Sexual Politics and Scientific Logic: The Issue of Homosexuality

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A significant portion of society today is of the belief that homosexuality is a normal form of sexual behavior different from but equal to that of heterosexuality. Many religious leaders, public officials, educators, social and mental health agencies, including those at the highest level of government, departments of psychiatry, psychology, and mental health clinics, have been taken in by a widespread sexual egalitarianism, by accusations of being "undemocratic" or "prejudiced" if they do not accept certain scientific assertions thrust upon them, as if deprived of all intellectual capacity to judge and reason. It is my contention in this paper that this threat of revolutionary change in our sexual mores and customs has been ushered in by a singular act of considerable consequence: the removal of homosexuality from the category of aberrancy by the American Psychiatric Association (December 1973). It is furthermore a fateful consequence of our disregard for psychoanalytic knowledge of human sexual behavior.

In what follows, I shall present a detailed account of social and political forces both within and without our organization responsible for this act and critically examine the spurious and pseudoscientific reasons put forth for the removal of a diagnosis from the *Diagnostic and Statistical Manual.*

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This act was naively perceived by many psychiatrists as the "simple" elimination of a scientific diagnosis in order to correct injustices. In reality, it created injustices for the homosexual as it belied the truth that prevented the homosexual from seeking and receiving psychoanalytic help. At the social, group, and community level, it proved to be the *opening* phase of a two-phase sexual radicalization; the second phase being the raising of homosexuality to the level of an alternate life style, an acceptable psycho-social institution alongside heterosexuality as the prevailing *norm* of behavior.

POLITICAL FACTORS LEADING TO DIAGNOSTIC CHANGE

In 1963, growing concern in the press and the medical profession prompted the New York Academy of Medicine to entrust its Committee on Public Health to study the subject of homosexuality. While the Committee in its report (1964) concluded that "homosexuality is indeed an illness, the homosexual is an emotionally disturbed individual who has not acquired the normal capacity to develop satisfying heterosexual relations," it sounded an alarm: it warned that "some homosexuals have gone beyond the plane of defensiveness and now argue that deviancy is a 'desirable, noble, preferable way of life.'" Spokesmen for homosexual groups argued that homosexuality was not an aberration; those so oriented were merely a different kind of people living an acceptable way of life, and, for one thing, they claimed it was the perfect answer to the problem of a population explosion (!). Clearly a disturbing trend was developing, with homosexuals banding together, not to demand help from psychiatry and the medical profession and public recognition of their condition (alongside those individuals with any form of neurosis or emotional disorder) or simply to protest against legal injustices, but to proclaim their "normality" and attack all opposition to this view. Those who took this view in the past constituted a vocal but very small minority of homosexuals compared to the large number of homosexuals who desired more help, not less, or who remained silent. To my mind, just as alcoholism and drug addiction had become recognized as illness over the past several decades, so was sexual deviation increasingly to be understood as an emotional disorder and, similar to other mental disorders, not to be penalized when practiced among consenting adults. Freedom from persecuto y laws as well as the granting of full civil rights constituted an integral part of this approach to homosexual individuals.

As a young analyst encouraged by the therapeutic response of my homosexual patients to the freedom they found in being relieved of the yoke of their homosexuality, I decided that the moment had come to act directly on the behalf of the homosexual and anyone else suffering from a sexual disorder, with the idea of making help available on request to

many. I wrote to Stanley F. Yolles, M.D., then Director of the National Institutes of Mental Health, asking to meet with him to discuss some suggestions for a national program for the prevention and treatment of homosexuality and other sexual disorders. I wrote, "Of the whole range of sexual disorders, homosexuality is the most misunderstood. Homosexuality not only causes suffering for the individual but is inimical to the preservation of the family unit. The psychological conflicts which lead to the development of homosexuality, the anguish of the homosexual himself and the damage to his family and close associates produces tragic consequences. It should be the task of psychoanalytically informed psychiatry and modern medicine to dispel the mystery that surrounds homosexuality and dissolve the fear which attends any attempt at free discussion. Homosexuality, I predicted, could well be alleviated in many instances by fresh approaches to therapy. Hope could then be offered to many who had often surrendered in despair, the very real hope that a favorable prognosis was quite possible in most cases when homosexuals voluntarily sought help. Dr. Yolles' encouraging reply was that I meet with members of his staff with the possibility of implementing such a program, but representatives of our nation's central mental service (NIMH) dismissed it out of hand at a meeting in Washington, D.C. (February 3, 1965). I went on, however, writing and publishing my findings (1968, 1978) and was invited by my colleagues to address the Adult Psychiatry branch of the NIMH on the problem and treatment of homosexuality in 1967. Shortly thereafter, NIMH appointed a Task Force on homosexuality. In October 1969, this Task Force submitted its final report in which it acknowledged at least in part the validity of my earlier proposal by recommending "the coordination of NIMH activities in the broad area of sexual behavior for the establishment of a center for the study of sexual behavior."

This task force did not by any means represent the forefront of knowledge on the issue of homosexuality. Only three psychiatrists were participants. One of them, Dr. Judd Marmor, had for years espoused the view that homosexuality was "normal." The Chairperson was psychologist Evelyn Hooker, Ph.D.,[1] who was of the same long time conviction. The Kinsey-Hopkins faction was represented by Dr. Paul Gebhardt, Ph.D., Director of the Institute for Sex at Indiana University, and John Money, Ph.D., from Johns Hopkins, an early proponent of transsexual surgery and the acceptance of homosexuality as normal. The law was represented by the Honorable David M. Bazelon, who at one point during the Task Force deliberations resigned. Psychoanalytic clinicians such as Bieber, Hadden, Bychowski, Rado, Lorand, myself and others who had worked for many years in depth therapy with homosexual patients were pointedly left off the committee. On a subsequent occasion I was told by Gebhardt that this action was taken as Bieber, I and

others were considered "professionally biased" because of our "Freudian approach." The NIMH report concluded: "Some of the primary goals of the NIMH service study of sexual behavior should be to develop knowledge, generate and disseminate information, mollify taboo and myths, provide rational basis for intervention, and provide data to policy makers for use in their efforts to frame social policy." The report asked for society's toleration and understanding of the homosexual condition and the gradual removal of persecutory laws against such activities between consulting adults. These positions were good and well taken, but where the report failed abysmally was that it never concluded that exclusive homosexuality was a form of emotional illness, arrested psychosexual development, or a pathological condition of any kind, thereby lending tacit approval to emerging concepts of deviancy.

Meanwhile, militant political homosexual groups continued to disrupt a number of scientific programs both at the national and local level in which findings as to the psychopathology of homosexuality, its origins, symptomatology, course, and treatment, were going to be discussed, e.g., national meetings of the American Psychiatric Association; Association for Psychoanalytic Medicine (Columbia University); Panel on Homosexuality: "A Current Controversy," New York Academy of Medicine (November 27, 1973). Psychiatrists who dared to speak of their clinical findings were "discredited" even in the pages of the official newspaper of our own organization, e.g., "Psychiatrists Blast Colleagues' 'Prejudice' Against Homosexuals" *Psychiatric News*, June 7, 1972).[3] Some of these public attacks were augmented by hate-filled letters, threatening attacks over the telephone, and even threats of terrorist action against those who continued to speak of their scientific findings. Marmor, utilizing the nationwide distributing capacity of the newsletter distributed by SIECUS[3] (Scientific Information and Education Council of the U.S.), a private non-governmental organization heavily in favor of "new liberal concepts of sexuality" including homosexuality, denounced a *Journal of the American Medical Association* article entitled "Homosexuality and Medicine (1970) by this author as "an unfortunate potpourri of prejudice and misinformation [which] stems ... from obvious personal prejudices."

As a counter to such tactics, which tended to silence all scientific debate, I proposed to the New York County District Branch of the American Psychiatric Association that it should establish a task force as an official committee of that organization in order to shed light on the nature, meaning, and content of homosexuality to psychiatry and an increasingly bewildered public. Thus the first all-psychiatric task force on homosexuality was born. It was and has been the only such medically oriented body in the country. After two years of deliberations and sixteen meetings the task force, composed of a dozen experts affiliated with

the major medical centers of New York City, attempted to submit its report on homosexuality to the Executive Council of the New York City District Branch, a report which unanimously documented the fact that exclusive homosexuality was a disorder of psychosexual development and simultaneously asked for civil rights for those suffering from the disorder. The report was "not acceptable" to the new members[4] (and some old) of the Executive Committee. Other business took its place in the Executive Committee meeting and although general statements were accepted as to its content it was not accepted into the minutes of the meeting. The message was coming through loud and clear: the only report acceptable would have been one which was not only in favor of civil rights but one which declared homosexuality *not* a psychosexual disorder. The committee was then dissolved. Its members, determined that the report see the light of day, eventually published it as a "study group" report in the late Spring of 1974 (New York City District Branch APA Task Force Report).

In mid-1973, Vice President Judd Marmor of the APA and John Spiegel, President, APA, and other psychiatrists met with the Gay Activist Alliance, the Mattachine Society and its female ancillary, the Daughters of Bilities, and the Nomenclature Committee of the American Psychiatric Association at Columbia University, New York City, to discuss the deletion of "homosexuality" from the diagnostic nomenclature (*New York Times*, Spring 1973).

In November 1973, I was asked by a *Newsweek* reporter if I would care to comment on the upcoming celebration/cocktail party to take place at the APA headquarters in Washington, D.C. in December commemorating the "greatest of gay victories"—the "purging" of homosexuality from the realm of psychiatry. Dr. Robert L. Spitzer, a psychiatrist at the Columbia University College of Physicians and Surgeons, and Secretary of the APA Committee on Nomenclature and Statistics, had been made chairman of the Nomenclature Task Force on Homosexuality, apparently setting it apart from the Nomenclature and Statistics Committee itself. Dr. Henry Brill, a respected and dignified psychiatrist embodying the best traditions of the state hospital system, had been removed from a position of authority in respect to the issue. Spitzer, who to my knowledge had never previously published a single article on homosexuality or the sexual deviations, had composed a position paper on the meaning and content of homosexuality. It was upon his rationale that the Nomenclature Committee (or the task force part of it) had proceeded. His new definition was sent to the Council on Research and Development. The head of the group, in a telephone call I made to him soon thereafter, stated: "After all, homosexuals must be protected and this might be the best way to do it." I argued that we were all for protecting the homosexual against persecution, but this was a different matter.

Should we dismiss our scientific findings for social/political reasons? Joseph Stalin's insistence on substituting Lamarkian concepts in place of those of Mendelian inheritance for political purposes and the serious consequences to the science of genetics immediately came to my mind. We psychoanalytic clinicians had long been and continue to be in the vanguard of protecting our homosexual patients against assertions of degeneracy and unfair laws. After all, it was Freud who first admitted homosexuals and others were sexually deviant into the consultation room as respected and worthy patients on a par with all those suffering from emotional disorders of any kind. Psychoanalysis had begun to understand the homosexual condition: was the homosexual to be "buried" by stating that this was a "non-condition?" Such an action would constitute a repudiation of all we have learned about sexual deviation. I said that homosexuals were individuals who out of *inner* necessity must engage in homosexual practices or otherwise experience anxiety. This was clearly a psychiatric disorder. We got nowhere.

From the Council on Research and Development the proposed change in the *Diagnostic and Statistical Manual* went to the Assembly, thence to the APA Reference Committee. "Minor changes" were made in these committees, it was later announced. These "minor changes" were hardly minor, e.g. "*heterosexual* orientation disturbance" was to be included along with homosexuality as a "sexual orientation disturbance" to signify those people who were "disturbed" at the knowledge that they were heterosexual(!) (Minutes, APA Council, 11/3/73). It was decided a few weeks later that this was unwise, and therefore "heterosexuality as a disorder" was deleted. The new position favoring deletion of *homosexuality* was obviously clinically untenable and scientifically fallacious, even to a first-year resident in psychiatry. There was no scientific explanation for this deletion except the statement that the homosexual did not experience "suffering"; those who disliked being homosexual and "suffered over it" or "complained" were to be considered to have a "disorder." We persisted that respect for the tradition of open scientific debate as well as professional ethics and morality required that we be given a hearing on this matter.

Our group of dissidents consisting of three members of the APA out of a committee of twelve received a hearing immediately preceding the Board of Trustees vote on December 14, 1973. I reviewed before the Board the serious consequences' of this change during an allotted five-minute presentation by stating that as a result of this position: (1) An alteration of theoretical concepts of healthy versus abnormal sexual development would have to "logically" take place; (2) Sex education in our schools would in all likelihood include homosexual sex education (this has already come to pass); (3) Despair would be created within the individual homosexual who wished help. The homosexual would forfeit

his mammalian heritage, the chance to engage in the male-female design; (4) Homosexuals would not enter therapy or be dissuaded for long periods in doing so: tremendous resistances to therapy would result, injuring the patient's progress; (5) Suicides among those with gender identity disorder might well increase.[6] Where would individuals get help if they could not turn to psychiatry? The individual homosexual who wished to be helped, to rid himself of his condition, would be doomed by pronouncements of the Board of Trustees, family and friends would despair. (6) The decision would confuse other medical disciplines such as pediatrics, to whom families and youngsters turned for advice, to say nothing of the rest of the medical profession; (7) Homosexuals were already giving lectures on the value of homosexuality as an alternative life style to some of our public schools and in our colleges; (8) Psychiatric residents would be reluctant to enter an area of psychiatric research where they would only receive attack, belittlement, and demeanment. Thus there would be a decrease in both our knowledge and psychiatric research in this condition. We strongly urged postponement of voting by the Board of Trustees.

The Board of Trustees voted practically unanimously against us, with two abstentions. It is interesting to note that only two thirds of the members of the Board of Trustees were present, barely enough to constitute a quorum for this important decision. Were some members simply avoiding a confrontation with the majority view already determined and adamant in their conviction? Otherwise, how could one explain their absence on such a critical issue?

A few weeks later, the "rationale" for the deletion of homosexuality as a psychiatric disorder was presented to the medical community. The "rationale" for this change was to be found in two items: The first was an official position paper presented by Robert F. Spitzer, Chairman, Nomenclature Task Force on Homosexuality, before the Board prior to its decision (Spitzer, R.L. [1974], "The Homosexual Decision—A Background Paper," *Psychiatric News,* pp. 11-12). According to *Psychiatric News,* it was "essentially upon the rationale of Dr. Spitzer's presentation that the Board made its decision" (p. 11). This paper in essence repeated Kinsey's earlier assertion that exclusive homosexuality was a normal part of the human condition at one end of the Kinsey "homosexual-heterosexual scale."' It did not meet the requirements of a psychiatric disorder since it "does not either regularly cause subjective distress or [is] regularly associated with some generalized impairment in social effectiveness or functioning" (Spitzer). The second item consisted of conclusions supplied by Drs. Marcel T. Saghir and Eli Robins in their book *Male and Female Homosexuality* (1973). Saghire and Robins' "scientific" evidence did not employ any psychoanalytic methodology, but was a descriptive survey from which the conclusion that homosexuality

was a normal condition was derived from one structured lengthy interview with homosexuals (recruited through homophile organizations) and "unmarried heterosexual controls" (solicited by mail and paid for the interview) and coincided with the position paper above.

The term "sexual orientation disturbance (homosexuality)" was now to be substituted for homosexuality. It was defined as follows:

> This is for individuals whose sexual interests are directed primarily toward people of the same sex and who are neither disturbed by, in conflict with, or wish to change their sexual orientation. This diagnostic category is distinguished from homosexuality, which by itself does not constitute a psychiatric disorder. Homosexuality *per se* is one form of sexual behavior, and with other forms of sexual behavior which are not by themselves psychiatric disorders, are not listed in this nomenclature" (*Diagnostic and Statistical Manual of Mental Disorders,* July 1974).

This diagnostic category underwent several metamorphoses in several editions of the *DSM III,* including establishing a separate category of "ego-dystonic homosexuality" (for those who were "unhappy" that they were homosexual) to the ultimate elimination of the word "homosexual" from the *DSM III Revised 1987* as a scientific category (APA Diagnostic Criteria *DSM III,* American Psychiatric Association, Washington, D.C.)

A reversal of the decision by the Board of Trustees would require two hundred members requesting a referendum. It was for this purpose that a referendum was asked for. Fortunately, the American Psychoanalytic Association was holding its midwinter meeting in New York City at the time and two hundred and forty-three signatures from psychoanalytic practitioners (members and fellows of the APA who were familiar with the clinical problems of the homosexual) petitioned for a reversal of the Board of Trustees vote. It was a credit to psychiatrists in general that in the voting of the general membership (April, 1974) that was to follow on this issue (voting marred by hidden lobbying by homosexual activists)[6] held months later, forty percent of the psychiatrists who voted (10,000) took issue with the Board of Trustees' action, asserting that there were no legitimate scientific reasons for the APA's change in fundamental psychiatric theory. It is fallacious to conclude from this vote that the majority of psychiatrists in the United States were in favor of the action, for only 25% of those eligible to vote out of more than 25,000 psychiatrists sent in their ballots. Despite this fact, the decision stood.[9]

By declaring a condition a "non-condition," a group of practitioners had removed it from our list of serious psychosexual disorders. The action

was all the more remarkable when one considers that it involved the out-of-hand and peremptory disregard and dismissal not only of hundreds of psychiatric and psychoanalytic research papers and reports[10] but also of a number of other serious studies by groups of psychiatrists, psychologists, and educators over the past seventy years, for example, the Report of the Committee of Cooperation with Governmental (Federal) Agencies of the Group for the Advancement of Psychiatry (1955); the New York Academy of Medicine Report (1964); the Task Force Report of the New York County District Branch of the APA done in 1970-72 (Socarides, et. al., 1973).

To the psychoanalyst, this was psychiatric folly. Psychoanalysts comprehend the meaning of a particular act of human behavior by delving into the motivational state from which it issues. Obviously these decision makers had not viewed individuals in this manner. When individuals with similar behavior are analytically investigated, we then arrive at objective conclusions as to the meaning and significance of a particular phenomenon under examination. Thus is insight achieved. To form conclusions as to the specific individual meaning of an event simply because of its frequency of occurrence (the number of homosexuals was often alluded to as indicating that it was normal)[11] is to the psychoanalyst scientific idiocy. Only in the consultation room, using the technique of introspective reporting and free association, protected by all the laws of medicine, psychology, and psychiatry, will an individual reveal the hidden (even from himself) meaning and reasons behind his act. The meaning of a particular act of piece of behavior can only be decided on the basis of the motivational context from which it arises.

The concept of "disadvantage" was introduced as a reason for declaring homosexuality a "non-disorder" by the Nomenclature Committee two years after the deletion (1976). The view that the homosexual of the obligatory type is at "no social disadvantage" is a denial of the realities that surround us when one considers that a society governs the behavior of its members from birth to death through its laws, mores, and other institutions. A human being is born with responses that constitute his mammalian heritage (a product of evolution). He is then introduced into a web of social institutions, a product of cumulative tradition which constitutes his cultural heritage. The two, mammalian and cultural heritages, lead man to his sexual pattern—heterosexuality. Heterosexuality has a biological and social usefulness. It creates the family unit and allows men and women to live together under conditions where there is likely to be the least amount of fear, rage, and hate. It furthermore regulates this relationship through a series of laws, penalties, and rewards.

Additional proof of the politicization of American psychiatry was to be provided later from an unexpected source: a book by Ronald Bayer, a

fellow of the Hastings Institute of New York. He stated that Spitzer was "sympathetic to the viewpoint of the gay liberation group" (pp. 130-131) and Brill was suffering from "indecision and discomfort with Spitzer's aggressive assumption of leadership on this issue." Even more important was the revelation (never previously acknowledged) that the Council on Research and Development of the APA did not officially investigate or study the issue thoroughly before it gave formal approval to the deletion of homosexuality from the *DSM II*.

> It was to Monroe's council, comprised of five senior psychiatrists who were responsible for providing the APA with advice on matters of policy and with information on current issues in psychiatric research, that Spitzer's proposal [for deletion] was first under consideration. Though officially coming from the Committee on Nomenclature, in fact it had *never been formally approved* by its members and thus presented Spitzer's own effort to resolve what many APA leaders considered "a hot potato" (Bayer, pp. 130-131, emphasis added).

Bayer laid bare developments that took place in December 1973. He states that the Board of Trustees "satisfied the formal requirements of providing a fair hearing [and proceeded] to render its verdict," but he omitted the fact that the requests for such a hearing had to be aggressively pursued (there was no "invitation" to appear and permission to address the Board of Trustees was granted most reluctantly by its chairman, Dr. John Spiegel). Furthermore, this "fair hearing" consisted of a five-minute allowance for each person testifying, including Drs. Irving Bieber (Clinical Professor of Psychiatry, New York Medical College), John McDevitt (Associate Clinical Professor of Psychiatry, University of Cincinnati), Armand Nicholi of the Harvard Medical School Student Health Service—and myself. The time limit was strictly adhered to and no time was allowed from discussion. The suggestion by the Ad Hoc Committee Against the Deletion of Homosexuality (the "psychiatric dissidents"), headed by myself, that a pro-civil rights statement be made but that the question of scientific merits of the diagnosis" be left for further study and reflection, was peremptorily dismissed. Our proposal was unacceptable. For the next 18 years, the APA decision was to serve as a Trojan horse, opening the gates to widespread psychological and social change in sexual customs and mores. The decision was to be used on numerous occasions for numerous purposes with the goal of normalizing homosexuality and elevating it to an esteemed status.

To some American psychiatrists this action remains a chilling reminder that if scientific principles are not fought for they can be lost—a disillu-

sioning warning that unless we make no exceptions to science, we are subject to the snares of political factionalism and the propagation of untruths to an unsuspecting and uninformed public, to the rest of the medical profession, and to the behavioral sciences.

Beyond the disservice to homosexual patients and their families, the confusion in the mind of the public, and the pushing back of the frontiers of our knowledge, what is the fate of society in all this? Abram Kardiner, psychoanalyst, former Professor of Psychiatry at Columbia University, recipient of the Humanities Prize of *The New York Times* in 1966, warns:

> There is an *epidemic* form of homosexuality, which is more than the usual incidence, which generally occurs in social crises or in declining cultures when license and boundless permissiveness dulls the pain of ceaseless anxiety, universal hostility and divisiveness. Thus in the Betsileo of Madagascar the incidence of homosexuality was visibly increased at a time when the society was under a state of collapse. Supporting the claims of the homosexuals and regarding homosexuality as a normal variant of sexual activity is to deny the social significance of homosexuality. To do this is to give support to the divisive elements in the community ... Above all it militates against the family and destroys the function of the latter as the last place in our society where affectivity can still be cultivated.
>
> Homosexuals cannot make a society, nor keep ours going for very long. Homosexuality operates against the cohesive elements in society in the name of fictitious freedom. It drives the opposite sex into a similar direction. And no society can long endure when either the child is neglected or when the sexes war upon each other (Kardiner, personal communication to the author, 1973).

THE PSYCHOANALYTIC POSITION

The psychoanalyst's compassion and concern as regards the external conflicts faced by the homosexual due to societal disapproval should not blind us, however, to the internal conflicts, conflicts which occur between various conscious and unconscious tendencies within the individual which are causative of this disorder. The homosexual, no matter what his or her level of adaptation and function in other areas of life, is severely handicapped in the most vital area—interpersonal relations.

A typical family constellation is that in which there is a psychologically crushing mother (in extreme cases) and an absent or abdicating father who does not assume his appropriate masculine role in relation to his son that allows the son to identify with him. In the female homosexual there is a corresponding inability to identify with what is viewed by the girl as a malevolent, malicious mother and a father who does not respect the femininity of his daughter. The female homosexual seeks femininity in the body and personality of her female partner.

Pathology, organically and psychologically, may be defined as a failure to function, with concomitant pain and/or suffering. It is this failure, its significance and manifold consequences that are so obvious in obligatory homosexuality—a failure in functioning which, if carried to its extreme, would mean the death of the species. Beneath this obvious failure of function and the secondary *external* conflicts it may provoke, lie the agony, sorrow, tragedy, fear and guilt of a both conscious and unconscious nature which pervades the homosexual's life. Psychiatrists who treat such individuals in depth know this very well. Those who do not practice depth psychotherapy or psychoanalysis often do not observe or may tend to minimize the degree of suffering the homosexual endures—suffering induced by internal conflicts—inasmuch as the homosexuality also provides temporary relief from severe anxiety. Furthermore, obligatory homosexuality (in contrast to episodic, situational, or variational *homosexual behavior*, which is not considered a pathological condition *per se*) may cause such disruption in the equilibrium of the individual that all meaningful relations in life are damaged from the outset and are peculiarly susceptible to breakdown. Attitudes toward the opposite sex are often filled with distrust and fear as to render them incapable of any relationship at all, except on the most superficial and brittle basis. The obligatory homosexual is unable to function in the most meaningful relationship in life; the male-female sexual union and the affective state of love, tenderness and joy with a partner of the opposite sex.

The homosexual engages in a compromise adaptation, "choosing" a same-sex partner for sexual gratification in order to save the self from anxiety. The ability of the homosexual to neutralize anxiety motivates the homosexual to use this as a face-saving rationalization—that is, that he or she is not suffering from an emotional disorder at all, especially if one is convinced that there is no help for changing their condition. Despite the appearance at any given time of an adequate life performance, *internal* conflict threatens to disrupt this fragile adjustment.

Major breakthroughs have been made in psychoanalytic knowledge

leading to the conclusion that oedipal-phase conflict in certain homosexual patients is always superimposed on deeper, basic preoedipal nuclear conflicts. In certain cases of homsexuality, it is apparent that object relations pathology contributes more to the development of homosexuality than the vicissitudes of the drives—in other words, that the central conflict of the homosexual is an object relations one rather than a structural one. These views apply to relatively pronounced cases in which the perverse development is clear and definite.

The combination of infant observational studies and developmental theories in the psychoanalytic material derived from the study of adult homosexuals helps to explain that the fixation of the homosexual lies in all probability in the later phases of the separation-individuation process, producing a disturbance in self identity as well as in gender identity, persistence of a primary feminine identification with the mother (in the case of the female homosexual, an identification with the mother perceived as malevolent and hateful), separation anxiety, fears of engulfment (restoring the mother-child unity), and disturbance in object relations and associated ego functions.

The homosexual *has no choice* as regards his or her sexual object. The condition is unconsciously determined, is differentiated from the behavior of a person who deliberately engages in same-sex sexual contact due to situational factors or a desire for variational experiences. As noted above, these constitute non-clinical forms of *homosexual behavior*. The nuclear core of true homosexuality is never a conscious choice, an act of will; but rather it is determined from the earliest period of childhood, in terms of origin, of course, not in practice. The homosexogenic family environment has been noted above. The presence of external conflicts which complicate the lives of homosexuals should not be allowed to obfuscate the valid clinical data secured through in-depth psychoanalytic studies, for this misinforms psychiatrists, the general reader, and, unfortunately, a vulnerable public.

Lastly, it should be stated that it is obvious to some psychoanalysts that the requirements for definitions of a condition or disorder on the basis of conscious anxiety and suffering ran counter to everything we knew dynamically about the mechanisms involved in this serious disturbance. For example, the enactment of any sexual deviation helps to keep the individual in equilibrium and neutralize anxiety. It has been unconsciously specifically fashioned for this purpose. Therefore, the presence or absence of anxiety cannot be an adequate criterion to use when determining whether the condition is a disorder or not. Some of the most severely disturbed homosexuals have no anxiety because of their constant enactment of the homosexual act. Furthermore, Spitzer's proposal, as noted above, disregarded the following: (1) the presence of a specific need, desire, compulsion, or other symptom formation may so

circumscribe pathology that a patient may appear to be functioning well in every other aspect of his life; (2) fully developed neurotic symptoms can mask illness as well as express it; and (3) the mechanism of sexual deviation results in the production of an ego-syntonic symptom, namely, one that allays and neutralizes anxiety.

The official position of the American Psychoanalytic Association is indicated by its definitions of homosexuality which appear in *A Glossary of Psychoanalytic Terms and Concepts*, edited by B.E. Moore, M.D. and B.D. Fine, M.D. This glossary, first published in 1968, underwent its third printing in 1983. It states:

> In the male homosexual there is, as a rule, an overly strong attachment to the mother up to and including the oedipal phase, which is not resolved by *identification* with the father but rather by partial identification with the mother. *Object choice* is narcissistic in type, i.e., the loved person must be like the self, and sexual excitation is experienced in regard to men instead of women. Due to strong castration fears, the homosexual man cannot tolerate a sexual partner without the tremendously valued male organ. Another common motive for homosexual object choice is the avoidance of rivalry with fathers and brothers.
>
> In female homosexuality (lesbianism), the woman retains a strong original preoedipal attachment to the mother, which is displaced onto the homosexual partner. As a result of an unsatisfactory outcome of oedipal conflicts, her identification with the mother is incomplete and she holds onto mother as an object of love [p. 48].

EPILOGUE

In the material cited above, I have described a movement within the American Psychiatric Association which through social/political activism has accomplished the first phase of a two-phase radicalization of a main pillar of psychosexual life: the erosion of heterosexuality as the single acceptable sexual pattern in our culture. The motive force for this movement was the wish to protect the homosexual against injustices and persecution which could to all intents and purposes have been removed by the demand for equal rights for the homosexual, a demand that could well have been fulfilled through humanitarian motivations so deeply embedded in our humanistic science. Instead, the false step of removing homosexuality from our *Diagnostic and Statistical Manual* was substituted. This amounted to a full approval of homosexuality and an encouragement to aberrancy by those who should have known better,

both in the scientific sense and in the sense of the social consequences of such removal. (The relationships between social approval and homosexuality as a developmental disorder will be dealt with in a subsequent paper.) The devastating *clinical* fallout from this decision was to follow. Those who would wish to retain homosexuality as a valid diagnosis have been practically silenced by lectures, meetings, and publications, both originating within our association and from other sources. Political parties and religious leaders have been utilized to reinforce this silence. The press has been influenced as well as the media;[14] television and movies promote homosexuality as an alternative life style as well as censor movies which might show homosexuality as a disorder. Homosexual sex education has entered our schools and colleges—and pro-Gay activists, homosexual or otherwise, portray their way of life as "normal as apple pie" and intimidate others with different views. In essence, this movement within the American Psychiatric Association has accomplished what every other society, with rare exceptions, would have trembled to tamper with, a revision of a basic code and concept of life and biology: that men and women normally mate with the opposite sex and not with each other.

Forces adamantly insisting that homosexuality is an alternative life style have not been stopped by appeals to tradition, enlightened self-interest or even the findings of psychoanalysis.[15] Threats about what would happen to society do not have much effect: nobody considers himself society's guardian. The average citizen says he doesn't quite know what these social interests are and, after all, aren't personal decisions about sex a private matter? The answer to that question, contrary to popular opinion, is NO.

Psychoanalysis reveals that sexual behavior is not an arbitrary set of rules set down by no one knows who for purposes which no one understands. Our sexual patterns are a product of our biological past, a result of man's collective experience and his long biological and social evolutionary march. They make possible the cooperative coexistence of human beings with one another. At the individual level, they create a balance between the demands of sexual instinct and the external realities surrounding each of us. Not all cultures survive; the majority have not, and anthropologists tell us that serious flaws in sexual codes and insitutions have undoubtedly played a significant role in many a culture's demise (Kardiner, A., 1939). When masses of people think similarly about previous sexual customs, their collective behavior will, in the last analysis, have a profound impact on the whole of society.

Scientists, psychologists, psychiatrists, political leaders, public officials and others with vested interests today ransack literature for bits of fact and theory which can be pieced together into a pro-homosexual or bisexual concept of nature, man and society. Some of the individuals say that homosexuals are healthy, society is sick and that science should cure society. Others raise false or outdated scientific issues in their war with traditional values. Many of our values could use change, but polemical pseudoscience is not the way. No society has accepted adult preferential homosexuality. Nowhere is homosexuality or so-called bisexuality a desired end in itself. Nowhere do parents say: "It's all the same to me if my child is heterosexual or homosexual." Nowhere are homosexuals more than a small minority at the present time. Nowhere does homosexuality *per se* place one in an enviable position (Karlen, A., 1971).

Some pro-homosexual proponents within the behavioral sciences state that mental illness is simply a product of social definition and that sexual behavior considered normal in one society may be deviant in another. Examination of the facts shows that this is not true of all illness and all behaviors. Some behaviors are universally deviant, and every society thinks them disruptive. Incest, rape, psychopathic (apparently unmotivated) violence are considered taboo in all societies. So is predominant or exclusive homosexuality or even bisexuality.

The counter to such forces is the knowledge that heterosexuality has self-evident adaptive values: decades and even centuries of cultural change are not likely to undo thousands of years of evolutionary selection and programming. Man is not only a sexual animal but a care-bonding, group-bonding, and child-rearing animal. The male-female design is taught to the child from birth and culturally ingrained through the marital order. This design is anatomically determined, as it derives from cells which in the evolutionary scale underwent changes into organ systems and finally into individuals reciprocally adapted to each other. The male-female design is thus perpetually maintained and only overwhelming fear or man's false pride and misdirected individual enterprise can disturb or divert it.

APPENDIX A

Spitzer's rationale for removing homosexuality relied heavily on the work of Alfred Kinsey and his belief in the normality of homosexuality. For that reason, it shall be commented on in some detail.

The Kinsey Report of 1948 has been likened in importance by some to man's radically altered view of himself initiated by Darwin's discoveries. His conclusions are accepted even among some well-intentioned and educated people. The Kinsey Report has had in several ways a severe and damaging delayed impact on our sexual mores, especially as they pertain

to homosexuality. Alfred Kinsey, a Ph.D. in zoology, made a valuable statistical survey between 1939 and 1948 of the sexual behavior of twelve thousand American males. His figures are still widely cited as there are no others of comparable scope to contradict them. In general, there is no reason to dispute his data as to *incidence*. The value of the exhaustive and informative survey was that it enumerated the manifold forms taken by a force so powerful it cannot be denied expression. The enormous public curiosity about Kinsey's figures blinded most people to some of the erroneous interpretations to which some of the figures gave rise, especially in the area of homosexuality. The Kinsey conclusions and interpretations have become a banner under which the gay liberationists and similar pleaders have rallied, citing them as sexual gospel. Kinsey, however, erred in attempting to interpret his statistics, a fault which was perpetuated by his followers. Kinsey concluded that homosexuality is present in ten percent of all males in a persistent (obligatory) form and in thirty-five percent of all males in the transitory form. He believed this was due to the fact that homosexuality is a biological variant. Kinsey invented a scale based on the incidence revealed in his own studies of homosexuality-heterosexuality, representing a continuum between homosexual and heterosexual behavior. To him this connoted that exclusive homosexuality was a normal part of the human condition, of normal sexuality, and simply existed at one end of the "homosexual-heterosexual scale." Exclusive heterosexuality was purportedly at the other end for apparently the same reason, because it was a "biological given." Conscious and unconscious motivations in the causation and/or expression of homosexuality, whether of the exclusive (obligatory) type or not, were completely disregarded.

The statistical studies of the type Kinsey offered ignored the concepts of repression, unconscious mind, and motivation. While they supply incidence rates of certain phenomena, they do so as if behavior has no connection with motivation. Since neither conscious nor unconscious motivation is even acknowledged, these studies arrive at a disastrous conclusion that the resultant *composite* of sexual behavior is the *norm* of sexual behavior. The next step was to demand that the public, the law, medicine, religion, and other social institutions unquestioningly accept this proposition. Even intelligent laymen, gulled by the false interpretation of these statistics, were taken in and continue to be so.

In contrast to the psychoanalytic method of investigating behavior (motivational analysis), the only differentiation Kinsey and his followers admitted to is a quantitative one. For example, among the various forms of homosexuality, Kinsey was opposed to considering a man homosexual in whom the "heterosexual-homosexual balance" was only slightly or temporarily shifted to the homosexual side. Psychiatrically, this is incorrect, for the quantitative approach cannot replace the psychogenetic one.

Edmund Bergler, a psychoanalytic pioneer into understanding homosexuality, was fond of comparing this quantitative approach to the situation that would exist if someone invented the idea of subdividing headaches entirely according to quantitative principles, rating them from one to six according to severity.

> Medically speaking, a headache is only a symptom indicating a variety of possibilities: from brain tumor to sinus infection, from migraine attack to uremia, from neurosis to high blood pressure, from epilepsy to suppressed fury. Instead of the causal (what causes the headache) viewpoint, we would have in this new order only quantitatively varying degrees of big, middle-sized, and small headaches (1969).

The Kinsey yardstick omits differentiation of the underlying conditions. Moreover, as Bergler notes, "in the previously mentioned rating of headaches, at a specific moment a headache produced by a sinus attack could be more severe than one produced in certain stages of a brain tumor." The homosexual "outlet" covers a multitude of completely different genetic problems. Hence a causal yardstick is *necessary* for the differentiation and therapy of the confusion and many-faceted types of human relationships.

From the beginning, when Kinsey's figures were made known, few individuals—except for Lionel Trilling in the literary arts and some eminent psychoanalysts, especially Bergler, Kubie, and Kardiner—cared to criticize Kinsey's findings. Still fewer treated them lightly, although H.L. Mencken in his volume *Christomathy* quipped: "All this humorless document really proves is: (a) that all men lie when they are asked about their adventures in amour and (b) that pedagogues are singularly naive and credulous creatures."

According to social historian Paul Robinson (1976), Kinsey's heterosexual-homosexual rating scale was a "pathetic manifestation of Kinsey's philosophical naivete ... a hopelessly mechanical contrivance, which sought to promote a system of classification that bore little relation to reality" (pp. 73-74). It was a gargantuan scientific hoax promoted by Kinsey for reasons of his own. In psychoanalytic terms, it was a massive form of denial as defense. With remarkable prescience, Lionel Trilling, social and literary critic, predicted the dire consequences of this idea for the scientific community as early as 1948. He stated that in the future

> Those who most explicitly assert and wish to practice the democratic virtues [will have taken] as their assumption that all social facts—with the exception of exclusion and economic

> hardship—must be *accepted* not merely in the scientific sense but also in the social sense, in the sense, that is, that no judgment must be passed on them, that any conclusion drawn from them which perceives values and consequences will turn out to be "undemocratic" (Trilling, 1948).

And so it is today. Charges of being "undemocratic," "cruel and inhuman" (Marmor, 1973), "irresponsible, homophobic and prejudiced" (Isay, 1986) are leveled at those who would question the normality of homosexuality. These accusations are then reinforced by the media, motion pictures, and the press, and render the ordinary citizen who disapproves of such practices, as well as faint-hearted members of the psychiatric profession, mute before their onslaught.

APPENDIX B

The ability to engage in variational sexual experiences and substitute them for the standard coital pattern (male-female sexual coital pairs) (Rado, 1949) is a consequence of man's evolutionary development. Evolutionary development is used by proponents of normality of homosexuality for purposes of their own: they turn to Ford and Beach, prominent ethologists, and ransack their studies on primates to support the concept that "a biological tendency for inversion of sexual behavior [homosexuality] is inherent in most if not all mammals including the human species" (Isay, 1983, p. 238). Ford, however, says nothing of the sort. He states that same-sex mounting behavior is not an evidence of inborn homosexual patterns which can he generalized to humans. Beach corrected this erroneous interpretation in 1971: "I don't know any authentic instance of male or female in the animal world preferring a homosexual partner—if by homosexual you mean complete sexual relations, including climax. It's questionable that mounting in itself can properly be called sexual" (p. 399).

Ford has made stunning discoveries—discoveries which prove the opposite. They noted that above the level of the chimpanzee, only three automatic mechanisms for orgastic release remain: erection, pelvic thrust, and orgastic release itself. Everything else is learned behavior. Man builds up his sexual pattern by virture of his cerebral cortex in combination with early childhood experiences. In man, due to the tremendous development of the cerebral cortex, motivation, both conscious and unconscious, plays the crucial role in the selection of individuals and/or objects that will produce sexual arousal and orgastic release. Furthermore, not only is man's cortex responsible for the development of heterosexual patterns and the associated social and cultural structures which support them, but it is the unique action of the cerebral cortex which allows man to develop all the sexual deviations as partial attempted

solutions to inner conflict as well as facilitating roundabout methods of sexual release in the face of insurmountable fears. Sexual deviations are beyond the mental and motivational capacities of lower animals. Evolution has relieved us of pheromones, sexual and olfactory responses to sexual stimuli as a major factor in sexual arousal, but it has left in its wake the possibility of deviant practices as well as other complex neurotic behavior. These deviant practices then may become the bane of one's existence when they become stereotyped and inflexible.

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1. Evelyn Hooker's widely quoted studies of homosexual men (1957, 1958) had been widely used by pro-normalization proponents to buttress the argument that homosexuals differ from heterosexuals only in that they are homosexuals. They are not otherwise pathological and the adjustment of many is in the normal range, perhaps even superior to that of heterosexuals. Hooker's reports consisted of a detailed examination by clinical interviews and psychological tests of thirty male homosexuals and thirty heterosexual controls. They were not psychoanalytic interviews nor in-depth psychoanalytic studies. A careful review of her work by the Task Force on Homosexuality, New York County District Branch, American Psychiatric Association (1973) concluded that

   > With regard to her major thesis, that there is no evidence to show that homosexuals are maladjusted ... her study shows nothing of the kind. It is too full of methodological errors (particularly the spurious "controls" and confused thinking) to warrant any such conclusion ... With regard to the "adjustment" of the homosexual, the study shows nothing, one way or the other. It was not adequately designed to do so (pp. 471-475; evaluation prepared by Ruben Fine, Ph.D., Clinical Professor of Psychology at Adelphi University, Supervisor of Psychology, Elmhurst Hospital; Vice President of the National Psychological Association for Psychoanalysis.)

2. Homosexual groups began lobbying the APA and its meetings in earnest in 1970, according to F. Charles Hite, reporter for the *Psychiatric News* (1/2/74, Vol. 9, No. 1.) Homosexual militants severely disrupted programs at the annual meeting in San Francisco in 1975.

3. The SIECUS propaganda of the normalcy of homosexuality and the advocacy of homosexual sex education is a philosophy prevailing in several university centers and medical schools and dominates several societies for the study of sex, e.g., The Scientific Study of Sex, Eastern Region, University of Pennsylvania. It has dominated the

Master's Degree Program, Department of Health Education, New York University, Human Sexuality Program to the point where heterosexual students were asked to engage in "homosexual experimentation" and students are "indoctrinated with theories of sexual orientation that are propaganda and not science" (personal communication, E.W. Eichel, M.A.; Sexual Education, letter to the Dean of New York University, Health Education Program, 1986, quoted with permission).

4. Dr. B. Diamond, President, New York District Branch 1970-1971, who had formally authorized the task force, died in mid-1971. This was a great loss to all of us nationwide.
5. Similar arguments with different emphases were made by Drs. I. Bieber and J. McDevitt.
6. Over one-third of Harvard-Radcliffe student suicide attempts (25 out of 65, or 37%) between 1965 and 1967 were made by individuals severely disturbed by homosexual conflicts (reported in a survey by the National Institutes of Mental Health, 1974) (Bunney, Melitta, Roach). More recently, *The New York Times* reports that "young American men from 15-24 years old are killing themselves at a rate 50% higher than at the beginning of the previous decade according to a new Federal study" (*New York Times*, 2/22/87). While the increasing use of drugs may play a role, disturbances in gender defined self identity, in my clinical opinion, are of crucial importance.
7. See Appendix A for a critical evaluation of Kinsey's material and conclusions.
8. The details of this lobbying effort are to be found in my paper "The Sexual Unreason" (1974, pp. 180-183).
9. In late 1977, ten thousand psychiatrists, members of the American Medical Association were polled on this issue. Of twenty five hundred replies received, approximately sixty eight percent answered the question "Is homosexuality usually a pathological adaptation (as opposed to a normal variation)?" in the affirmative. This strongly suggested to the interpreter, Dr. Harold I. Lief, Professor of Psychiatry at the University of Pennsylvania, an authority on sexual problems and leading sex educator, that the "previous APA vote was *influenced by political and social considerations* [emphasis added] and that the vote was [mis]perceived as a step toward the denial of rights to homosexuals" (Lief, 1977, p. 110).
10. An exhaustive bibliography of these contributions can be found in my book, *Homosexuality* (1978).
11. The significant incidence of homosexuality (8-10% of the population) may well be due to the necessity for all human beings to undergo the separation-individuation phase of early childhood (Mahler, 1967), which is decisive for gender identification. A substantial proportion of children fail to successfully complete this developmental process and, therefore, are unable to form a healthy sexual identity in accordance with their anatomical and biological capacities. This is the *core* of the disorder.
12. Dr. Nicholi could not appear due to illness in his family.
13. An alternative argument to homosexuality simply being an alternative life style was that it was simply a "biological variant." This argument is discussed in Appendix B.
14. The destructive effects of the mass media in this regard requires special study beyond the purpose of this paper. Such a study, however, begins with understanding the *mechanism* through which mass media exerts its effort. The mass media satisfy a pressing need for expression, keeps people from feeling painfully alone, and distracts individuals from their own problems. Its content arises from the prevailing social currents and its aim is to relieve tension. Needs are constantly stimulated and wishes encouraged in every way. Although we do not do something sexual or aggressive, we get a kick out of watching others do the forbidden. The knowledge that life and emotion

may be thereby devalued makes no difference. There is an implied permission to do the same thing.

15. At the present time (1986-1987) pro-gay activists groups, even within the American Psychoanalytic Association, are asserting that Freudian analysts who treat homosexuals for their disorder are "homophobic" and have been "prejudiced" by our culture.

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