

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.

Why would such a weak conclusion be of any interest? A study's scientific importance is a function of the claims it addresses. The current scientific context contains explicit or implicit universal claims that sexual reorientation therapy is unhelpful and/or harmful. Spitzer's study offers *prima facie* exceptions that cast doubt on these generalizations; thus, it is scientifically useful.

Comparably weak studies have influenced other areas subject to universal hypotheses. For example, when some alcoholism researchers maintained that alcoholism is a universal disease with a predictable course of deterioration, methodologically weak studies using newspaper ads to find people who self-reported having recovered from alcoholism without treatment had substantial impact. Despite their inconclusiveness, the studies raised *prima facie* doubts regarding the universal disease entity hypothesis and thus challenged attitudes about treatment derived from it.

What Are the Study's Implications for the Ethics of Reorientation Therapy?

Given the historical and ongoing oppression of homosexual individuals, it is understandable that therapeutic attempts to change homosexual orientation have been looked upon with suspicion, often justifiably so. However, in the absence of evidence that subjects' self-reports lack credibility, Spitzer's study offers *prima facie* support for the ethical acceptability of reorientation therapy in some cases of severe ego-dystonic homosexuality. Subjects' symptoms (depression, bothered by homosexual feelings) declined precipitously from PRE to POST. Even if reorientation therapy only rarely offers substantial benefits, it is potentially unethical to ignore evidence of such substantial reduction of suffering in some highly motivated, deeply conflicted patients when considering treatment options, especially given the lack of any proven alternative. Under such conditions, a difficult decision regarding possible benefits versus possible harms must sometimes be made, and the ethical focus should be on informed consent and sensitivity to patient preferences rather than on a general ethical judgment applying to all patients. The study thus implies that recent professional association statements declaring such therapy unethical are potentially oppressive to some clients and should be rescinded or revised.

The study alerts us to two clinical circumstances in which attempts to change sexual orientation in severely ego-dystonic homosexual individuals may be ethically justified by patient self-determination and need: (1) The patient strongly wants to save or improve a marriage he or

she considers more important than satisfying homosexual desires. For many patients, marital dissolution may be the best choice, but any rule about treatment goals that ignores individual circumstances and preferences is ethically unacceptable. (2) The patient's deeply held religious, social (wanting to remain part of a community), or moral convictions cause severe conflict with homosexual desires, and the patient strongly considers the convictions more important than the desires.

Spitzer's study particularly supports the occasional power of therapy to improve marital heterosexual functioning of ego-dystonic homosexual individuals. Spitzer demandingly defines "good heterosexual functioning" (GHF) as requiring a loving ongoing heterosexual relationship with sex at least several times monthly, high emotional and physical satisfaction, and at most rare same-sex fantasies during heterosexual sex. Of 55 subjects in continuing PRE-to-POST marital relationships with regular sex, only 5% displayed GHF PRE versus 84% POST. In the overall male sample, just 3 (2.1%) displayed GHF PRE versus 94 (65.7%) POST (Spitzer, personal communication, March 15, 2003). It would be unethical to preclude such help for homosexual patients' marriages or marital aspirations.

The ethics of sexual reorientation therapy must be distinguished from other issues. Many therapists practicing sexual reorientation therapy unethically impose an antigay bias on clients; but therapists need not do so, and it is also unethical to impose an antichange bias. Most of Spitzer's subjects almost certainly had negative attitudes towards the gay rights movement; nonetheless, they have a right to help that is not politically constrained. Many critics of reorientation therapy assume its acceptance implies the repathologization of homosexuality (i.e., that homosexuality is considered a disorder), but there is no such implication and it is generally recognized that individuals with nondisorders may benefit from treatment (even the *DSM-IV* contains a section coding nondisorder problems that are often the focus of treatment). Spitzer's subjects clearly needed help with their intense conflicts whether or not they had a disorder.

What about the objection that the patient's desire to change homosexuality is always due to internalized homophobia; thus, sexual reorientation therapy is always collaboration with social oppression? This interesting but unproven hypothesis is a one-size-fits-all etiological speculation that ignores the diversity of clients' meaning systems and should not take priority over client self-determination. Giving homoerotic sexual desires higher priority than relationship commitments and religious meanings with which they are in conflict is a value judgment that is itself a product of one internalized

socially constructed meaning system among many. Imposing this approach on all clients unethically sacrifices individual clients' possible relief from suffering on the altar of sexual politics. It is all too easy for the oppressed in this way to inadvertently rationalize becoming the oppressor.

Did Reorientation Therapy Change Core Sexual Orientation?

Granting that reorientation therapy likely benefited some subjects and is sometimes ethically defensible, did at least incremental changes in core sexual orientation also occur, as Spitzer claims? Impressively, Spitzer goes beyond reporting changes in subjects' orientational self-labeling, symptoms, and behavior, which changed dramatically but do not necessarily indicate orientation change. He also reported changes in experiential variables that are generally more valid indicators of sexual orientation (e.g., fantasies during masturbation and intercourse, attraction, lustful looking), and these changed substantially, although not as much as self-labeling, symptoms, and behavior.

One common objection to claims of orientation change is that subjects were bisexual PRE and simply suppressed homosexual responses and focused on heterosexual responses POST. Even if true, this objection would only cast doubt on whether core sexual orientation changed. It would not vitiate the importance of the changes subjects reported. In any event, this objection is countered by Spitzer's report that even those most extreme and exclusive on homosexual measures and history prior to treatment changed in ways and at rates similar to others. If, as some claim, everyone is inherently bisexual and just selecting from a menu of sexual object choice options, then the whole notion of sexual orientation has to be rethought.

Nonetheless, uncertainties about orientation change remain because of subtleties in the relation of the orientation construct to the study's measures. The measures (e.g., spontaneous masturbation fantasies) are excellent indicators of sexual orientation in the general population, but have unknown validity in subjects consciously attempting to influence their "spontaneous" desires. Sexual orientation is a dispositional/theoretical construct referring to a hypothesized internal structure that disposes one to respond with desire to males or females or both. Such a disposition is consistent with the desires not actually being experienced (i.e., remaining "latent").

Blocking a disposition's expression is not the same as changing it. Salt remains water-soluble even when stored away from water and even though it fails to dissolve when

placed in water under high pressure, because water solubility refers to a disposition to dissolve in water under certain standard circumstances. Correspondingly, potential desires and fantasies that under standard circumstances would be generated by one's sexual orientation may be habitually blocked from conscious development with minimal effort or awareness through techniques such as redirection of attention, thought-stopping, or placing experiences within narratives portraying them as irrational expressions of unresolved family-of-origin problems. Such efforts may or may not solidify into enduring structural changes in core dispositions.

Consider an analogy: A married male patient, troubled by a low-threshold disposition to intensely sexually desire attractive women strangers, cultivated a counterfantasy that the woman would be horrifically difficult in a relationship, bursting the erotic fantasy bubble. The counterfantasy became so automatic and effective that the patient stopped experiencing substantial longing and claimed to be cured. However, when he subsequently became casually acquainted with one such woman, his counterfantasy became implausible, his defense crumbled, and his disposition expressed itself in desire, leading to an affair. The conceptual moral is that to restrain experiential expression of a desire-disposition is not necessarily to change the core disposition.

Of course, habitual inattention or reframing may eventually solidify into new psychic structures and dispositions that endure across environments and constitute true change in core sexual orientation. However, 21% of Spitzer's subjects were still in treatment POST, presumably needing continued intervention to maintain new experiences. Others reported actively counteracting spontaneous homoerotic desires. Remaining subjects may have developed habitualized strategies for influencing desire and fantasy, but these strategies' stability and effectiveness across situations remains unknown.

Uncertainties about orientation change notwithstanding, the findings that subjects report impressive changes toward more satisfying lives, including major changes in sexual behavior and experiences and reduction in symptoms, stand as *prima facie* arguments for reorientation therapy's acceptability in carefully selected cases fitting the profile of Spitzer's subjects, with due awareness of and informed consent regarding the likelihood of failure and possible negative effects. Moreover, Spitzer's provocative report usefully moves questions about orientation change from the political to the scientific domain and opens them to fresh critical scrutiny, hopefully inaugurating overdue scientific examination of issues currently highly politicized.