' responses dismissable as lies or self-deceptions, as some critics claim? (2) Is the study's design too weak to show anything of scientific interest, as critics also claim? (3) Does the study imply that reorientation therapy is sometimes ethically allowable, contrary to recent professional association edicts? (4) Do the data demonstrate change in core sexual orientation itself, as Spitzer claims?

Can Subjects' Reports Be Dismissed as Deceptions?

Given the subjects' personal and political motivations to represent therapy as successfully changing sexual orientation or related variables (I use "sexual reorientation" for convenience throughout, but only later consider whether sexual orientation itself really changed), it remains possible that subjects massively lied or deceived themselves, as critics suggest. However, to assume without evidence that reports of changes must be deceptions begs the question of whether change sometimes occurs. Moreover, for reasons somewhat different from Spitzer's, I believe the data suggest that lies and self-deceptions are probably not the major source of reported changes.

First, some changes are publicly verifiable and thus presumably not as subject to lies or self-deception, such as the enormous increase in the percentage of subjects in ongoing heterosexual relationships (for males, from 26% PRE to 87% POST). Although this variable indicates sex-

ual orientation less directly than others, changes in relationship behavior are important in themselves and tend to corroborate reports of psychological changes that may facilitate relationship changes.

Second, regarding crucial subjective experience indicators of sexual orientation, if subjects were massively prevaricating or self-deceiving to support evidence of change, why would so many males report POST continuing significant same-sex masturbatory fantasies (45%) and significant same-sex attraction (50%)? It might be argued that subjects were sophisticated enough deceivers to avoid extreme claims. However, subjects were highly motivated to deny *any* continued homosexual interest. Moreover, in usual social desirability responses, moderation may be exercised because extremes are uncommon and sometimes even of questionable desirability (e.g., always honest). In contrast, complete and exclusive heterosexuality is considered both common and socially desirable (within subjects' communities), so the "moderate lie" hypothesis lacks motivation.

Third, the Dyadic Adjustment Scale (DAS) was independently completed by the subjects' partners POST, and their scores corroborated the subjects' positive relationship reports. Spitzer also pertinently observes that both the subjects' and their partners' DAS scores were not inflated from norms. Again, one might argue that spouses also lied. However, such increasingly elaborate ad hoc hypotheses, while not impossible, demand independent evidence to be taken seriously.

Fourth, when asked to explain changes, subjects generally cited standard cognitive, psychodynamic, and behavioral therapy techniques that have face validity as causes of such changes. Indeed, the suggestion that standard therapeutic techniques can sometimes influence sexual object choice is a fascinating aspect of Spitzer's study.

Taken together, these considerations, plus the current lack of any evidence of massive deception, suggest the data should be taken to have some *prima facie* credibility.

Is the Study Methodologically Too Weak to Show Anything of Scientific Importance?

Many critics set up straw men by misinterpreting the study's purpose, then criticizing the study for not achieving that purpose. Certainly, given the study's retrospective nature, subject self-selection, and lack of controls, the study cannot *prove* anything about the general or even occasional effectiveness of sexual reorientation therapy. Rather, it offers inconclusive *prima facie* evidence that a few severely conflicted and highly motivated patients may be enabled by this kind of therapy to change their behavior and experiences in ways they believe are helpful.