THE PROFESSIONAL DIVISION OVER THE TREATMENT OF HOMOSEXUALITY AND HOW IT HAS BEEN INFLUENCED BY THE GAY POLITICAL MOVEMENT

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Introduction

Historian Thomas Kuhn, Ph.D. described a paradigm shift in a scientific field as a reconstruction of the discipline, resulting not from the cumulative process of science, but from revolution. A paradigm was described by Kuhn as "universally recognized scientific achievements that for a time provide model problems and solutions to a community of practitioners."[1] The recognized achievements form a set of beliefs from which the facts of the discipline are understood. They are essential to scientific inquiry because they provide "at least some implicit body of intertwined theoretical and methodological belief that permits selection, evaluation, and criticism."[2] Kuhn's model is founded on the assumption that "Without commitment to a paradigm there could be no normal science."[3]

According to Kuhn, "the differences between successive paradigms are both necessary and irreconcilable."[4] A paradigm shift means a change of view, a change of methods, and a change of goals that require new textbooks. Kuhn's research found that new textbooks after paradigm shifts disguised the revolution that took place and offered little history of the discipline. The illusion put forth by the leaders of the revolution is that the new paradigm occurred through the cumulative process of scientific knowledge. Assimilation of the new paradigm requires the destruction of the old paradigm. But new paradigms do not solve all the problems of the old paradigm and they do not necessarily move the scientific discipline closer to truth.[5] All these characteristics of Kuhn's

paradigm shifts apply to the change in status of homosexuality in the American Psychiatric Association (APA) at the end of 1973.

Kuhn's paradigm shift theory states that paradigm shifts are the equivalent of scientific revolutions and they are "the usual developmental pattern of mature science." In order for a scientific revolution to take place there must be rival paradigms and the existing paradigm must have a persistent failure or anomaly that becomes a recognized crisis. The paradigm rivaling the existing paradigm has anomalies too, so the debate shifts to philosophical issues of competing standards of which paradigm solves the more significant problems. Each paradigm usually considers its own anomalies of less significance[6].

The existing paradigm in the APA up until 1973 viewed homosexuality as a disorder or a symptom of a disorder. For purposes of this paper it will be referred to as the "1973 paradigm." Psychoanalysts who treated homosexuals with unwanted homosexuality were able to help clients change their sexual orientation about 25 to 30 percent of the time. Opponents of the 1973 paradigm considered the low success rate of sexual orientation change a persistent failure. Opponents also pointed out that many homosexuals were comfortable with their homosexuality and did not believe that their homosexuality was a disorder or symptom of a disorder. Homosexuals who claimed that they were comfortable with their homosexuality and who functioned well in society were an anomaly within the 1973 paradigm.

Mental health professionals accepting of the 1973 paradigm responded to the criticism of persistent failure and the anomaly with the following arguments. First, the lack of success in changing sexual orientation was not surprising or indicative of failure,

because the psychotherapeutic success rate was similar to the treatment of other addictive type disorders including alcoholism and drug addiction. Second, homosexuals who accepted their homosexuality and functioned well in society were not seen as an anomaly within the 1973 paradigm, because framers of the 1973 paradigm understood homosexuality to serve a reparative function that helped the individual compensate for unresolved anxiety related to crisis of sexual identity in childhood.

In 1973 the American Psychiatric Association leaders choose to establish a new paradigm. The association leaders officially rejected the view that homosexuality was a disorder or symptom of a disorder. In its place the APA leaders officially adopted the view that homosexuality was a normal variant of sexuality and as such not considered a disorder. For purposes of this paper the normal variant paradigm will be called the "post-1973 paradigm" and "normal variant" will refer to homosexuality. The post-1973 paradigm had at least three anomalies: claims by individuals that their homosexual attractions were unwanted; the clinical evidence that was used to argue homosexuality was a symptom of a disorder; and the testimony of individuals who had changed their sexual orientation.

The post-1973 paradigm promoters responded to these three anomalies with the following arguments: first, those who did not want their homosexual attractions had those negative feelings because society condemned homosexual behavior; second, the clinical evidence should be dismissed because it was presented by those biased by religious prejudice; and third, those who claimed they had changed their sexual orientation actually had not, because many still had a varying amount of homosexual thoughts and attractions.

Kuhn's theory of paradigm shift also stated that those professionals who convert to a new paradigm do so based on future promise rather than past achievement. Another point of his theory stated that when paradigm shifts take place they change the world with them.[7] There were difficulties from the 1973 paradigm that the post-1973 paradigm promised to solve. Foremost, the APA's post-1973 paradigm improved the relationship with the gay activists who had been accusing the APA of contributing to the discrimination and suffering of homosexuals. Gay activists had been systematically disrupting APA conferences and presentations on homosexuality since 1970. The post-1973 paradigm was seen as a way the APA could influence society to end its discrimination against homosexuals.

In addition, for many mental health professionals the prospect of helping those with unwanted homosexuality to accept their homosexual attractions seemed a better alternative than helping them change their sexual orientation. Other professional associations, political organizations, and academia followed the lead of the APA. The paradigm shift in the APA did change the world.

The literature search for this paper revealed a wealth of information on homosexuality published before the 1973 APA decision. This paper will look at the theories of causal factors of homosexuality, homosexual lifestyles and subcultures, and treatments of homosexuality. A good grasp of the knowledge base on homosexuality before 1973 allows a person to see how big and dramatic the APA's paradigm shift was. Once that knowledge base has been established, the 1973 APA decision will be scrutinized as well as its consequences. Finally, the treatment controversy as it exists today will be examined.

Among others this paper will feature three of the most influential medical professionals who saw homosexuality as a disorder in 1973. They were Irving Bieber, M.D., Charles W. Socarides, M.D., and Lawrence J. Hatterer, M.D. Bieber headed a comprehensive study on the causation of homosexuality published in 1962. From the late sixties into the early seventies Bieber was the author of the section on homosexuality in the *Comprehensive Textbook of Psychiatry* edited by Alfred M. Freedman, M.D. and Harold I. Kaplan, M.D. The textbook was referred to as the psychiatrist's bible. Socarides and Hatterer each authored books before 1973 describing their treatment of homosexuals, their results and observations. Socarides also had contributions in the *American Handbook of Psychiatry* in the early 1970s. All three had homosexuals as patients in psychotherapy and had successfully helped a significant number change their sexual orientation.

Among others this paper will feature five of the most influential medical and research professionals that sought the removal of homosexuality from the APA's list of clinical disorders in 1973. They were Evelyn Hooker, Ph.D., Judd Marmor, M.D., Hendrik M. Ruitenbeek, Ph.D., George Weinberg, Ph.D., and Thomas Szasz, M.D. Marmor, Ruitenbeek, and Weinberg were psychoanalysts whose writings and therapies supported the post-1973 paradigm. All five became gay rights advocates.

Hooker's 1950s comparative study of male homosexuals and male heterosexuals concluded that homosexuality was not necessarily a psychological disorder. Marmor edited an anthology on homosexuality that was published in 1965. Marmor held positions of vice president and president in the American Psychiatric Association after the 1973 reclassification of homosexuality. He and Hooker were appointed by the National

Institutes of Mental Health to a task force on homosexuality in 1967. In addition, Marmor was a founding member of the Sex Information and Education Council of the United States.

Ruitenbeek edited two anthologies on homosexuality, one in 1963 and the other in 1973. Both anthologies contained articles by academics whose views supported the post-1973 paradigm. Ruitenbeek also served as chairman of the trustees of the Homosexual Community Counseling Center in New York City. He and Hooker were featured speakers at homosexual conferences. Weinberg was a frequent contributor to the New York City magazine *Gay* and in 1972 published a theory that claimed most all the problems related to homosexuality came from society's condemnation of homosexuality. Szasz was best known for his philosophical claims that psychiatrists were serving the role of the guardians of traditional morality by labeling biblically sinful behavior as disorders. His books and articles made psychiatrists aware of their cultural power.

Ronald Bayer, an independent researcher, wrote a book on the American Psychiatric Association's historic 1973 paradigm shift eight years after the event. At the time he researched and wrote *Homosexuality and American Psychiatry – The Politics of Diagnosis* Bayer was an Associate for Policy Studies at The Hastings Center, Institute of Society, Ethics and the Life Sciences.[8] Stake holders on both sides of the APA's paradigm shift have praised Bayer's account. Robert L. Spitzer, M.D., the psychiatrist Bayer credited with pushing the reclassification of homosexuality through the APA's committees and boards, stated that "the author [Bayer] tells the whole story with the objectivity and accuracy of a historian, and with the punch of a spy story."[9] Richard Pillard, M.D., an openly gay psychiatrist involved in the APA's paradigm shift of 1973,

wrote, "Ron Bayer's book is scholarly, fair to everyone, and fascinating to read."[10] On the side that supported the existing 1973 paradigm Charles Socarides referred to Bayer's book as "an objective report that didn't take sides."[11] Bayer's investigative research offered tremendous insight into this turning point in history. Charles Socarides also wrote of those events after the fact, adding to what Bayer had already documented. In addition, Charles Silverstein, Ph.D., a gay identified participant, wrote about the Gay Activist Alliance's presentation before the APA Committee on Nomenclature in 1973.

The conflict over the treatment of homosexuality between the two rival paradigms has continued into the first two decades of the twenty-first century. Two mental health professionals stand out as leaders of the respective sides of the conflict. A prominent leader on the side that homosexuality is a normal variant of human sexuality is Jack Drescher, M.D. Drescher openly identifies as gay and has chaired the APA's Committee on Lesbian, Gay and Bisexual Issues. He authored a book on psychotherapy with homosexuals that was published in 1998 and he has co-edited several anthologies on psychotherapy with homosexuals.

A prominent leader on the side that views homosexuality as a clinical disorder or a symptom of a disorder is Joseph J. Nicolosi, Ph.D. Nicolosi was a founding member of the National Association of Research and Therapy of Homosexuality in the early 1990s, along with the late Charles Socarides mentioned earlier. Nicolosi wrote a book on reparative therapy with homosexuals that was published in 1991 and a book detailing advancements in reparative therapy using affect-focused therapy that was published in 2009. Nicolosi coauthored a book on the prevention of homosexuality that was published in 2002.

At the beginning of the twenty-first century the APA's post-1973 paradigm has been accepted by many professional associations and institutions. Both rival schools of thought regarding homosexuality still exist. Both look at the facts from different perspectives. The post-1973 paradigm has been dominant for several decades now and has had positive and negative consequences. In addition to presenting the information discussed above, this thesis will examine the professional, academic, and social consequences of the post-1973 paradigm.

A major positive consequence of the post-1973 paradigm has been a greater acceptance of homosexuality by society. This acceptance has been in the form of approval from others, sexual orientation anti-discrimination laws, and greater self-acceptance by many homosexuals. The post-1973 paradigm has been the foundation stone of the modern gay rights movement.

Of importance when comparing the positive and negative consequences is the fact that the leaders of the 1973 paradigm also sought to influence society to better accept homosexuality. They supported sexual orientation anti-discrimination laws and they supported the right of an individual to seek a gay identity. In addition, they helped the committed homosexual who did not want to change their sexual orientation. A significant portion of the positive consequences of the post-1973 paradigm would have been achieved had the 1973 paradigm remained.

The thesis will present evidence and take the position that the negative consequences of the post-1973 paradigm have outweighed the positive. Negative consequences of the post-1973 paradigm include fewer treatment options for those with unwanted same-sex attractions. Parents whose children have gender identity conflicts

also have fewer treatment options. The post-1973 paradigm has stymied academic and professional research into the causes of homosexuality and treatments for those who desire to change their sexual orientation. Research into the prevention of homosexuality has also been negatively impacted. Consequently, information given to parents and students ignores the causative factors of homosexuality, does not present the possibility of sexual orientation change, and ignores information parents could use to help a child develop a heterosexual identity.

Since the post-1973 paradigm's dominance the American Psychiatric Association and the American Psychological Association have disregarded the individual client with unwanted same-sex attractions. Gay caucuses, committees, and task forces dominate these association's official views and publications on homosexuality. From a physical health perspective, the normalization of homosexuality through the paradigm shift of 1973 resulted in many more Americans contracting sexually transmitted diseases, including HIV and AIDS.

Notes

[1] Kuhn, *The Structure of Scientific Revolutions*, x.

[2] Ibid., 16-7.

[3] Ibid., 100.

[4] Ibid., 103.

[5] Ibid., 96, 110, 137-9, 170.

[6] Ibid., 12, 82, 110.

[7] Ibid., 135, 157-8.

[8] Bayer, *Homosexuality and American Psychiatry*, inside cover.

[9] Ibid.

[10] Ibid.

[11] Socarides, *Homosexuality a Freedom Too*, 165.

PART I

The Knowledge Base in 1973 and History of the Division

Chapter 1

Etiological Knowledge of Homosexuality in 1973

"Homosexuals do not choose homosexuality. The homosexual adaptation is a substitutive alternative brought about by the inhibiting fears accompanying heterosexuality."[1]

Irving Bieber, M.D. (1965)

Opening note

The academic literature on homosexuality before 1973 is large. Many academics had researched the homosexual condition in various environments and through many individual cases. Most of the research and published studies were on male homosexuals. The reason for that is obvious as one studies homosexuality and examines the differences between male homosexuality and female homosexuality. Male homosexuality was and is much more openly promiscuous. Male homosexuals were frequently arrested for having indiscriminate sex in public places, like public toilets and parks. This widespread pattern of having indiscriminate sex in public places was not observed in female homosexuality.

When the etiological literature on homosexuality before 1973 is examined, one often finds each side of the disorder conflict interpreting the same evidence from a different point of view, and from some authors a disregard of the evidence. Another interesting pattern can be observed where academics postulating etiological theories of

homosexuality regularly crossed into other academic fields to explain homosexuality in their own field of expertise.

Anthropologist perspectives

· Clellan S. Ford, Ph.D. and Frank A. Beach, Ph.D. (1951) studied homosexuality in seventy-six societies, and their work is referenced in many writings on homosexuality before 1973. Their most significant hard data stated that in "49 (67%) of the 76 societies other than our own for which information is available, homosexual activities of one sort or another are considered normal and socially acceptable for certain members of the community. The most common form of institutionalized homosexuality is that of the berdache . . . a male who dresses like a woman, performs women's tasks, and adopts some aspects of the feminine role in sexual behavior with men.". . . "At the same time we have seen that homosexual behavior is never the predominant type of sexual activity for adults in any society or in any animal species."[2]

Branching into the fields of sociology and psychology for their explanation of homosexual behavior, Ford and Beach postulated that "Human sexual behavior is controlled and directed primarily by learning and experience. It is possible to begin with a male whose physiological constitution is entirely normal and, by a process of cultural or individual conditioning, make that person an exclusive homosexual. And this can be done precisely because human sexuality is so labile, so dependent upon individual experience."[3]

Mental health professionals who treated homosexuality as a disorder put emphasis on the hypothesis put forth by Ford and Beach that "human sexual behavior is

controlled and directed by learning and experience." To them this research and hypothesis supported the position that homosexuality is a changeable condition. They accepted the fact that homosexuality had a long history in human society, but saw that fact as only the history of the disorder in human society.

Mental health professionals with a normal variant philosophy of homosexuality, who did not view homosexuality as a disorder, tended to ignore the Ford and Beach implications about changing sexual orientation, and emphasized instead Ford and Beach's reference to the long history of homosexuality in human society and its acceptance in many cultures. They argued that the extended history of homosexuality inferred that it was not necessarily a behavioral disorder. Instead of seeing homosexuality as a disorder, the normal variant viewpoint claimed that the only dysfunction with homosexuality was American society's lack of accepting homosexuality as ancient cultures had.

Anthropologist, sociologist, and psychiatrist Marvin K. Opler, M.D. (1965) criticized the interpretations of the Ford and Beach study by making the point that, "Unfortunately, most studies of the survey sort tear information out of context, so that one is quite uncertain whether the investigator is concerned with the normative sexual experiments of preadolescents or with adult homosexuality."[4] Psychological researcher Evelyn Hooker wrote that although the Ford and Beach study was "very important material" it "is limited by the fact that careful and detailed data on homosexual behavior are lacking in many of the ethnographic descriptions in the Human Relations Area Files, on which they relied."[5]

Opler summarized the historic record of homosexuality in this statement, "no society, save perhaps ancient Greece, pre-Meiji Japan, certain top echelons in Nazi Germany, and the scattered examples of such special status groups as the berdaches, Nata slaves, and one category of Chukchee shamans, has lent sanction in any real sense to homosexuality. ... homosexuality in practically all cultures is regarded as a deviation from the majority values and norms of conduct."[6] Opler also pointed out that although berdaches were American Indian men who took on women's roles, they only "sometimes (apparently a minority) lived homosexually in actual fact."[7]

Ford and Beach also researched the sexual behavior of mammalian species below humans including the primates. Proponents of the normal variant view of homosexuality were prone to explain any mounting patterns in the animal world as evidence of homosexuality being biological. Most of the male on male mounting patterns of primates were the language of who is the dominate male and do not lead to orgasm. Because of the misuse of this research "Beach corrected this erroneous interpretation in 1971: 'I don't know of any authenticated instance of males or females 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.'"[8]

In the 1930s George Devereux, Ph.D. was able to get second hand information on actual berdaches in the Mohave Indian tribes of southwest America. In the Mohave culture berdaches were transvestites and were expected to duplicate the behavior pattern of the adopted sex. They were considered somewhat crazy by their own tribe and a disappointment to their parents. Male berdaches were called "alyhā" and if taken as a wife would cut their legs to mimic menstruation and periodically take herbal concoctions

to create constipation to mimic pregnancy. When the pressure was unbearable the alyhā would go into the woods and relieve himself. He would then bury the feces with a small log and then mourn the death of the imaginary still-born child. The alyhā only played the passive male homosexual role substituting his anus for a vagina. Interestingly, the male who took an alyhā as a wife was not considered a homosexual, but was subject to ridicule. One male who had alyhā wives was reported to have complained that other Mohave men "would kick a pile of animal dung and say, 'those are your children.'"[9]

A young adolescent boy became an alyhā through an initiation ceremony that made him the center of attention. The ceremony was also considered "an ultimate test of his true inclinations. ... The effects of the ceremony were permanent." Devereux speculated that the initiation ceremony itself could exert a strong pull on a child who was confused with self-identity and who longed for attention. As far as youthful homosexual activities in the Mohave culture were documented, "Mutual masturbation was not absent but rather uncommon. Older boys, however, often performed forced rectal intercourse on their younger playmates." This behavior, which American culture would consider rape, was "dismissed as mere infantile naughtiness" by Mohave adults.[10]

Regarding homosexuality in ancient Greece, Gordon Rattray Taylor (1965), the director of the social research organization The Acton Society Trust, and other scholars documented that the accepted romantic love between two members of the male sex was not a homosexual relationship between two adult men, but a mentoring type of vocational training and pederast relationship between an adult man and an adolescent boy. Pederasty is anal sex where an adult man is the penetrator and an adolescent male is the submissive recipient. "The man was called the inspirer, the boy the listener, and each such

arrangement was made by prior agreement with the boy's parents." While the Greeks considered the homosexual relationship between a consenting man and a consenting adolescent male (pederasty) a high form of love, they generally condemned adults having sexual relationships with preadolescent children (pedophilia), and the culture "ridiculed effeminate youths."[11]

Apparently the Greek homosexual model has lived on throughout history as Taylor found evidence of it in England around 1700. "At the turn of the century, Dudley Ryder was warned that it was dangerous to 'send a young man who is beautiful to Oxford,' for 'among the chief men in some of the colleges sodomy is very usual.'"[12] Psychoanalyst Sandor Ferenczi, M.D., an outstanding early pupil of Sigmund Freud, also found this type of homosexual behavior occurring at the beginning of the twentieth century. His work brought him in contact with homosexuals who were "almost exclusively interested in young, delicate boys with an effeminate appearance."[13]

Saul H. Fisher, M.D. (1965) offered an interesting etiological hypothesis on Greek homosexuality that is worth noting. "In the dialogues of Plato, love is always pederasty [love of boys] or homosexual love. Homosexuality was legally recognized. ... Of course, homosexuality in Greece did not preclude heterosexual relationships and marriage, and, at this point, it is appropriate to ask what the status of women in ancient Greece was. The answer is startling ... the position of the woman was a degraded and depreciated one. She had no political or economic rights, except those brought by her dowry. ... Because of her poor education and her lack of function, there was no common ground between man and woman, and she was excluded from the cultural activity of the times."[14] Fisher suggested that the cultural changes in Greek society that led to the

degraded status of women, starting in the sixth century B.C., could have been a causal factor for the rise of pederasty in ancient Greece during that same time period.

In *The Laws* Plato acknowledged that many Crete and Sparta citizens would not be persuaded with an argument that homosexuality was unnatural. Yet when he proposed the idea of passing a law that stated homosexual behavior was to be "desirable, or not at all *un*desirable," he concluded, "Everyone will censure the weakling who yields to temptation, and condemn his all-too-effeminate partner who plays the role of the woman. So who on earth will pass a law like that? Hardly anyone, at any rate if he knows what a genuine law really is." For Plato the law was meant to encourage and promote virtue. In the code of conduct for his utopian vision of the perfect community, Plato recommended "suppressing sodomy entirely."[15]

Sigmund Freud – Sandor Rado

According to psychiatrist Irving Bieber (1962), Sigmund Freud, M.D. at the beginning of the twentieth century "was the first to question the concept that homosexuality was a degenerative disease – a concept that was a pseudoscientific reformulation of a moralistic attitude which considered homosexuality synonymous with degeneracy. Freud's formulation of the etiology of homosexuality postulated a continuum between constitutional and experiential elements. As a consequence, he regarded homosexuality as resulting in some cases solely from constitutional predisposition and in other cases from exclusively experiential factors, although he cited no clinical or experimental proof for either contention."[16]

Anthropologist Marvin Opler (1965) gave Freud similar credit for influencing his academic discipline, "The principle he [Freud] established was that biological functioning in humans is subject to profound social and cultural inhibitions and that, in this sense, psychological factors have primacy and control over organic ones." Freud indirectly "proclaimed it [culture] the principle by which individuals are normatively controlled."[17]

Psychiatrist, Charles Socarides (1968) emphasized Freud's important discovery that "'the connection between the sexual instinct and the sexual object' is not as intimate as one would surmise. Both are merely 'soldered together.'" Freud postulated that male homosexuality can have its roots in "the earliest stages of development" with a "very strong mother fixation. Upon leaving this attachment they continue to identify with the mother, taking themselves narcissistically as their sexual object. Consequently, they search for a man resembling themselves, whom they may love as their mother loved them." Freud also postulated that homosexuality could form in a person "as a means of defense against persecutory paranoia."[18] Freud's experiential hypotheses were given a lot of weight by those who treated homosexuality as a disorder, because their own observations suggested pathological parental-child relationships were a causal factor of homosexuality.

From the normal variant viewpoint, psychiatrist Judd Marmor (1965) emphasized the importance of Freud's bisexual predisposition hypothesis. Marmor summarized Freud as believing "that homosexuality was the expression of a universal trend in all human beings, stemming from a biologically rooted bisexual predisposition. Freud, in line with the strong Darwinian influence of his thinking, believed that all human beings went

through an inevitable 'homoerotic' phase in the process of achieving heterosexuality. Certain kinds of life experiences could arrest the evolutionary process, and the individual would then remain 'fixated' at a homosexual level. Furthermore, even if the development were to proceed normally, certain vestiges of homosexuality would remain as permanent aspects of the personality."[19] In this particular hypothesis Freud crossed over into the field of biology to introduce a hypothetical bisexual predisposition to support the constitutional aspect of his hypothesis on homosexuality.

Even though Judd Marmor believed that Freud's etiological hypothesis of human bisexuality was important in 1965, it had been essentially dismissed academically by Sandor Rado, M.D. in 1940. Marmor included the 1940 Rado treatise in his anthology on homosexuality. Rado argued, "The standard developmental pattern of our species provides for each individual only one reproductive action system. ... anatomic malformation ...impedes or destroys one form of reproductive functioning while creating no new capacity to function in the opposite way. ... Using the term bisexuality in the only sense in which it is biologically legitimate, there is no such thing as bisexuality either in man or in any of the higher vertebrates."[20] This empirical assessment by Rado became a building block in the etiological search for the cause of homosexuality. Bisexuality was a valid sexual orientation classification describing behavior and attractions, but in the biological functions of anatomy mankind was definitely not bisexual.

To explain aberrant sexual behavior, including homosexuality, Rado hypothesized that "the chief causal factor is the affect of anxiety, which inhibits standard stimulation and compels the 'ego action system in the individual' to bring forth an altered

scheme of stimulation as a reparative adjustment. (Rado, 1936-1940; 1939). Both the inhibitory and the reparative processes begin far back in early childhood, leading up to the picture which we encounter in the adult."[21] Rado postulated that "Sexual organization has an early start: its development begins soon after birth. But in our culture, its completion takes fifteen or more years. ... it is the responsibility of society to furnish the young with knowledge and experience needed to set up their pattern intelligently. It was Freud's epochal achievement that he awakened society to this responsibility."[22]

Rado observed that the parental training of children regarding sex often created a fear in the child. Threats were often made to boys who were caught in self-stimulation. Girls were taught to "view the male's sexual approach as an assault." Added to this mix were oedipal desires toward the opposite sex parent that caused jealous resentment toward the same-sex parent. This jealous resentment was normally repressed or punished. "In some children these fears and guilty fears persist through life in a conscious or unconscious state; we do not know why. ... To an individual filled with such persistent fears and guilty fears, sexual activity is not a promise, but a threat; he is predisposed not to sexual fulfillment but to sexual failure ... he may discover that he can obtain orgastic satisfaction, if not through standard performance, then through some modified form of sexual activity."[23] This hypothesis became another building block for many psychoanalysts who treated homosexuality as a disorder.

Sandor Rado did not see homosexuality as always being a reparative process to overcome inhibiting childhood based anxieties. His summation of the causation of homosexuality was as follows, "there is no such thing as an innate orgastic desire for the same sex. Three discernable causes may prompt the individual to develop mechanisms of

orgastic arousal involving the same sex: hidden but incapacitating fears and resentments of the opposite sex; situational inaccessibility of the opposite sex; and desire for variation."[24] The last two causes are not necessarily pathological, but were considered perverse by traditional cultural standards.

Psychoanalytic and sociological perspectives introduction

Before these next perspectives are examined it should be pointed out that both sides of the 1973 American Psychiatric Association (APA) conflict are represented. Irving Bieber, M.D. and Charles Socarides, M.D. actively argued against removing homosexuality from the APA's list of clinical disorders in 1973. Lawrence Hatterer, M.D. sided with Socarides in 1972 that homosexuality should be treated as a disorder[25], and Abram Kardiner, M.D. would go on record as calling the APA's 1973 decision a mistake.[26] Edmund Bergler, M.D. died a full decade before 1973, but his research on homosexuality and criticism of Alfred Kinsey in the 1950s made him one of the most prominent psychoanalysts of that decade.

Those representing the other side of the conflict worked to establish the post-1973 paradigm. Judd Marmor, M.D. actively argued for removing homosexuality from the APA's list of disorders.[27] Evelyn Hooker, Ph.D. provided evidence that homosexuality should not be considered a pathological condition. Her research and arguments were used by gay activists before the APA's Nomenclature Committee in 1973.[28] Hendrik Ruitenbeek, Ph.D. was a passionate promoter of the normal variant viewpoint of homosexuality and was one of the psychoanalysts providing more general arguments to the gay rights movement.[29] Robert Linder, Ph.D. was a psychoanalyst whose

philosophical arguments in the 1950s proposed that homosexuals were being told their behavior was an illness solely because they were different than the majority.[30]

In 1962 Irving Bieber published this succinct summary of the philosophical conflict over homosexual etiology. "All psychoanalytic theories assume that adult homosexuality is psychopathologic and assign differing weights to constitutional and experiential determinants. All agree that the experiential are in the main rooted in childhood and are primarily related to the family. Theories which do not assume psychopathology hold homosexuality to be one type of expression of a polymorphous sexuality which appears pathologic only in cultures holding it to be so."[31] This is a very interesting and definitive statement. Bieber acknowledged a large division in the priorities of two distinct groups of academics. His point was that the theories that concluded that homosexuality was not psychopathological were not psychoanalytic theories at all, but cultural relativist philosophies that ultimately could not label any sexual behavior deviant. The non-psychoanalytic philosophies did not care what happened in the childhood of individuals that led to aberrant sexual behavior. They were concerned with how society created sexual norms of behavior.

Hendrik Ruitenbeek made a similar distinction in 1963. "The sociologist is less concerned that they do take this road than in knowing what in our society encourages them to do so. The psychoanalyst continues to have a scholar's interest in what in the patient's past made him susceptible to society's encouragement to take the homosexual way ..."[32]

Bergler, Bieber, Socarides, Hatterer - psychoanalytic perspectives

Edmund Bergler was a contemporary of Sandor Rado and an early pioneer in psychoanalysis. He took Freudian concepts and successfully applied them to psychotherapy in the 1940s and 50s. His early success helping one hundred homosexuals change their sexual orientation demonstrated that he was on to something. Bergler saw most neuroses starting early in infancy when the infant was forced to face the reality that he/she is not the center of the world. The infant first sees himself as omnipotent, magically providing for itself. Inevitably, the infant is forced to face reality, but before the infant abandons this omnipotent picture of himself "the child has sustained a series of psychic wounds. Normally, these heal, leaving harmless scars. But in some cases they do not." In some cases where the child's fury turns inward he learns to extract "pleasure from an 'impossible' situation. This '*pleasure-in-displeasure pattern*' is technically called psychic masochism." Bergler contended, "The homosexual is not merely an over dimensional psychic masochist, but a psychic masochist *–plus*. ... This plus consists of the application of infantile megalomania to the sex organ ... the [male] homosexual has unconsciously declared that the maternal breast is identical with his own sex organ ... All this goes on in the unconscious, and consequently is totally eclipsed in consciousness."[33]

From his analytic experience Bergler believed that lesbianism began with a masochistic attachment of the little girl to her mother. Maybe the little girl hated the way her mother treated her or how her mother let her father abusively treat her, yet the little girl craved any attention at all from her mother. From the masochistic attachment the little girl developed a false hatred toward her mother, and then she unconsciously refused to hate her mother in any respect. From this battle inside the little girl's unconscious came a false love for her mother that impaired her relational development with her

mother. Thus, according to Bergler, "lesbianism is not 'woman's love for woman,' but the *pseudolove of a masochistic woman, admitting to an inner alibi that she consciously does not understand.*"[34]

Bergler hypothesized causation principles behind several types of male homosexual behavior. While Bergler saw the active and passive homosexual couple as "*an imitation of the husband-wife relationship,*" he considered it "*a reenactment of the baby-mother situation*," with the active homosexual enacting the role of the mother. Bergler observed in analysis that some homosexuals used their homosexuality to show how they should have been treated as a child, while others used it to show how they should not have been treated. This type of behavior he hypothesized was "in effect a public relations campaign, undertaken by the unconscious ego as part of its battle of unconscious alibis against the inner conscience." Similarly, the homosexual relationship where the underlying effort telegraphs that "father loves his little boy" is in reality "a relationship between two people, each of whom feels masochistically mistreated, misunderstood, and made a victim of ingratitude."[35]

Perhaps Bergler's most upsetting hypothesis for adherents of the normal variant viewpoint was his comparison of certain types of homosexual behavior to criminosis. Bergler explained that many criminals unconsciously perform crimes to take revenge on their mothers. "The deepest root of the criminal's conflict is the pre-Oedipal masochistic helplessness, and the feeling that the mother and her successive representatives do not believe in the child's power to avenge himself or even to help himself."[36] Related to this "deepest root" are the criminals who have no reason to commit a crime, but do so compulsively, and the homosexual who does not need to have homosexual sex in public

places, but does so compulsively. The only type of homosexual Bergler saw as potentially dangerous was the male homosexual whose wounding led him to attempt to duplicate himself as a boy, because his "defensive camouflage" made him prone to specialize in minors.[37]

The most extensive, comparative, and statistical study of homosexual childhood environments before 1973 was the report of Irving Bieber et al. in 1962. While Edmund Bergler was drawn to hypothesize on the conflict going on in the subconscious of the homosexual, Bieber and his colleagues compared notes on the family relationships of their homosexual clients. Bieber's group, the Society of Medical Psychoanalysts, used a sample of 100 male heterosexuals and 106 male homosexuals who were receiving psychoanalytic counseling. They acknowledged that their study sample was not random. The Bieber group assumed that "heterosexuality is the biological norm and that unless interfered with all individuals are heterosexual. Homosexuals do not bypass heterosexual developmental phases and all remain potentially heterosexual."[38] Like Freud, these psychiatrists and psychologists, crossed into another academic discipline, assuming a heterosexual biological norm, in order to build a hypothesis on homosexual causation.

What the Bieber study did find was widespread psychological and behavior dysfunction, "psychopathology," in the parent-child relationship of male homosexuals. Severe emotional problems of the parents resulted in conflicts that would entrap their son. "The father played an essential and determining role in the homosexual outcome of his son. In the majority of instances the father was explicitly detached and hostile. In only a minority of cases was paternal destructiveness effected through indifference or default."[39] . . . "Almost half the H-mothers [mothers of homosexuals] were dominant wives who

minimized their husbands. The large majority of H-mothers had a close-binding-intimate relationship with the H-son. In most cases, this son had been his mother's favorite . . . Most H-mothers were explicitly seductive, and even when they were not, the closeness of the bond with the son appeared to be in itself sexually provocative. In about two-thirds of the cases, the mother openly preferred her H-son to her husband and allied with the son against the husband. In about half the cases, the patient was the mother's confidant."[40] The Bieber study argued, "Much of the data of this study document[s] the importance of the father in his son's sexual outcome. ... Where a father has been devaluated by a wife's contempt while the son has been elevated to a position of preference, and where the father's potentially supportive role is undermined, a highly unrealistic and anxiety-laden grandiosity is promoted in the son. To be treated as superior to the father deprives the child of having the paternal leadership he craves and the support he requires."[41]

The Bieber group disagreed with the argument that homosexuality was not pathological because of its frequency in society. Bieber argued that "frequency as a phenomenon is not necessarily related to absence of pathology." The Bieber group also refuted the Kinsey group's hypothesis that "the personality disturbances associated with homosexuality derive from the expectation of adverse social reactions." Although most of the male homosexuals in the Bieber study "were apprehensive about being exposed as homosexuals," Bieber argued that "anxiety about social acceptance would not account for the many significant differences between homosexual and heterosexuals . . . in particular, hostility to the H-father, to brothers rather than to sisters, the close relationship with the mother, and so forth. Moreover, some patients had no apparent problems about social acceptance. Without minimizing its importance, the emphasis upon fears of censure and

rejection as promotive of the personality disorders associated with homosexuality seems to be a quite superficial analysis of this complex disorder."[42]

Bieber's group also refuted the Ford and Beach anthropological hypothesis which implied that homosexuality was not pathological because "a biological tendency for inversion of sexual behavior is inherent in most if not all mammals including the human species."[43] [Freud coined the word "inversion" to designate the practice of homosexuality.[44]] Bieber's group argued that Ford and Beach had used the wrong terminology and made a false statement. The correct terminology should have read that there is a biological capacity for homosexuality, not a tendency. Bieber continued in his argument that "a homosexual phase is not an integral part of sexual development. At any age, homosexuality is a symptom of fear and inhibition of heterosexual expression. . . . there is so much evidence on the side of the nurture hypothesis and so little on the side of the nature hypothesis, that the reliance upon genetic or constitutional determinants to account for the homosexual adaptation is ill founded."[45] In the homosexual adaptation heterosexual goal-achievement is thwarted but "sexual gratification is not renounced; instead, fears and inhibitions associated with pleasure and excitement to a member of the same sex develops as a pathologic alternative."[46]

In the 1965 anthology edited by Judd Marmor, psychiatrist Cornelia Wilbur, M.D., a member of the Bieber Research Committee, addressed female homosexuality. After listing several factors that had been suggested as causes of female homosexuality she concluded, "What is known of female homosexuality to date suggests strongly that it is the result of psychodynamic factors rather than of physiological ones. ... The statement has been made that homosexuality is a pathological alternative that develops in the face

of fears and inhibitions associated with heterosexuality. ... Statements from female homosexuals about sexual training at home show a wide range of distortions. The treatment of heterosexuality as completely taboo, behavior of the family as if there were no such thing as heterosexuality, both overt and covert parental reactions suggesting that heterosexuality is something very bad have all been reported. ... Conversely, never a word is spoken about any sexual dangers implicit in a girl-girl relationship." But parents' anti-heterosexuality could not be the only dynamic producing lesbianism, Wilber believed that "the dynamics of female homosexuality must also depend on the *kinds* of individual the parents are." Wilbur stated the Research Committee had come to some preliminary agreement on the nature of the "typical" mother of a female homosexual. "[T]he 'typical' mother seems to be an overbearing individual who is dominant in the family and excessively controlling of the girl ... The female child destined to be a homosexual looks upon her mother with hostility and rebellion. She is in conflict, however, because of the concomitant presence of great longing for affection and approval from her mother. Identification with the mother is impaired by her own hostility."[47]

Charles Socarides (1968) stated that "It is well known that an over-intense affective relationship to the mother often with conscious incestuous desires and a father who is inaccessible to the child are standard factors in the production of overt male homosexuality."[48] Socarides explained, "The mechanism of identification plays a crucial part in the development of homosexuality. The continued *primary identification* with the mother arises from the inability to make the separation from her during the separation-individuation phase of development [12 to 36 months of age]. ... The absence of a strong father furthermore predisposes the child to this primary identification and precludes a

shift to identification with the father. The boy later becomes painfully aware of this lack of masculine identification and searches for it in his homosexual relations. He seeks partners who represent strong masculine figures and who would give him almost by 'transfusion' the missing masculine attributes which diminish and deprive him, make him feel empty and demasculinized." Socarides continued "It is crucial to separate the primary identification with mother from the *secondary identification* with the male as achieved in homosexuality. The latter is completely transitory and must be continually replenished by male love objects."[49]

Socarides acknowledged the psychic masochism element of homosexuality, but he saw it only as one of the psychological components of homosexuality and not necessarily the main component. He wrote that "All homosexuals suffer from a severe degree of psychic masochism" originating from the helpless child reacting to the overpowering mother. However, Socarides hypothesized that the main causative factor of homosexuality was a conflict in the past "in which victory was impossible for the ego and repression was only partially successful." It was the unresolved conflict that caused the homosexual attractions. The "Homosexuality thus serves to protect the personality against regression." Without the homosexual behavior the homosexual's ego would experience a loss of boundaries and "dissolution of self. Overt homosexuality is crucial for the survival of the ego when it is faced with the catastrophic situation of imminent merging with the mother and the pull toward the undifferentiated phase of development."[50]

Lawrence Hatterer (1970) added this assessment to the complex issue of male homosexual etiology, "homosexuality frequently begins long after the cessation of direct

parental influence, as a result of social circumstances – even though the man in question may have been vulnerable to homosexual influences because of an uncertain male self-image which may date back to his childhood ... family can make a boy vulnerable to homosexuality, and vulnerability can lead him to homosexual habits, but family influence does not *necessarily* explain why homosexual habits become permanent. The cause of that must be sought among hundreds of other variables concerning the man himself and the world he lives in."[51] Hatterer added that "Another potential contributing factor is the blatantly sexual tone of so much in contemporary society and culture. A young person with doubts about his masculinity may find such an ambience almost impossible to cope with. ... Further pressure comes from the supposed desirability of experimentation with anything new, even with a new drug or a new and possibly abnormal sexual experience. Often the family can do nothing to counteract outside influence of this kind. But as we have seen, psychiatrists have up to now given very little attention to such environmental influences on male homosexuality. They are at last coming to agree, however, that homosexuals are not born but made and that genetic, hereditary, constitutional, glandular, or hormonal factors have no significance in causing homosexuality. That at least is a development that indicates considerable progress in treatment and research."[52]

The hypotheses and evidence cited by Bieber, Wilbur, Socarides, and Hatterer were supported by many other medical and mental health professionals. For example, Lionel Ovesey, M.D., Willard Gaylin, M.D., and Herbert Hendin M.D. (1963) came to the conclusion from a small study of male homosexuals that an important causal element of male homosexuality resided "in the avoidance of self-assertion by the male child who fears to take on the masculine role. This fear spreads to all aspects of behavior, so that in

adult life heterosexual desires revive the earlier fear and normal heterosexual behavior is inhibited."[53] John Money, Ph.D., Joan G. Hampson, M.D., and John L. Hampson, M.D. (1957) "concluded that gender role was entirely the result of a learning process which was independent of chromosomes or hormonally determined sex: that is, the gender role adopted was that which had been assigned by the parents and consistently reinforced. The critical period for the establishment of gender role was 18 months to 3 years."[54] The importance of a child identifying with family members of the same sex at an early age was also emphasized by psychiatrist and child development researcher R. A. Spitz (1959). His research found that "when a psychological development which is age adequate for a given critical period cannot take place, it will be difficult, if not impossible, for the individual to acquire it at a later stage."[55]

Marmor, Ruitenbeek related – psychoanalytic perspectives

Judd Marmor (1965) argued that "there is as yet no single constellation of factors that can adequately explain all homosexual deviations. The simple fact is that dominating and seductive mothers; weak, hostile, or detached fathers; and the multiple variations on these themes that are so often suggested as being etiologically significant in homosexuality abound in the histories of countless heterosexual individuals also and cannot therefore be in *themselves* specific causative factors. In saying this it is not my intention to imply that such family relationships are irrelevant to the etiology of homosexuality. On the contrary, they are highly relevant as the work of Bieber and his co-workers has convincingly demonstrated. ... We are probably dealing with a condition that is not only multiply determined by psychodynamic, sociocultural, biological, and

situational factors but also reflects the significance of subtle temporal, qualitative, and quantitative variables. For a homosexual adaptation to occur in our time and culture, these factors must combine to (1) create an impaired gender-identity, (2) create a fear of intimate contact with members of the opposite sex, and (3) provide opportunities for sexual release with members of the same sex."[56]

Marmor also argued that Bieber and his co-workers were wrong on their assumption "that heterosexuality is the 'biologic norm' and homosexuality cannot therefore occur without some anxiety-provoked inhibition of heterosexuality. ... All the evidence from comparative zoology indicates, on the contrary, that bisexuality or 'ambisexuality' is the biologic norm and that exclusive heterosexuality is a culturally imposed restriction."[57] Here again a psychiatrist is arguing that there is a hypothetical biological sexual norm. Marmor's theoretical starting point is a biological norm of bisexuality or ambisexuality.

Another position Marmor took was that "If sexuality operates adaptively ... we must concede at least the possibility that a homosexual object-choice can be determined on the basis of early or persistent *positive* conditioning to objects of the same sex, rather than solely the fears of the opposite sex." He then proceeded to rule out that possibility in "contemporary Western civilization, with its abhorrence of and hostility to homosexual behavior and its powerful pressures toward heterosexual conformity." On this point he concluded that "For our time and culture, therefore, the psychoanalytic assumption that preferential homosexual behavior is always associated with unconscious fears of heterosexual relationships appears valid."[58]

In his 1965 anthology Judd Marmor had William H. Perloff, M.D., a specialist in hormones and reproduction, address hormones as a possible cause of homosexuality. Perloff gave this summary of the scientific knowledge, "We have seen that genetic factors exert no influence upon the choice of the sex object. Hormones, similarly, do not influence the choice of the object of affection. ... Three elements are involved in the determination of human sexuality. The genetic factor sets the sexual pattern and defines the general limits within which the other factors may operate. The hormonal factor develops the organs needed for the sex act and increases their sensitivity to stimulation. The psychological factor essentially controls the choice of sex object and the intensity of sexual emotions. ... It must be concluded that homosexuality is a purely psychological phenomenon."[59]

One psychological experience suggested as a causal factor in female homosexuality was both penis envy and penis fear beginning in early childhood. Psychoanalyst May E. Romm, M.D. explained, "There is little doubt that young female children on first becoming aware that males have organs that they themselves do not possess are puzzled, confused, and desirous of what they do not have. We can speculate that the female child's reaction to the discovery of the penis depends on several factors: her age at the time of the discovery, the age of the possessor of the male organ, the circumstances ... If her questions are handled with respect, honesty, and proper concern for enlightenment, she may count this experience as simply another new discovery. If she sees the penis of an adult, however, it may be a frightening experience for her, or, if she is shamed, threatened, or punished because of her interest, it may prove highly traumatic for her." ... "It is important to bear in mind that every individual reacts in a specific

manner to each situation. What may be traumatic to one individual in the formative years may make only a slight impression on another person of similar age."[60]

Hendrik Ruitenbeek attempted to discount the work of Bieber and Socarides. While offering no etiological theories or evidence of his own he claimed that "Bieber and Socarides base their beliefs on unsupported or at least inadequate evidence. The far fetched conclusions they draw from seeing about a hundred homosexuals are simply appalling."[61] In the same anthology that Ruitenbeek wrote that indictment he included several psychoanalysts who professed the same etiological conclusions as Bieber and Socarides. One example was the Peter M. Miller, John B. Bradley, Richard S. Gross, and Gene Wood report on five studies of homosexuals, none of which involved Bieber, Socarides, or Hatterer. Ruitenbeek noted that all four of these men had doctoral degrees and were connected with the University of South Carolina.[62] The report stated that "The experimental evidence dealing with particular family patterns among homosexuals is by far the most consistent ... Taken as a whole these studies indicate a characteristic family pattern associated with homosexuals which includes an over-intense, over-critical mother and an unloving, critical, physically or psychologically absent father."[63]

The only essay in Ruitenbeek's 1973 anthology that refuted the experiential theory of homosexuality with evidence was not from a medical professional, but from novelist Faubion Bowers. Bowers wrote, "Investigation has discounted the once accepted notion that homosexuals were the offspring of close, binding, intimate mothers and weak, absent, or dead fathers. Among others, Dr. Ray Evans, a psychiatrist at the Loma Linda University School of Medicine in California, reporting the results of a National Institutes of Health study, found that 'only a little more than a quarter of [the] homosexual sample

had such a parental combination,' as well that '11 per cent of [the] control patients also had such parents [yet] did not become homosexual.' In brief, parents are off the hook, but without quite getting the brass ring. One explanation for these many psychological *volte-faces* is that psychiatrists usually deal with disturbed homosexuals rather than with stable ones."[64] Rather than undermining the experiential etiological theory of Bieber and others, the Evans' report could be used as evidence for Bieber's theory, because that particular survey showed the experiential scenario in question occurred more than twice as often for the homosexual sample.

In that same 1973 anthology edited by Ruitenbeek, group therapists reported similar etiological backgrounds as the Bieber group. In one essay two counselors from the San Jose State Counseling Center, Keith W. Johnsgard and Ray M. Schmacher, (both with doctoral degrees according to Ruitenbeedk[65]) described the backgrounds of overt male homosexual students who voluntarily sought treatment. "Their etiologies, similar to those reported in previous articles, stemmed from common backgrounds which provided no real father figure, a guilt-provoking mother who centred her needs around the male child, and early homosexual experiences which resulted from needs to be accepted by and cared for by a man. Their basic problems seemed to centre around a lack of masculine identity, rather profound feelings of worthlessness, and a fundamental incapacity to enter into and maintain a trusting, intimate, long-term relationship with anyone of either sex."[66]

In Ruitenbeek's 1973 anthology New York City psychoanalyst Elizabeth Mintz shared these observations from the ten overt homosexuals she treated through group therapy. "Overt homosexuals often express feelings which, if explored, turn out to be disguises or rationalizations for powerful unconscious fears. Paradoxically, what seems to

be guilt about homosexuality often proves to disguise guilt about unconscious heterosexual impulses. Similarly, what seems to be guilt about social disapproval often proves to represent a sense of personal guilt about being incomplete or inadequate as a male"[67]

An article from Ruitenbeek's first anthology on homosexuality (1963) also addressed the etiological knowledge of homosexuality. Clara Thompson was a psychoanalyst and a professor at four medical schools, including Johns Hopkins. In 1947 she wrote that "more recent analysis has led to the conclusion that homosexuality is but a symptom of more general personality difficulties. ... a symptom with different meanings in different personality setups. One might compare its place in the neurosis to that of a headache in various diseases. ... The next concern is to determine if possible why this symptom is chosen as a solution of the difficulty." Thompson listed several possible causes like "the child's awareness that his sex was a disappointment to his parents... personality damage and the role of accidental factors ... People who have been greatly intimidated or have a low self-esteem... A homosexual way of life also attracts people who fear intimacy and yet are equally afraid of loneliness... early seduction by homosexuals, and many homosexuals attribute their way of life to such experiences. However, many people have such experiences without becoming homosexual."[68] Thompson's theme that homosexuality was a symptom with "different origins in different cases" shared similarities with Sandor Rado's reparative anxiety theory.

Sociological perspectives

In an Evelyn Hooker essay (1965) on homosexuals that lived productive and stable lives she wrote, "At critical junctures in individual life histories, the determinants of involvement in patterns of action that will result in final commitment to a homosexual career are not only psychodynamic but also cultural and situational in character."[69] Hooker was a psychological researcher who did extensive research on homosexuals in their own social environments. Although her research was not concerned about the causative factors of homosexuality, she observed three distinct forces contributing to homosexuality: the psychodynamic, the cultural, and the situational. She hypothesized that within each of these distinct forces were many other possible variables.

In Judd Marmor's introduction to his 1965 anthology on homosexuality he wrote, "There is reason to think that the growing complexity of our Western civilization renders the achievement of masculine identity increasingly difficult for the adolescent male and enhances the desire to flee the demands and responsibilities of the masculine role. The feminine revolution, the emerging dominant tendencies of many American women, the rise of 'momism,' and the diminishing importance of the paternal role in the home are other significant sociological factors that reverberate in intrafamily relationships and hinder the development of healthy masculine identifications. The tendency of English upper-class families to send their sons away at an early age to sexually segregated schools is believed to be one of the factors responsible for a relatively high incidence of sexual inversion among them."[70] Marmor thought it probable that societal forces played a significant part in many cases of homosexuality. Societal expectations created anxieties, which lowered self-esteem and hindered same sex gender identity. Even the cultural

tradition of sending adolescent boys to private boy's schools created what Sandor Rado referred to as a "situational inaccessibility of the opposite sex."

In 1963 Hendrik Ruitenbeek thought the presumed increase of homosexuality in that time period was "most usefully understood in the context of social crisis and family disintegration which is part of the critical transition which contemporary society is experiencing." Ruitenbeek pointed out that deep personal relationships in America's competitive culture had become a disadvantage; divorce was increasing and children could no longer assume they would spend their early years with the same parents. Children and parents no longer knew what to expect of each other, the roles of men and women had changed, and the typical masculine vocations were rapidly disappearing. Ruitenbeek argued, "The confusion of roles in the American family is not entirely new, then, but it has been intensified by the swiftness with which society is changing." The sociologist "is, or should be, concerned with inquiry into the relationship between the rise in male homosexuality and the decline of the authoritarian father."[71]

Another leading authority on homosexuality during this time period was Lionel Ovesey, M.D. His "adaptational" hypothesis of psychological behavior saw "behavior as the resultant of two forces: the needs of the individual and the societal demands." He contended that childhood behavior "is molded in accordance with social demands as mediated by the parents." Anxieties and inhibitions can develop in children through excessive or improper parental discipline, and "Inhibitions do not stay confined to the behavior area in which they are originally laid down." Because of the "fiercely competitive" nature of American society and its emphasis on success, "the man who lacks it [self-esteem] and fails to meet success goals is plagued with doubts about his

masculinity." Ovesey saw the "the homosexual act itself as a confession of masculine failure."[72]

From Abram Kardiner's perspective "the social factor always influences the developmental factor." Kardiner proposed five routes that could lead a male into homosexuality. Besides the childhood developmental anxiety routes he also agreed with socio-arguments of causation; "social-role failure and inability to compete effectively" could act as a "demasculinizing agent" leading one into homosexuality. Kardiner saw homosexuality as "both a symptom of social distress and a safety valve. Why a safety valve? Because it deflects energy into a channel that encapsulates it and prevents it from becoming explosive in the form of aggression against society."[73]

From the observation of his homosexual patients psychoanalyst Robert Lindner came to the conclusion that some effeminate men had chosen homosexual behavior because they had been "successfully propagandized by influential inverts through various media ... this myth depicts inversion in terms of mystery, excitement, and magic, and it has won for homosexuals a large following. Another reason is that being conformists, they adopt the behavior fashionable at any time; and being opportunists, they exploit what they consider to be the weakness of those in a position to offer them social or commercial advantages." Lindner also believed some effeminate men sought out the gay community "because therein they can find the tolerance denied them by the 'jam' or straight world."[74]

In one of the early essays on lesbians French writer Simone de Beauvoir argued that "Woman's homosexuality is one attempt among others to reconcile her autonomy with the passivity of her flesh." De Beauvoir alleged that woman's "presumed 'instincts'

for coquetry, docility, are indoctrinated, as is phallic pride in man." De Beavoir agreed that the dynamics of young girls with either a too anxious mother or psychotic mother could be a causative factor in lesbian development, but she contended "fixation on the mother is not by itself enough to explain inversion [homosexuality] ... The truth is that there is never a single determining factor; it is always a matter of a choice, arrived at in a complex total situation and based upon a free decision ... Environmental circumstances, however, have a considerable influence on the choice."[75] There were indicators in de Beauvior's essay that there could be major differences in the causation of male homosexuality and lesbianism, with social forces acting in dissimilar ways.

Prevention of homosexuality

Also related to etiology was the concept of preventing homosexuality. If the main causes of an individual's homosexuality were caused by "extraordinary parental psychopathology," then it should have been possible to prevent homosexuality in that individual. Three essays in Judd Marmor's anthology refer to changing a child's environment to prevent homosexuality in the individual. Irving Bieber gave this scenario, "An adhesive tie between a mother and son promotes in the boy intensely rivalrous and murderous feelings toward the father; fear of retaliation gives rise to irrational fears of the father. Since most such sons have fathers who respond to a situation of this kind by acting out hostility or covertly expressing it through apparent disinterest and lack of involvement, a mutually competitive struggle between a young child and an adult enfolds. ... When a father adequately fulfills the paternal role, that is, when he meets the

realistic dependency needs of his son and encourages a masculine identification, the sexually determined competition is then neutralized or counteracted."[76]

In discussing female homosexuality Cornelia Wilber stated that failure for a young woman struggling with homosexual feelings to establish herself in a heterosexual peer group "seems only to intensify her homosexual adaptation. It is possible that peer-group acceptance, particularly by other females, would promote heterosexuality."[77] Judd Marmor concluded an essay in his 1965 anthology on homosexuality with this sentence, "It is to be hoped that the following chapters may contribute to better understanding of some of the complex factors that enter into the development of patterns of homosexual behavior and so enable us ultimately to institute more effective means of prevention than now exist."[78] Prevention of homosexuality was not a developed psychoanalytic tool in 1973, but it was a concept and considered a worthy goal by many.

Gay political perspectives

Homosexuals have historically sought to explain homosexual desires as something with which they were born. It was Evelyn Hooker's observation (1965) that "The majority believe either that they were born as homosexuals or that familial factors operating very early in their lives determined the outcome. In any case, homosexuality is believed to be a fate over which they have no control and in which they have no choice."[79]

The German homosexual rights movement began decades before the American gay rights movement, and was led for a time by a homosexual physician named Magnus Hirschfeld. In pre-Nazi Germany Hirschfeld used Freud's bisexuality theory to argue that

homosexuality was "an inborn characteristic brought about by a specific proportion of male and female substances in the hereditary composition of the brain."[80] The innate hypothesis was then used by Hirschfeld as a foundation for political action seeking public acceptance of homosexual behavior. Hirschfeld did not have empirical evidence to support his innate theory.

In the late 1960s, an argument emerged that homosexual etiology was insignificant and irrelevant to homosexuals. Professors Simon and Gagnon, both associated with the Kinsey Institute of Sex Research, articulated the new perspective, "from a sociological point of view, what the original causes were may not even be very important for the patterns of homosexuality observed in a society."[81] Ruitenbeek wrote that the various homosexual activists groups in 1973 "by and large are not interested any more in the causes of homosexuality but have accepted homosexuality as an alternative life style."[82] Gay activist Frank Kameny advocated this view in the early 1970s, "It is society which is defective and at fault and needs our attention, not the homosexual. ... Thus, the homophile movement and Gay Liberation explicitly reject concern with those twin obsessions of psychiatry: cause and 'cure.' ... psychiatry is taken strongly to task as not only an adversary, but THE archenemy."[83] By 1973 the gay rights movement had become anti-science with respect to homosexual etiology.

Conclusions

Virtually all who researched the etiology of homosexuality between 1947 and 1973 agreed that the causal factors of homosexuality were numerous and generally experiential. There was no evidence that homosexuality was an innate, genetic, or a

hormonal condition. Childhood gender identity problems starting as early as 12 months of age combined with anxieties derived from pathological parent-child relationships were believed to be a main causal factor of homosexuality. This early in life causative scenario helped explain why so many adult homosexuals believed that they were "born that way."

The etiological knowledge was overwhelmingly based on observations of male homosexuals who sought help from psychoanalysts. Many psychoanalysts saw the same pathological patterns that Irving Bieber identified. These observations showed "the homosexual to be the interactional focal point for extraordinary parental psychopathology. Mothers relate to sons who become homosexuals in characteristic ways. The typical pattern is an overclose intimacy, possessiveness, domination, overprotection, and demasculinization. In families in which there are other children, the mother generally favors the pre homosexual son ... In the large majority of cases, the homosexual hates, fears, or lacks respect or admiration for his father, who minimizes, humiliates, and spends little time with him."[84] Yet, it was pointed out by Bieber's critics that many heterosexuals were raised in similar environments and did not become homosexuals. The same point was true for the hypothesis that molestation was a causative factor of homosexuality. Even though a large percentage of homosexuals were molested in their youth, others who had been molested as a child ended up heterosexual. It was apparent to all that other determinants were involved that either caused one to become a homosexual or not to become one. Bieber had said that all psychoanalytic theories of causation of homosexuality included both constitutional and experiential elements. Many experiential elements were shown to be probable causal factors, but the constitutional factors of the individual's personality were for the most part still a mystery.

Judd Marmor theorized that homosexuality was caused by a combination of variables that were "psychodynamic, sociocultural, biological, and situational factors." Lawrence Hatterer agreed with Marmor that homosexuality had multi-faceted causal factors. He stated that besides the known pathological family patterns there were "hundreds of other variables concerning the man himself and the world he lives in" that could contribute to the development of homosexuality. Hatterer mentioned the sexual tone of the culture and an individual's desire to experiment with risky behavior as examples. Marmor also reasoned that it was possible to raise a child to be exclusively homosexual, and Robert Lindner was convinced that some of his homosexual patients had taken on a gay identity because the media and influential homosexuals led them to believe that the gay life was exciting and magical.

There was nothing from the Bieber side of the etiological issue that really disagreed with the theory that other variables contributed to homosexual development, and there was nothing from the Marmor side that really disagreed with the Bieber theory that pathological patterns in the parent-child relationship was the most common causal factor of homosexuality. It did appear that every causal factor was a variable factor in the sense that it was not evident in all the cases observed and/or it had varying degrees of influence.

There were specific sociological factors that were of interest too. It was suggested that the changing cultural role of the father played a factor in the increase of homosexuality, because parents and children no longer knew what to expect from each other and many of the traditional masculine occupations were now being done by women. Masculinity was also associated with economic success, and economic failure was

thought to contribute to a lack of self-esteem that could become a causal factor of homosexuality. Sandor Rado included "situational inaccessibility of the opposite sex" and "desire for variation" as factors that could cause homosexual behavior, and the homosexual behavior at some of the elite all boy schools seemed to substantiate Rado's assessment. From another observation Simone de Beauvoir believed that women who became lesbians ultimately chose that lifestyle based on their total situation.

The most interesting aspect in the etiological knowledge of homosexuality in 1973 was that all of the psychoanalytic hypotheses and assessments on homosexual etiology stated in this chapter could be true and not necessarily contradict one another. Early gender identity issues and pathological family patterns could cause a child to identify more with the opposite sex, and lead that person into homosexuality. Sexual molestation could confuse a child and later be a causative factor of homosexuality. An adult male's experience of failure in the competitive world could create feelings of weakness and demasculization that lead to homosexual behavior due to the constitutional elements in his personality. It was even probable that favorable marketing of the homosexual life could lure a person into it.

The theories that did contradict each other were theories of biological sexual norms. Sandor Rado made the point that biologically speaking humans were not bisexual, because no human had ever had the ability to perform both reproductive processes – to impregnate and to become pregnant. From Rado's viewpoint sexual function was the only place biology entered into the science of sexuality.

The biological norm of human sexuality that Irving Bieber and Judd Marmor squabbled over, if it existed, was some biological drive toward a particular sexual object.

Bieber based his heterosexual biological drive on the distinct male and female genital apparatus made for sexual union with each other. Marmor based his bisexual biological drive on the history of sexual behavior in both humans and animals. The debate between Bieber and Marmor over whether there was a "heterosexual" or "bisexual" biological drive was futile, but it reflected on the conflict over how homosexuality should be treated clinically and socially. If biology played a role in the choice of the sex object, it affected psychotherapeutic goals; because if there was a heterosexual biological drive, then a psychotherapeutic goal to change a homosexual orientation to heterosexual could always be validated by it. Alternately, if there was a bisexual biological drive or if homosexuality was innate, then homosexual rights advocates could use it to argue that homosexuality should be given equal societal status as heterosexuality. These different theories both sought justification for conflicting goals.

The psychological theories were distinct from the biological theories of homosexuality. While the psychological theories were based on clinical observation and research, the biological theories were based only on speculation. The psychological theories could accommodate each other. The biological theories could not.

Notes

[1] Bieber, "Cinical Aspects of Male," 254.

[2] Hatterer, *Changing Homosexuality*, 8-9. Quotes originally from *Patterns of Sexual Behavior* by Clellan S. Ford and Frank A. Beach, 129-130 and 143, New York: Harper and Row, 1951.

[3] Ibid., 8. Ford and Beach quote from page 236-7 of *Patterns of Sexual Behavior.*

[4] Opler, "Anthropological and Cross-Cultural Aspects," 112.

[5] Hooker, "Male Homosexuals," 86.

[6] Opler, "Anthropological and Cross-Cultural Aspects," 114.

[7] Ibid., 111.

[8] Socarides, *Beyond Sexual Freedom*, 99. The Beach quote was published earlier in *Sexuality and Homosexuality* by Arno Karlen, New York: Norton, 1971.

[9] Devereux, "Institutionalized Homosexuality," 183-226.

[10] Ibid., 184, 195-6.

[11] Taylor, "Historical and Mythological Aspects," 155.

[12] Ibid., 141-2.

[13] Ferenczi, "Nosology of Male," 3, 5.

[14] Fisher, "Note on Male," 168-9.

[15] Plato, *Laws*, 334, 340.

[16] Bieber et al., *Homosexuality: A Psychoanalytic Study*, 3.

[17] Opler, "Anthropological and Cross-Cultural Aspects," 109-10.

[18] Socarides, *Overt Homosexual,* 23-6.

[19] Marmor, "Introduction," in *Sexual Inversion*, 2.

[20] Rado, "Critical Examination," 181-2.

[21] Ibid., 186-7.

[22] Rado, "An Adaptational View," 105.

[23] Ibid., 105-8.

[24] Ibid., 123.

[25] Bayer, *Homosexuality and American Psychiatry*, 113.

[26] Ibid., 141.

[27] Ibid., 109.

[28] Ibid., 118.

[29] Ibid., 87.

[30] Lindner, "Homosexuality and the Contemporary," 73.

[31] Bieber et al., *Homosexuality: A Psychoanalytic Study*, 18.

[32] Ruitenbeek, "Men Alone:," 93.

[33] Bergler, *Homosexuality: Disease or Way?* 31-2, 47-8.

[34] Ibid., 264-5.

[35] Ibid., 69-77.

[36] Ibid., 83.

[37] Ibid., 70-72.

[38] Bieber et al., *Homosexuality: A Psychoanalytic Study*, 319.

[39] Ibid., 310.

[40] Ibid., 313.

[41] Ibid., 316.

[42] Ibid., 303-4.

[43] Ibid., 305. See note 2 regarding the original quote from Clellan S. Ford and Frank A. Beach.

[44] Socarides, *Overt Homosexual*, 22.

[45] Bieber et al., *Homosexuality: A Psychoanalytic Study*, 305-6.

[46] Ibid., 303.

[47] Wilbur, "Clinical Aspects of Female" 274-7.

[48] Socarides, *Overt Homosexual*, 43.

[49] Ibid., 65, 74.

[50] Ibid., 62-4, 97.

[51] Hatterer, *Changing Homosexuality*, 42-3.

[52] Ibid., 46-7.

[53] Feldman and MacCulloch, *Homosexual Behavior: Therapy*, 6-7. Their reference was from "Psychotherapy of male homosexuality" by L. Ovesey, W. Gaylin, and H. Hendin, in *Archives of General Psychiatry*, (1963) vol. 9, 19-31.

[54] Ibid., 169. This information by J. Money and R. Hampson was originally published as "Imprinting and the establishment of gender role" in the "*Archives of Neurology and Psychiatry 77*" (1957), pp. 333-6.

[55] Socarides, *Overt Homosexual*, 66.

[56] Marmor, "Introduction" to *Sexual Inversion*, 5.

[57] Ibid., 11.

[58] Ibid., 10-12.

[59] Perloff, "Hormones and Homosexuality," 67-8.

[60] Romm, "Sexuality and Homosexuality," 285, 292.

[61] Ruitenbeek, Introduction to *Homosexuality: A Changing Picture,* 147.

[62] Ruitenbeek, Notes on Contributors in *Homosexuality: A Changing Picture*, 10.

[63] Miller, Bradley, Gross, and Wood, "Review of Homosexuality Research," 150.

[64] Bowers, "Homosex: Living the Life," 112.

[65] Ruitenbeek, Notes on Contributors in *Homosexuality: A Changing Picture*, 11.

[66] Johnsgard and Schumacher, "Experience of Intimacy," 170.

[67] Mintz, "Overt Male Homosexuals," 183.

[68] Thompson, "Changing Concepts of Homosexuality," 41, 46-9.

[69] Hooker, "Male Homosexuals," 90.

[70] Marmor, "Introduction" to *Sexual Inversion*, 15.

[71] Ruitenbeek, "Men Alone," 84-88.

[72] Ovesey, "Homosexual Conflict," 130, 133-4, 138.

[73] Kardiner, "Flight from Masculinity," 21, 35-6.

[74] Lindner, "Homosexuality and the Contemporary," 70-1.

[75] Beauvoir, "Lesbian," 230-1, 238-240.

[76] Bieber, "Clinical Aspects of Male," 251.

[77] Wilbur, "Clinical Aspects of Female," 280.

[78] Marmor, "Introduction" to *Sexual Inversion*, 22.

[79] Hooker, "Male Homosexuals," 102.

[80] Rado, "Critical Examination," 178.

[81] Simon and Gagnon, "Homosexuality: The Formulation," 22-3.

[82] Ruitenbeek, "Introductory Essay: Homosexuality," 14.

[83] Kameny, "Gay Liberation and Psychiatry," 76-7.

[84] Bieber, "Clinical Aspects of Male," 249-250.

Chapter 2

Knowledge of the Homosexual Life in 1973

"While the agreements resulting in 'one-night stands' occur in many settings -the bath, the street, the public toilet - and may vary greatly in the elaborateness or simplicity of the interaction preceding culmination in the sexual act, their essential feature is the expectation that sex can be had without obligation or commitment. Regardless of person, time, place or city, in the United States, at least, wherever homosexuals meet, this expectation is a stable, reproducible, standard feature of their interaction."[1]

Evelyn Hooker (1965)

Opening note

There is a wealth of literature published before 1973 by psychoanalysts and other researchers on homosexual life styles and life experiences. This information was relevant to the question of whether homosexuality was pathological or whether it was healthy, and

to whether it was a reparative response or a lifestyle choice. Most all scholars of homosexuality acknowledged that there were destructive aspects in the homosexual lifestyle, but there was a debate as to whether the destructive elements were caused by pathological elements of homosexual causation or by society's negative response to homosexuality. Clinical psychoanalysts recorded patient data on homosexuals relating to childhood, adolescence, and current behavior as they would with any other type of patient coming to them for help. Sociological researchers studied homosexuals that were generally not in treatment programs and they studied them as a subculture. One of the criticisms of the 1973 paradigm put forth by the normal variant viewpoint was that the psychiatrist and psychologist only saw homosexuals who had mental and behavioral problems. They never saw the "normal" homosexual. The following data comes from academics and professionals on both sides of the 1973 debate over whether homosexuality should be classified as a disorder.

Observations of the psychoanalyst

"Homosexuals differ from one another, as do all individuals. The phrase 'the homosexual' is no more descriptive or identifying than is the term 'the heterosexual.'"[2] That was the beginning sentence of Irving Bieber's essay in Judd Marmor's 1965 anthology on homosexuality. In the essay Bieber mentions some reoccurring life patterns that he had observed. "Homosexuals tend to begin object-related sexuality earlier than do heterosexuals, and there is a tendency toward more frequent sexual relations. ... social life is restricted to the company of other homosexuals and to superficial, guarded relationships with heterosexuals that are based in part on the fear of inevitable exposure

and rejection. Older homosexuals often become dissatisfied and disenchanted with homosexual society, but the dread of isolation and emotional impoverishment leads them to feel hopeless about dissociating themselves from the homosexual coterie."[3] On homosexual relationships Bieber stated, "The disruptive behavior associated with jealousy frequently contributes to the dissolution of homosexual partnerships. ... the power conflict is another disruptive factor. Psychopathologically dependent attitudes further militate toward the transiency of homosexual couplings. Each seeks compensations from the other for inhibitions in emotional, sexual, and social areas. Each hopes, not only to preserve genital gratification, but to secure fulfillment of romantic longings. The frustration of unrealistic demands and dependency precipitates overtly hostile behavior. Though it may be concealed ... hostility and mistrust are intrinsic to the homosexual relationship."[4] Bieber concluded in another work that "Much in the homosexual relationship is destructive. Yet there may exist positive aspects. There is some attempt to establish and preserve human contact and to develop and maintain meaningful relationships."[5]

Lawrence Hatterer found that "The majority of men committed to a homosexual way of life live in homosexual subcultures in urban communities." Hatterer's list of subcultures highlighted the diversity of homosexual life styles and associated behaviors within each subculture. He categorized ten distinct urban subcultures: "the *homophilic*, such as the Mattachine Society; the *bar* groups, including 'trade,' 'piss elegant,' and 'leather,' . . . ; the *transients* who prowl toilets, Turkish baths, parks, . . . ; *living colonies*, such as those in neighborhoods, buildings, and resorts; groups identified with *work*, such as those in theatre, hair dressers, ballet dancers . . . ; the *professionals*, including

prostitutes, hustlers, nude models, and 'kept' men; the *'married'* couples . . . where the homosexual couple is totally removed from all other homosexual environments; those whose identifications are predominantly *feminine*, such as queens, transvestites, transsexuals, and female impersonators; the *off-beats*, including sadomasochists, homosexual addicts, and group-sex addicts; and finally the more or less *disguised* group, such as bisexuals, closet queens, and married males who regularly practice homosexuality." Hatterer added, "Needless to say, many groups overlap. The single most common denominator for every subculture is the belief in and permissiveness of one or a variety of homosexual practices and/or homosexual consciousness."[6]

Hatterer's research also revealed "a highly stratified caste system" within homosexual subcultures. He wrote, "Competitions and comparisons very nearly parallel those found in heterosexual society, but they tend to concentrate more on youth, superficial physical beauty, sensuality, and virility than on socioeconomic, culture, and educational factors. The male who 'comes out' in a homosexual subculture is generally rated on a scale of priorities that relate to his youth, physical attractiveness, and/or capacities for abandoned and vigorous sexual activity. Sensitivity and/or behavior that approximates normal male physical virility and aggressiveness are also highly valued."[7]

"In homosexual society, penis size comes to symbolize virility, high potency, and a capacity to give sexual pleasure. ... Many a competitively oriented man wears tight pants without underwear in order to outline his genitalia. In this way, he intends immediately to establish his status with those on the prowl or with those who wish to compare themselves with him. If involved in these activities, a man can constantly feel minimized and emasculated by compulsively looking for and comparing himself with

more adequately endowed men. He can become obsessed with 'cruising,' that is, looking at every attractive male who fits his idealized type and attempting either to possess that male's penis or submit to it."[8]

Psychoanalysts found that male homosexuals had difficulty sustaining long term relationships. Lawrence Hatterer discovered from his committed homosexual clients that "after the initial period of 'coming out' into homosexual living, the majority of men from this group tired of their existence in transient and bizarre subcultures." If these men have never been in a stable homosexual relationship they find "themselves wishing for and seeking a stabilized homosexual relationship. Their search is never ending and fraught with trauma as the male becomes older and less physically attractive. For those who have established stabilized relationships, the problems of sustaining such a relationship past seven years often become insurmountable. The majority of patients who came for treatment could not report-beyond a few isolated instances-any significant number of successful sustained homosexual relationships that lasted more than twenty years among their many hundreds of contacts."[9]

From his observations Hatterer hypothesized that the interpersonal dynamics of male homosexual relationships were in themselves a cause of relationship disintegration. "Acute and chronic problems occur in establishing a balance between and sustaining submission and dominance or passivity and aggressivity, that is, male-female role-playing in the committed homosexual's relationships. Whether these gender conflicts relate to economic or sexual roles in the living arrangement, the outgrowth of distortions can be overt or subtle or unrevealed. They often result in sado-masochistic patterns of

behavior between homosexual partners which generally threaten or even destroy one partner or the other."[10]

Charles Socarides had this to say on transient male homosexual encounters, "There is no empathic affective reciprocity in the male homosexual relationship. Each partner is playing his part as if in isolation with no cognizance of the complementariness of a sexual union, as if the act were consummated in 'splendid isolation' with the other person merely a device ... This is a masturbatory equivalent and highly narcissistic. The act permits discharge and expression only of individual dynamic forces." He gave this example to support his hypothesis. "Some homosexuals prefer to achieve contact through the aperture in a toilet stall door, extend and /or grasp the penis without face-to-face encounter."[11]

On female homosexuality Cornelia Wilbur wrote, "Although some homosexual relationships may appear stable, continuity is unusual. In some apparently stable female homosexual relationships, either or both partners secretly indulge in homosexual relationships on the side. ... Within the relationship itself, there are a great many tensions ... The frequency of verbal or physical fighting between homosexual partners and among homosexuals in groups suggests that there is much in homosexual relationships that is destructive. There is certainly a longing to develop and maintain meaningful relationships. Frequent attempts to relate are frustrated by chronic ambivalence, hostility, and anxiety."[12]

Psychiatrists Peter Mayerson, M.D. and Harold I. Lief, M.D. conducted a follow-up study on homosexuals who had psychoanalytic therapy. They found that the most striking difference between male and female homosexual relationships was in their

stability. "Whereas all our female patients had had stable homosexual relationships (relationships lasting longer than two years), only one of twelve paired males had had such a stable relationship. The women generally seemed much less dissatisfied with their homosexual lives than did the men. The female relationships seemed to be primarily vehicles for expression of dependent or passive needs; dynamically they seemed to be mother-daughter relationships in which actual or symbolic sexual gratification assumed far less importance than in the male pairs."[13]

Group psychotherapists at the San Jose State College Counseling Center, Johnsgard and Schumacher, observed that "In the heterosexual world, tremendous cultural pressures are exerted to encourage long-term and hopefully permanent relationships in marriage. ... However, in the homosexual world, even greater cultural pressures exist which tend to discourage long-term relationships and to promote endless repetitions of casual relationships in which both parties are protected from confronting their needs and fears of intimacy and commitment." Some of the common relational feelings that young gay men shared in Johnsgard and Schumacher's group psychotherapy included "the inordinate dominance-submission patterns in their homosexual relationships; of the giving in to impulses, lack of trust and general 'to hell with your buddy' attitude in the homosexual world; and of their faith in, and endless search for the ideal, life-long relationship with another male." After the first semester of group therapy Johnsgard and Schumacher observed that "The men began to feel that their basic problem centred around really trusting and caring about other human beings and that the odds of accomplishing this in the gay world were dismally small."[14]

Edmund Bergler, was probably the first to document a homosexual using his position of power to discriminate against homosexuals who were trying to change their sexual orientation. When the homosexual rights movement became more radical in the mid 1960s it was common for gay activists to consider homosexuals who left the gay identity as traitors, but Bergler's account predates that period of time by ten or fifteen years. Bergler was treating two homosexual clients who came to him for the purpose of changing their sexual orientation. Both men were scientists who worked in the same department of a distinguished New York institution, and although they were friends, they were not sexually involved with each other. The head of their department was "a notorious homosexual who combined business with pleasure: his young assistants were his homosexual prey." Both men had had "sporadic relations" with their boss and when the boss found out they had entered into analysis with Bergler, the boss's "attitude toward them became cold. He did not disguise his displeasure, and he was generous with references to the imminence of the period when yearly contracts were renewed or dropped."[15]

Some time passed and the head of the department initiated sexual propositions to the two in treatment and both objected to the sexual advances made by their boss. Each was told separately by their boss that their treatment seemed to be ineffective because it did not banish all their "guilt feelings." Each in turn told their boss that their treatment was not to stabilize their homosexuality by removing guilt, but to "destroy the perversion." Their boss thought they were joking with him, and soon realized they were not. Both scientists' contracts were not renewed and they had to leave New York to

pursue other work. The story did have a good ending. Both scientists "became very well known in their scientific fields within the next few years."[16]

Edmund Bergler had this commentary on the darker side of the homosexual lifestyle. "*Power misused, malice exaggerated, cynicism pronounced, subtle systems of emotional blackmail perfected* – these elements combine to make the *working method of some homosexuals*. Regrettable, but true."[17]

Observations of the socio-cultural researcher

In 1973 an anthropologist from Kinsey's Institute of Sex Research, David Sonenschein, Ph.D., gave an objective description of male homosexual relationships based on clandestine "observations and interviews of informants of a homosexual community in the Southwestern United States." He categorized male homosexual to male homosexual relationships in six categories. The first two categories he labeled "permanent social relationships" and "non-permanent relationships." The first category was "their best and closest friends" ... "usually found in the same clique structure" while the second category of relationships was "good friends" ... "usually found outside of an individual's clique." Sonenschein "noticed that first and second order friendships were seen to be entirely social and non-sexual in nature," but "while genital relations between first and second order friends were extremely rare, sex play was very common. There seemed to be a rather definite joking relationship among these individuals ... On the other hand, members within each group became more competitive with each other for social and sexual partners. This many times resulted in a good deal of tension in the confrontations in the context of the homosexual institutions."[18]

The third category Sonenschein observed was "permanent sexual relationships" which was called "being kept." "The homosexual who is being 'kept' is in the role of a mistress; the 'kept boy' was a younger individual whose interest in the relationship was primarily materialistic and monetary and whose emotional involvement with his partner was superficial and exploitative. ... This younger individual was 'kept' by an older, more well-to-do homosexual whose physical appearance and/or ageing had tended to move him out of the system of competition for partners in the homosexual community. ... it was very unstable, the biggest factor of breakup being the infidelity of the 'kept boy.'"[19]

The fourth of Sonenschein's categories was "non-permanent sexual relationships," which were divided into "two main examples: the 'one night stand' and the 'affair.' ... Both types were extremely depersonalized, the sole basis of the relationship being the purpose of sexual activity and orgasm. The briefest and most superficial of the two was known as the 'quicky' and may be consummated in anywhere from a few hours of activity to the few minutes it takes to reach orgasm. This form involved the highest degree of anonymity; it seemed to be the most popular form of sex for those homosexuals with a good deal of social rank and for those who were tremendously committed to sexuality. In this activity, the partners usually had never seen one another before and usually never saw each other again. The other type of the 'one night stand' was a more prolonged relationship such as for a whole night or a weekend. ... The variety called the affair was defined by the subject group as a primarily sexual relationship lasting over an indefinite period of time; ... Duration varied in terms of weeks or months. ... Participants rarely lived together in affairs. ... for some, an affair was a trial relationship, a prelude to a more committal one ... For others however, it was

a kind of 'going steady,' referred to as a kind of young puppy love that was frequently indulged in many times during one's life ... with the implicit knowledge that the affair will end when the novelty wears off ... Finally, for still others, the affair was merely an intensely physical relationship with another, ending when both partners were sexually satiated."[20]

The fifth category was "permanent sociosexual relationships." Sonenschein found that "To find a permanent partner was certainly a common goal of many homosexuals in the subject group but it was not as universal, as constant or as compulsive as the psychological literature would have us believe. Most of the younger individuals were more intent upon the satisfactions of the moment or having partners in extended encounters rather than questing after a permanent mate. It was usually only after 'aging' set in (about age 30) that finding a steadier mate became a significant concern." Sonenschein distinguished two main types of permanent sociosexual relationships. One resembled a traditional heterosexual marriage where each partner took a different gender role related to either the husband or the wife. The other relationship in this category Sonenschein viewed as more of a "co-habitation." "It too was based on a conception of love but the relationship was less predominately sexual as was the previous variety; there was a conscious attempt by the individuals involved to aim at a congruence of values and interest. ... The first variety of the permanent relationship was less stable than the second variety. ... It was continually observed in the subject community that as soon as any two individuals entered into a sexual or sociosexual relationship that was hoped to last for any period of time, these individuals rapidly withdrew from the activity of the community and

decreased their participation in group affairs, regardless of how active or popular they had been before."[21]

The last of Sonenschein's male homosexual relationship categories was "non-permanent sociosexual relationships." "They were between individuals who considered themselves 'friends' but also potential sexual partners. ... Social encounters seemed to occur before sexual activity with these individuals in contrast to those in cell IV, where sexual interaction usually preceded social acquaintance. ... although there were people who might fall into this category, they were relatively rare."[22]

Similar to Sonenschein's research findings sociology professors Maurice Leznoff and William A. Westley observed in the mid 1950s that "overt homosexuals gather in cohesive social groups which become the dominant focus of their lives." Within these close-knit male homosexual groups there is a prohibition against sexual relationships, "in a manner suggestive of the incest taboo." In the overt homosexual groups observed by Leznoff and Westley were leaders referred to as "the queen." "Generally the queen is an older homosexual who has wide experience in the homosexual world." As one homosexual was quoted, "The queen is always somebody pretty old and pretty much out of the game as far as getting anything for herself is concerned." Functionally the queen provided a place where the group gathered and "individual members may have their 'affairs.'" The queen was the group's hub of information and news. He also helped members in financial distress and served "as an intermediary in making sexual contacts."[23]

Both Simon and Gagnon had "been associated with the Institute of Sex Research in Indiana," and their data on sexual commitment within the homosexual community was

based on a Kinsey study "of 550 white males with extensive histories of homosexuality." They came to the conclusion that "most homosexuals cope fairly well." The details of the study showed that "About 60 per cent or more of their sexual partners were persons with whom they had sex only one time. Between 10 and 20 per cent report that they often picked up their sexual partners in public terminals, and an even larger proportion reported similar contacts in other public or semi-public locations. . . . For two fifths of the respondents the longest homosexual affair lasted less than one year and for about one quarter kissing occurred in one third or less of their sexual contacts. In addition, about 30 per cent reported never having had sex in their own homes." Simon and Gagnon also reported this troubling statistic, "Between a quarter and a third reported having been robbed by a sexual partner, with a larger proportion characteristically having exclusively homosexual histories."[24]

Simon and Gagnon compared the "coming out" phase of homosexuality with the honeymoon period of a marriage. They wrote that coming out "is that point in time when there is self-recognition by the individual of his identity as a homosexual and the first major exploration of the homosexual community. At this point in time the removal of inhibiting doubts frequently releases a great deal of sexual energy. Sexual contacts during this period are often pursued nearly indiscriminately and with greater vigour than caution. This is very close to that period in the life of the heterosexual called the 'honeymoon,' when coitus is legitimate and is pursued with a substantial amount of energy. . . . It is during this period that many homosexuals go through a crisis of femininity; that is, they 'act out' in relatively public places in a somewhat effeminate manner . . . During this

period one of the major confirming aspects of masculinity – that is, nonsexual reinforcement by females of masculine status – has been abandoned."[25]

According to Simon and Gagnon, "Another life cycle crisis that the homosexual shares with the heterosexual in this youth-oriented society is the crisis of ageing. While American society places an inordinate positive emphasis on youth, the homosexual community, by and large, places a still greater emphasis on this fleeting characteristic. In general, the homosexual has fewer resources with which to meet this crisis. ... Here, as with 'coming out,' it is important to note that most homosexuals ... manage to weather the period with relative success."[26]

Simon and Gagnon saw the homosexual community as a complex social system. It "serves most simply for some persons as a sexual market place, but for others as the locus of friendships, opportunities, recreation, and expansion of the base of social life. Such a community is filled with both formal and informal institutions for meeting others and for following, to the degree the individual wants, a homosexual life style. . . . Insofar as the community provides these relationships for the individual homosexual, it allows for the dilution of sexual drives by providing social gratification in ways that are not directly sexual. . . . It should be pointed out that in contrast to ethnic and occupational subcultures the homosexual community, as well as other deviant subcommunities, has very limited content. This derives from the fact that the community members often have only their sexual commitment in common."[27]

Evelyn Hooker thought that the discussion of homosexual behavior should "begin with the fact that individual patterns of personality structure and psychodynamics vary greatly among those adult males who engage in overt homosexual behavior. There are no

patterns common to all." But, "despite individual variability in personality structure and psychodynamics, regularities of behavior appear in social settings that must in part be functions of cultural, structural, social-system, or situational variables."[28]

In the 1960s homosexuals concealed their homosexuality from heterosexuals, especially at work. Hooker found that homosexuals shared the cultural norms of their work world while at work and the cultural norms of the gay world when they were in that environment. The most important gathering place for male homosexuals was the gay bar. Besides being a safe place to be openly homosexual and a place to meet other homosexuals, the gay bars served as "communication centers for the exchange of news and gossip and for the discussion of problems and hard-luck stories ... Bars also serve as induction, training and integration centers." In her research during the 1950s and 1960s Hooker documented sixty gay bars in the Los Angeles area.[29]

One regular pattern of male homosexual behavior that Hooker observed was the "'one-night stand.' If one watches very carefully and knows what to watch for in a 'gay' bar, one observes that some individuals are apparently communicating with each other without exchanging words, simply by exchanging glances – but not the kind of quick glance that ordinarily passes between men. ... Occasionally, one may see a glance catch and hold another glance. Later, as if in an accidental meeting, the two holders-of-a-glance may be seen in brief conversation followed by their leaving together – or the conversation may be omitted. Casually and unobtrusively, they may arrive at the door at the same time and leave. If one were to follow them, one would discover that they were strangers, who had agreed by their exchange of glances to a sexual exchange. The terms of the exchange remaining to be settled will be the place and nature of the sexual act. ... What I have

described is one form of 'cruising.' While the agreements resulting in 'one-night stands' occur in many settings – the bath, the street, the public toilet ... their essential feature is the expectation that sex can be had without obligation or commitment. Regardless of person, time, place or city, in the United States, at least, wherever homosexuals meet, this expectation is a stable, reproducible, standard feature of their interaction."[30]

Hooker observed that "Very often, the debut, referred to by homosexuals as the 'coming out,' of a person who believes himself to be homosexual but who has struggled against it will occur ... in the bar." In the gay bar the male coming out will find himself in the company of male homosexuals "who are physically attractive, personable, and 'masculine' in appearance, and his hesitancy in identifying himself as a homosexual may be greatly reduced. ... Once he has 'come out,' ... the process of education proceeds apace. Eager and willing tutors - especially if he is young and attractive - teach him the special language, ways of recognizing vice-squad officers, varieties of sexual acts, and social types. They also assist him in providing justifications for his homosexual way of life and help to reduce his feeling of guilt by providing him with new norms of sexual behavior in which monogamous fidelity to the sexual partner is rare."[31]

The homosexual convert soon learns "that sex can be had without obligation or commitment; that it is a meeting of strangers and that the too familiar face does not 'make out' in the sexual market; ... that success in the sexual market is increased by 'masculine' appearance and the appearance of youth; that life in the bars, for sexual purposes, is 'time limited,' that is, that men of thirty-five or more may not 'make out' unless they pay for partners; that although the potential supply of partners is large,

'making out' is difficult because many in the 'gay' world are afraid of rejection and the criteria of selection may be highly specific."[32]

In Evelyn Hooker's report on her tests of "normal" homosexuals provided by the Mattachine Society she gave a brief description of one of the subjects. "Man #50 is twenty-seven. He works in the electronics industry, in a very large firm in which he has a supervisory job. He lives alone in an apartment, though in an apartment house in which other homosexuals reside. His homosexual pattern involves rather a large number of homosexual partners. He is thoroughly immersed in the homosexual way of life, but apart from this I see no particular evidence of disturbance."[33] Hooker also acknowledged another branch of the homosexual community where there are "men who have established long term living relationships with other homosexuals and who rarely, if ever, go to bars or other public establishments, because of their sexually predatory and competitive character."[34]

Novelist Faubion Bowers gave this honest assessment of homosexuals he had known. "I have had occasion to know homosexuals who tell me they can never escape their reverberating nimbus of guilt, who liken their nights of loveless sex to daggers of icicles, who remind themselves hourly of their futility as men. I have heard others speak of how quickly the moment of diminishing returns arrives in relationships, sexual or not, how they lead treadmill lives of timid reform and incessant relapse. I know a fifty-year-old homosexual who, not having found a stationary kind of affection in his life, has contemplated death, and some younger ones who have actually tried it. I know, further, homosexuals whose bitterness against the world is so blindly diffuse that they try to destroy everyone around them. ...And the most successful sexual athlete I've

encountered, in the sense of 'making' handsome men with Olympian frequency, was undoubtedly the unhappiest human I have ever been near."

"But I have also met 'normal' homosexuals – happy in their work adjusted to their stratum of society, content that there are others both better and worse off than they are. They have friends, ambitions, middle-class virtues, a sense of usefulness to society and themselves. They watch TV, eat McDonald's hamburgers, attend church, and truly love life and those in it with them. I've never heard them complain about their sex life. Some of them are 'married' to others like themselves."[35]

When Albert J. Reiss, Jr., Ph.d. research on a homosexual subculture in the Nashville, Tennessee area was published in 1963 he was a sociology professor at the University of Michigan. He found a semi-organized culture of male homosexuals who would pay money to perform fellatio on adolescent boys. The boys were members of delinquent gangs from the lower-class areas of Nashville and the gangs set the norms of the exchange. The homosexuals, on the other hand, were from every strata of society. Because the boys only allowed the homosexual to perform fellatio and did not reciprocate, they did not develop a self-conception of themselves as a homosexual and after their adolescent period most did not engage in homosexual activity. The boys did, however, regard the homosexuals that sought them out as deviant. For the boys the sexual exchange was just another way to make some delinquent cash. If a homosexual would not pay the going rate or if the homosexual demeaned the masculinity of the boy, he would become the target of a beating. Reiss acknowledged that there were other lower-class delinquent gangs that were not part of his study "which 'queer-bait' for the express purpose of 'rolling the queer.'"[36]

There were some boys in the study that performed fellatio on adult homosexuals and/or allowed anal penetration. They were referred to as "punks" by the delinquent gangs and were not allowed in the gangs. Reiss also found cases of "kept boys" who developed strong dependency relationships with adult homosexuals. Of the hundreds of delinquent boys Reiss interviewed "almost all lower-class boys reported they were solicited by a queer at least once. A majority refused the solicitation. Refusal is apparently easy since boys report that queers are seldom insistent." Reiss discussed his findings with criminologists in Denmark and Sweden, and investigated some other American cities. He concluded that the sexual transactions that he documented in Nashville between male homosexuals and delinquent young males occurred in many other cities and social systems.[37]

Case history examples

Lawrence Hatterer published many patient case studies that gave insight into the homosexual life, culture, and causation factors. One mentioned in his book was the case of a middle-aged chunky, muscular man named Rick. He was a homosexual man who told Hatterer, "I've been mostly gay for all of my life, but I believe I'd make my own grandmother if it were another sensation ... What I'm trying to say is, I live for all forms of sensuality, sights, scenes, sounds, smells ... and mostly sex has dominated my every waking and half my sleeping hours. I'll do most anyone I really care for to have myself done. I believe in live and let live ... My first years in New York were strictly on whatever meat-rack I could get on. I was consumed, dedicated to doing every sex scene in town in depth ... I learned that loving a man loyally was not for me, particularly after I

discovered that the first man and only one I've ever loved left at 3 o'clock or later every morning, got himself up in leather to do the S-M bars and empty truck orgy bit on the waterfront. I followed him one night and saw him and fifteen guys fucking their freezing asses off in a cold empty truck. That was my last image of loving a man. When he found out I'd seen him, he tried to beat the shit out of me in one of his alcoholic rages. I'd had one sadistic father, I didn't need another." After years of being "laid, parlayed, and been relayed on several continents by most every set, the swinging, jet, think, social, and dedicated," he came to a psychoanalyst because, "I'm worn out, played out, tired ... I've got to stop or I'll drop dead from the whole bloody rat race! ... I'm really sick and I know it and I need help!"[38].

Although Rick burnt himself out on sexual excess, Rick's childhood and adolescence garnered sympathy. He was the youngest of eight children and his mother's favorite. She protected "him from his five rough brothers and a father who often beat him. As he grew older, he helped her with her chores . . . In his adolescence, he became her confidant. . . . They had their alliance against an 'ugly and aggressive world.' His brothers often treated him like a girl. He slept with two of them for a number of years, one of whom at first forced him regularly to masturbate him and later to fellate him. He so deeply wanted to please and be accepted by a man that even that form of recognition and acceptance, at first frightening and degrading, excited and satisfied him."[39] Later in adolescence a friend of one of Rick's brothers raped Rick and his journey into homosexuality would escalate into adulthood. Rick's story gave an extreme cause and effect example of how early life experiences contribute to the homosexual life of a man. "Rick felt that ever since that early experience with his brother and then the rape that he

had been in desperate flight from himself and a life of relentless sexual mania. He now wished to live at peace with himself."[40]

Socarides' patient V was the younger of two brothers and his "history revealed the typical primary identification with mother and the presence of a weak father who had suffered severe business reverses at the time the child was born ... The father assumed a quiet, benevolent, passive role but was extremely attentive to his older son who became, in time, prominent in athletics ... Patient V always felt inferior to his brother but developed a strong affective life and was rich emotionally in his social relationships." Patient V "was seduced by a male teacher at approximately age seven and later experienced a number of seductions by older men at his places of summer employment while still attending school. He was pleased with the affection men gave him but would develop anxiety on being fondled, caressed or otherwise sexually approached. ... Prior to entering treatment he had undergone a period of about six months of continual drinking, yearning to break away from the bondage of his homosexual life and fulfill himself in meaningful relationships to others and greater vocational attainment. ... His homosexual partner for the past decade had threatened to kill himself were the patient to leave him. He was filled with self-loathing and disgust during homosexual contacts all of which were preceded by anxiety and accomplished only by the use of alcohol. There were episodes of homosexual pick-ups in which he endangered himself by inviting police entrapment as well as physical abuse and loss of personal property at the hands of his momentary partner. He came to the realization that homosexuality 'is valueless, cheapening, aggressive, asocial, demoralizing and self-destructive. I have never met one happy homosexual.'"[41]

Another Socarides' client, "Patient B was an attractive, personable, charming young man, winning in manner, with many cultural talents and extremely intelligent." Early in his treatment Patient B "felt that his homosexual problem must be tied up with his mother and his feelings toward her." He told Socarides, "There's a strong resentment against her and a tremendous dependency." The mother also had a controlling influence on "the father through depreciation of him and forced his withdrawal from the family. He remained an insubstantial and weak figure to his son. The father had habitually thrown up his athletic proficiency to his son as he had always considered the boy a 'sissy.'" Patient B gave Socarides a letter he wrote to his mother but could never give her. Part of the letter read, "No one knows better than you how the 'sissy' problem hurt and tortured my childhood, it was always with me, and although it didn't keep me from a happy youth it was the ever present problem and bogey man. ... I do know that I have always wanted a man to love me. I think because I always felt Daddy didn't." Patient B had a profound fear of women. "I can't even think of looking at the sexual image of a woman. I'm scared of kissing, too. Even the thought of the female form scares me. ... I've always been so scared of men, too, but if a man wants me I have a hold on him." Patient B's "homosexual bouts often took place when he had been drinking and terminated by awakening in his own or some strange bed, possibly robbed and amnesic for the preceding events. His contacts were of a transient nature except in one instance when a relationship lasted approximately a year with an 'attractive, intelligent artist' who, however, mistreated him and stole money from him."[42]

The influence of gay political organizations

Within the literature on homosexuality before 1973 is information on the emergence of the major gay activist organizations in the United States and their influence on homosexual life. Their major influence on the homosexual subculture was the new social institutions created by the political groups themselves and the promotion of gay viewpoints. The viewpoints united the various gay subcultures on the common ground of their perceived victimization. Homosexuals felt victimized by the social reality, because the criminal, civil, and social penalties for homosexual behavior were harsh. Homosexuals were denied civil service job opportunities and could be fired from other jobs for just being a homosexual. Male homosexual patterns were openly promiscuous and sexual activity in public places was illegal. The mafia controlled many gay bars in the large urban cities and exploited their gay patrons. At the same time police harassment of gay men in gay bars was common. A gay viewpoint of perceived victimization was the widespread belief among homosexuals that homosexuality was an innate, non-changeable characteristic, and therefore many homosexuals felt society should not perceive it as deviant.

The American homosexual rights movement turned decisively more radical after the riots that occurred in June of 1969 outside the Stonewall Inn in Greenwich Village. One year after the Stonewall Riot "the first mass coordinated event of the gay liberation movement" took place in New York City. It was the first "Gay Pride Week" which culminated with a gay pride parade. The slogan's chanted in the parade reiterated their viewpoints, "Two-four-six-eight; gay is just as good as straight!" as well as the new militant attitude, "Out of the closets and into the streets!" A Gay Liberation Front member was quoted before the parade, "Well, Sunday we're going to march up Sixth

Avenue and you can stare and take pictures and scream fag all yau want, and we'll just say 'fuck you.' Because we don't care any more. We don't want anybody's *acceptance*. We've begun to stand up by ourselves."[43] Something had changed in the homosexual subculture in 1969. Militancy had emerged.

On the other side of the United States at about the same time as the Stonewall Riot a defrocked gay preacher started a gay denominational church using the precepts of the gay liberation movement. In the new Metropolitan Church homosexual behavior was not a sin, but fully equal to heterosexuality. By 1970 the gay political movement was multiplying with new political organizations throughout America and a newly formed church denomination preaching gay viewpoints. For many homosexuals gay liberation and new gay social organizations filled core relational and identity needs, but not all gay identified individuals welcomed the new social institutions. One male prostitute quoted by a *Village Voice* reporter stated, "the movement doesn't understand hustling, those guys don't give a shit about hustlers, hustlers are an embarrassment, they can take their liberation and shove it."[44]

Conclusions

In 1973 there was a lot of evidence that showed that the homosexual life was destructive for many homosexuals, but the evidence was interpreted differently depending on point of view. Some mental health professionals sided with the gay viewpoint and saw the social discrimination endured by homosexuals as the cause of virtually all destructive homosexual behavior. Other medical professionals saw the

destructive aspects of the lifestyle as the result of the psychopathological factors that caused homosexuality.

Judd Marmor asked in 1965, "Is homosexuality an 'illness,' or is it merely a different way of Life'?" Marmor then used Evelyn Hooker's findings to conclude "that sexual deviance in itself does not necessarily mean social maladjustment. ... this limitation may not necessarily interfere with reasonably satisfactory life adjustment."[45] From Hooker's and Marmor's professional viewpoint if a homosexual man sought promiscuous homosexual sex and functioned otherwise normal, his lifestyle should not necessarily be seen as destructive. It didn't matter what caused the man's homosexuality. To them the homosexual life should just be considered another way of life. Their position was more of a philosophical opinion on sexual morality than a medical opinion.

Irving Bieber saw the homosexual lifestyle as a reflection of a psychopathological disorder. "Homosexual society, however, in which membership is attained through individual psychopathology, is neither 'healthy' nor happy. Life within this society tends to reinforce, fixate, and add new disturbing elements to the entrenched psychopathology of its members."[46] Bieber saw his positional statement as a medical opinion, not a moral opinion. Bieber implied said that the gay bars, the baths, the gay cliques, and even the gay political organizations reinforced the psychopathology of the homosexuals who were a part of them.

A situation occurred in England before 1973 that shed light on the male homosexual lifestyles. In 1967 legislation was enacted in England that "made it legal for consenting adults to perform homosexual acts in private." In the August 29, 1971 edition of the London Times it was reported that the legislation had not affected the occurrence

of homosexual activity in public places like the "cinema and Victoria Station, public lavatories and public parks." Homosexual acts continued to occur in these places "just as they did before the 1967 act."[47] The risk of being arrested seemed to be just as much a part of the lifestyle of some male homosexuals as was indiscriminate sex. To the psychoanalyst this fact was evidence of a masochistic aspect in homosexuality and it supported Edmund Bergler's hypothesis that some cases of homosexuality are similar to criminosis.

There were cases of homosexuals having long term relationships before 1973, but they were considered rare by both those who saw homosexuality as a disorder as well as by those who supported homosexual equality. Alfred Kinsey wrote in 1948, "Long time relationships between two [homosexual] males are notably few."[48] Questions at the basis of homosexual relationships can be asked. Many in the homosexual community do not share the moral norms of the majority culture regarding sex, so why should they value monogamy over promiscuity? Are homosexual attempts at long term monogamous relationships an attempt to reproduce a culturally defined substitute relationship?

Sandor Rado introduced the cultural substitute concept in 1949, "the male-female sexual pattern is not only anatomically outlined but, through the marital order, is also culturally ingrained and perpetuated in every individual since early childhood. Those forced to take a mate of their own sex still strive to fulfill this pattern-by approximation. Such is the hold upon the individual of a cultural institution based on biological foundations. Naturally, neither the individual nor society is aware of the operation of this mechanism; the individual develops guilty fears, and society is ready to prosecute him under its laws."[49]

For many homosexuals, especially as they aged, the homosexual lifestyle was bittersweet or bitter. Homosexual playwright Tennessee Williams wrote this script in 1970 for a character identified as "Young Man." "There's a coarseness, a deadening coarseness, in the experience of most homosexuals. The experiences are quick and hard, and brutal, and the pattern of them is practically unchanging. Their act of love is like the jabbing of a hypodermic needle to which they're addicted but which is more and more empty of real interest and surprise."[50] If this prose accurately described the lives of many homosexuals, it is no surprise that many would seek treatment to change their sexual orientation.

Notes

[1] Hooker, "Male Homosexuals," 97.

[2] Bieber, "Clinical Aspects of Homosexuality," 248.

[3] Bieber, *Sexual Inversion*, 254-5.

[4] Ibid., 259.

[5] Bieber et al, *Homosexuality – A Psychoanalytic Study*, 253-4.

[6] Hatterer, *Changing Homosexuality*, 1970, 394.

[7] Ibid., 197.

[8] Ibid., 193.

[9] Ibid., 395.

[10] Ibid., 397.

[11] Socarides, *Overt Homosexual*, 135-6.

[12] Wilbur, "Clinical Aspects," 279.

[13] Mayerson and Lief, "Psychotherapy of Homosexuals," 322.

[14] Johnsgard and Schumacher, "Experience of Intimacy," 169-171.

[15] Bergler, *Disease or Way?* 296-7.

[16] Ibid., 297.

[17] Ibid.

[18] Sonenschein, "Ethnography of Male," 84-7.

[19] Ibid., 89-90.

[20] Ibid., 90-2.

[21] Ibid., 93-6.

[22] Ibid., 96.

[23] Leznoff and Westley, "Homosexual Community," 163, 170-1.

[24] Simon and Gagnon, "Homosexuality: The Formulation," 24.

[25] Ibid., 26.

[26] Ibid., 27-8.

[27] Ibid., 28.

[28] Hooker, "Male Homosexuals," 87, 91.

[29] Ibid., 94, 98-9.

[30] Ibid., 96-7.

[31] Ibid., 99-100.

[32] Ibid., 100.

[33] Hooker, "Adjustment," 154.

[34] Hooker, "Male Homosexuals," 101.

[35] Bowers, "Homosex: Living the Life," 114-5.

[36] Reiss, "Social Integration," 249-276.

[37] Ibid., 262-277.

[38] Hatterer, *Changing Homosexuality*, 177-8, 180.

[39] Ibid., 178-9.

[40] Ibid., 179.

[41] Socarides, *Overt Homosexual*, 76-9.

[42] Ibid., 138-143.

[43] Black, "Happy Birthday," 97, 99.

[44] Bell, "Meeting two hustlers," 139.

[45] Marmor, "Introduction," in *Sexual Inversion*, 15-6.

[46] Bieber et al, *Homosexuality – A Psychoanalytic Study*, 317.

[47] Socarides, *Beyond Sexual Freedom*, 107.

[48] Kinsey, Pomeroy, and Martin, *Male*, 633.

[49] Rado, "An Adaptational View," 117.

[50]Socarides, *Beyond Sexual Freedom*, 105.

Chapter 3

Treatment of Homosexuality Before 1973

"Every man troubled or untroubled by his past or present homosexual history who seeks help can derive some benefit from counsel, even if it only reassures him. However, discrete guidelines do exist as to who is most treatable and who is most capable of achieving specific goals."[1]

Lawrence J. Hatterer, M.D. (1970)

Opening note

In addition to psychotherapies, many treatments to "cure" homosexuality had been tried by 1973. Several would be called cruel by today's standards. Most did not work well, and numerous did not work at all. The nineteenth and twentieth centuries were a time of professional experimentation to alter behavioral disorders. Many of the same treatments that were tried on homosexuals were tried on alcoholics, drug addicts, exhibitionists, and a host of other aberrant behaviors. This chapter will review the most recognized treatments for homosexuality before 1973 with the main focus on the one with significant success - psychotherapy.

Extreme treatments discredited by 1973

In his book *Gay American History* Jonathan Katz reviewed many types of treatments that were used to "cure" homosexuality before 1973. Katz wrote from a gay activist point of view and did not include in his list of treatments any prominent works of the time that showed success. Nevertheless, his book on gay history is a resource of what treatments did not work, what was cruel, and what bordered on cruelty.

Castration

Castration and electric shock treatments were probably the cruelest type of medical treatment for homosexuality cited in Katz's book. It was known by the early 1950s that castration did not change the sex drives of perverts or homosexuals; it only lowered the intensity of the sex drive.[2] Katz gave two accounts of castration as a treatment for homosexual fantasies and behavior. The castrations occurred in 1914 and 1894. One man sought the castration procedure himself; the other man had surgical castration based upon the advice of friends. The man who sought castration lost his same-sex attractions and became asexual, while the man who was castrated on the advice of friends did not lose his same-sex attraction and within two months of his castration surgery he shot the male love interest he had been obsessively pursuing before the surgery.[3]

Electro-shock therapy

Two cases of electro-shock therapy cited by Katz before 1973 showed no impact on the individual's homosexual drive. The first case in 1944 involved a 23-year-old man who lived in a fantasy world that caused him to get in trouble with the police and

eventually landed him in a mental institution. He received electro-shock therapy in the mental institution and it temporarily removed him from his fantasy world, but the electro-shock therapy never removed the man's homosexual orientation, nor was it stated that the main goal of the electro-shock was to remove his homosexual orientation. The other case listed by Katz was of an anonymous male who claimed his parents committed him to a state mental institution in the 1960s and authorized electro-shock treatments on him due to his overt homosexuality. The result of this cruel treatment was that his homosexual desires did not change.[4]

Hormone treatments

It was well documented by 1950 that the treatment of homosexuality with hormone medication was ineffective. An experimental study on eleven male homosexuals in the early 1940s found that hormone medication increased the homosexual drive more times than it reduced it.[5] In 1965 hormone specialist William Perloff, M.D. published this summary on hormone treatments, "Estrogenic substances administered to homosexual females do not alter either the sexual drive or the choice of sex object. Large doses of estrogens administered to male homosexuals occasionally reduce their sexual drives but do not influence the choice of sex object. ... Androgenic substances, particularly testosterone, do not change the choice of sex object of either male or female homosexuals. They do however, when employed in large amounts, tend to increase the sexual activity."[6] Psychiatrist D.J. West reviewed hormonal treatment for homosexuality in 1968 and "found little evidence for the use of hormones in the treatment of homosexuality, the major finding being that androgenic hormones stimulate sexual desire without altering the direction of sexual interest."[7]

Aversion Therapy

K. Freund

Aversion therapy is a behavioral therapy aimed directly at the behavioral problem a person has without regard to what caused the behavioral problem. Aversion therapies were designed to be a quick fix and were not developed until the 1950s. Those who experimented with them were seeking a therapy method that was effective and less time intensive than psychotherapies.[8]

Aversion therapy was used for many behavioral problems before 1973, especially for alcoholism. It consisted of creating a series of negative physical reactions (aversions) in the patient and a method of associating the aversion to the problem behavior. The negative physical reactions were usually induced through nauseating drugs or mild electrical shocks. On other treatment days a series of positive physical reactions would then be associated to a stimulus related to the desired behavior.

One well documented therapist who experimented with aversion therapy in the treatment of homosexuality was K. Freund. In one of Freund's studies (1960) he gave 67 male homosexuals a chemical mixture made to produce nausea and vomiting. As the symptoms of nausea would come upon these men they were shown slides of males. In the second phase of this treatment Freund gave these men a mixture containing testosterone and then showed them slides of females. The results were not very good. Of the 67 male homosexuals in treatment, the twenty who had been referred by the courts were only able to make a heterosexual adaptation that lasted at most a couple of weeks. A three year follow up showed that of the remaining 47, "12 had shown some long term heterosexual

adaptation." A second follow-up two years later found that "None of them were able to claim complete absence of homosexual desires, and only 6 a complete absence of homosexual behavior."[9]

M. P. Feldman and M. J. MacCulloch

Feldman and MacCulloch wrote a book in 1971 on their experiments using aversion therapy to treat homosexuality. Their aversion therapy method used an electrical shock created by an 18 volt battery. What differed in the Feldman/MacCulloch therapy was that the patients brought in their own stimuli (pictures) whenever possible and the patients could avoid most of the electrical shocks by removing the stimuli from the screen. They categorized their type of aversion therapy as anticipatory avoidance, because the patient could avoid the adverse effects being imposed on them.

Feldman and MacCulloch's study was conducted on 43 homosexual patients who received an average of twenty sessions of treatment each. "In all cases, treatment was continued until either a change of interest occurred or it became clear that no change was likely," except for seven who terminated treatment early on their own. Of those who completed treatment, twenty reported "no overt practice or phantasy" after follow-up periods ranging from a year and a half to three years.[10]

In a second study Feldman and MacCulloch compared their anticipatory avoidance conditioning with classical aversion therapy conditioning and found no significant difference in the degree of success.[11] What they found of significance in the studies was that there were increased rates of success for those homosexuals who had "experienced past pleasurable heterosexual behavior." In the second study this differential was examined more thoroughly. 81% (17 of 21) of the homosexuals with past

pleasurable heterosexual behavior improved at some stage of the therapies toward a lessening of homosexual attraction and an increase in heterosexual attraction. In comparison only 22% (2 of 9) of those without this past pleasurable experience showed similar improvement. Another significant finding in the Feldman and MacCulloch study was that all their patients who were "suffering from a disorder of the self-insecure type, uncomplicated by any other disorder or abnormalities of personality, made a satisfactory response to treatment," whereas, their "patients, mainly suffering from personality disorders of the attention-seeking type," had little success in altering their homosexuality.[12]

Irving Bieber perspective

Irving Bieber was arguably the most recognized mental health authority on treating homosexuality in the nineteen sixties, and Bieber was very skeptical of aversion therapies to treat homosexuality. His opinion of them in 1967 was that although some good results had "been reported, this type of treatment seems to add injury to preexisting injury. It has given little promise of lasting results and at best is ineffective."[13]

Psychotherapy introduction

It was Sigmund Freud who was most responsible for developing the principles of psychotherapy at the beginning of the twentieth century. It quickly became known as "the talking cure." There were several types of psychotherapies developed before 1973 and this introduction will examine psychotherapies from a pre 1973 perspective. Psychotherapies were described as being interrelated and on a continuum. The most time intensive and delving psychotherapy was psychoanalysis, and it was used only by trained

psychiatrists. Psychoanalysis often took years and thousands of hours of treatment. The goal of all psychotherapies was to make a positive change in the patient's personality by dealing with hidden emotional problems or neuroses.

What is a neuroses? The *Comprehensive Textbook of Psychiatry* 1967 edition described neuroses this way. "Neuroses develop under the following conditions: (1) There is an inner conflict between drives and fears which prevents drive discharge. (2) Sexual drives are involved in the conflict. (3) The conflict has not been 'worked through' to a realistic solution. Instead, the drives which seek discharge have been expelled from consciousness through repression or another defense mechanism. (4) The repression merely succeeded in rendering the drives unconscious; it did not deprive them of their power and make them innocuous. Consequently, the repressed tendencies have fought their way back into consciousness, disguised as neurotic symptoms. (5) Finally, an inner conflict will lead to neurosi in adolescence or adulthood only if a neurosis, or a rudimentary neurosis based on the same type of conflict, existed in early childhood."[14]

What made psychoanalysis different from other psychotherapies was that it sought to create an illusionary relationship between the patient and the analyst. The treatment required the patient to lie on a couch with the analyst behind him and out of view. With the analyst out of view the talking relationship sought to eventually recreate a parent-child environment. As emotional problems arose from the patient's childhood the patient tended to view the analyst as the parent or person to whom the emotional problem was tied to. This phenomenon was called the transference neurosis. It might take a year of four treatments every week to get the transference neurosis to the point where the psychiatrist would uncover the root causes of the patient's neurosis. The psychiatrist then

determined the right moment to interpret the experience to the patient and show him how his wounding experience had stunted his growth as a person. As the therapy process continued the psychiatrist sought to enable "the patient to deal with the material which has been uncovered," by developing his ability "to evaluate objectively his own emotional experiences – at first through the eyes of his analyst, and later through his own." [15]

While psychoanalysis was limited in use by the time element, its cost, and on what patients it was suited for, psychoanalytic psychotherapy was more versatile and used more often in the decade before 1973. Unlike psychoanalysis, which uncovered and worked through "infantile conflicts as they may arise in the transference neurosis, psychoanalytic psychotherapy takes as its focus current conflicts and current dynamic patterns." It was based on analytic concepts similar to psychoanalysis, but the patient and analyst were generally "in full view of each other" making the therapist "seem a more real person." Consequently, transference was limited in psychoanalytic psychotherapy, but it still occurred. The patient was often helped by "corrective emotional experiences."[16] These were little episodes of awareness where the patient's fantasies were undone, or positive behavior or relational patterns were learned.

In general the various psychoanalytic psychotherapies were defined in the late sixties/early seventies by what they placed the most emphasis on. They all included insight, support, and relationship between the therapist and the client, but each distinct psychotherapy emphasized one of those elements more than the other two. It was the job of the therapist to diagnose the patient and choose which emphasis would be the most effective treatment. Support and relationship psychotherapies were suitable for use by

trained non-medical professionals like social workers, psychologists, and various counselors. Support psychotherapy put an emphasis on providing a period of acceptance and dependence for the patient to hopefully restore some impaired capacities. Relationship psychotherapy put its emphasis toward the therapist maintaining attitudes toward the patient that mirrored those of a good father, mother, or older sibling.[17]

Another psychotherapy similar to relationship psychotherapy was developed called client-centered psychotherapy. This psychotherapy put an emphasis on valuing the patient "as a self-responsible person, rather than an object for treatment." It was based on "the concept that the therapeutic success is dependent not primarily on the technical training or skills of the therapist, but on the presence of certain attitudes in the therapist." Those attitudes included: the therapists genuineness; his "unconditional positive regard for his client; and a sensitive and accurately empathic understanding of the client by the therapist." The client-centered approach had a wide following in the non-medical fields of counselors, teachers, clergy, and social workers.[18]

Also included in the psychotherapy heading was group therapy and individual/group therapy. In individual/group psychotherapy the therapist saw the client in individual sessions and in a group setting which the therapist moderated.

An important point to add to this introduction on psychotherapy is that sometimes an inexact interpretation by a therapist can give a patient comfort while not giving him true insight to his psychological problem. In this situation the inexact interpretation gives the patient an intellectual idea which he uses to rationalize his own problems. The patient's anxiety may be lessened, but the underlying problem is passed over. Sometimes an inexact interpretation "may restore a workable, but neurotic equilibrium" to the

patient. "At times they are resting places in the search for a more adequate understanding."[19]

Reparative psychotherapy

I have labeled this approach to treating homosexuality as "reparative" because from the clinical research on homosexuality this group of psychoanalysts believed that homosexuality often served as a reparative function or symptom of psychological wounding and impairment in childhood. Experience and clinical data led them to believe that a dysfunction in the psyche was at the root of most, if not all, perverse impulses and behavior. These therapists believed that changing a homosexual orientation to heterosexual was in the best interest of the patient who desired such a change. Reparative psychoanalysts consistently found that to treat a psychopathological condition in a homosexual client, the homosexuality also had to be treated. For the homosexual who was not able to change their sexual orientation or who did not want to, reparative psychoanalysts helped them overcome destructive behavior and interpersonal problems so that they could have a better life. Reparative psychoanalysts continued down the theoretical paths of Sigmund Freud and Sandor Rado.

Edmund Bergler

Edmund Bergler was an early pioneer in psychotherapy who successfully used theoretical Freudian concepts of the conscious and unconscious in clinical psychoanalysis. Over a period of thirty years Bergler helped 100 homosexuals overcome their homosexuality by exposing the masochistic substructure of their homosexuality, then helping the clients understand it and work through it. In a 1942 lecture he suggested

that psychoanalysts not accept every homosexual who presented themselves for treatment of their homosexuality. Bergler was the first to articulate that certain characteristics were necessary for psychotherapy to help a homosexual with the eventual goal of changing sexual orientation. Some of his suggested prerequisites were that the client have "inner guilt feelings" that could be put to therapeutic use, the client "voluntarily" accepted treatment, the client's "self-damaging tendencies" should not be too extensive, the client should not have the mindset that sexual orientation can not be changed, and the analyst needed to understand and use the "newer therapeutic procedures." Fourteen years later when he wrote his pioneering book on homosexuality he still subscribed to these prerequisites.[20]

Bergler informed psychoanalysts that a successful psychotherapeutic outcome where there is a complete lack of interest in homosexual gratification and "characterological change" would generally take one to two years "with a minimum of three appointments each week." Because of the extensiveness of the treatment and the cost to the client, Bergler recommended a "four-to six-week trial treatment" to ascertain whether the homosexual client was suitable for psychoanalytic treatment. Suitability for treatment would be determined by evaluating "the quantitative state of the patients masochism, as displayed in his past history," and his ego's elasticity and reactions when the analyst makes him "face his own masochism."[21]

Bergler described the clinical picture of psychic masochism as consisting of three steps. "1. Unconsciously, the psychic masochist provokes disappointment or refusal," then he unconsciously identifies the outer world "with the image of the 'refusing' mother of the earliest stage of development, the pre-Oedipal, 'gimme' phase." ... "2.

Pseudoaggression ... aimed not at the outer enemy but as alibi presented to the unconscious conscience." ... "3. Still unaware of the part he has unconsciously played, the psychic masochist consciously pities himself for his defeat and humiliation; at the same time he unconsciously enjoys masochistic pleasure."[22]

Bergler's case examples at the end of chapters ten and eleven in his book show the power of this psychoanalytic technique. One case he documented was a male transvestite he referred to as P. This man, who believed he was a woman, came to Bergler for treatment with an ulterior monetary motive. Client P. had no desire to change his sexual orientation or gender identity. P. entered psychotherapy to qualify for an inheritance. That motive was exposed by Bergler and when the motive no longer existed the man had progressed so much that he continued treatment and eventually became heterosexual and happily married.[23]

In one session Bergler was able to show P. he had a fear of women. At the appropriate time Bergler suggested that P.'s imitation of a woman was a camouflage and that he was inwardly "deeply afraid of women." When P. asked Bergler why he believed that, Bergler responded, "Because your two great enemies in childhood were your mother and your sister. ... let's test my suspicion. How well are you informed of the anatomy of the female genitalia?" ... P. "was genuinely astonished when the anatomical details were explained to him. 'Well,' I [Bergler] said, 'there is only one possible reason for such ignorance: fear.'"[24]

One piece of helpful advice Bergler gave was focused on the patient who had successfully completed psychotherapy and now identified as heterosexual. "In the end stages of successful analyses of homosexuals, after they have given up all homosexual

activity, one occasionally finds the wish for homosexual sex in fantasy. The advice, useful on such occasions, is simple: 'If at a particular moment you want to express masochism, why exactly via homosexuality?' A long series of patients (now ex-patients and cured) reported that this question – asked of oneself and answered by oneself at the specific moment – killed the homosexual wish with regularity. Of course, this is characteristic of a transitory period only."[25] This tactic was significant because science would later find that the brain can be rewired, but old imagery, psychic wounds, and psychic masochism origins are never completely erased. Bergler probably over-estimated the totality of the sexual orientation change his clients experienced, because later clinical data showed that homosexual fantasy occasionally occurred for years after homosexual clients had changed their sexual orientation.

Bergler criticized analysts who treated homosexuality as a problem of feminine identification. He argued that that diagnosis was an ineffective interpretation of homosexuality and it had little chance of helping the homosexual reach a goal of heterosexuality. Bergler also pointed out that an analyst has to be aware that temporary successes occur that are not really psychoanalytic successes. Sometimes when the client's "real basic motives" are touched upon the client reacts defensively by unconsciously renouncing his symptoms "in order to keep his general psychic structure intact." These successes are "abrupt transformations" and "there is no evident connection between the working through of the material in transference. … there is the virtual certainty of a relapse in these pseudosuccesses."[26]

Irving Bieber

Irving Bieber was insistent that homosexuality could be treated successfully. Like Bergler, his view of a successful treatment included a change in sexual orientation. Bieber with several medical colleagues produced a comprehensive study on the treatment of homosexuality in 1962. Through the techniques of psychotherapy "approximately 30 percent [29 of 106] of homosexuals in this study became and remained heterosexual."[27]

The treatment of choice for homosexuality was "psychoanalysis or psychoanalytically oriented psychotherapy. In reconstructive treatment, emphasis is placed on delineating the irrational fears of heterosexuality, helping the patient learn how his fears developed, and, over the course of time, helping him resolve his fears." Bieber informed the psychiatric profession that in "the psychoanalytic treatment of male homosexuals, the fear most centrally related to the avoidance of heterosexual involvement is attack from a male competitor. The homosexual anticipates the attack as primarily physical and murderous and secondarily as a threat of rejection by significant males."[28]

In the evaluation of the homosexual client the Bieber study pointed out several factors that favored a sexual orientation change as well as other factors that reduced the chances for its success. Favorable factors included: "(1) a wish to change verbalized at the outset of treatment; (2) respect and admiration for one's father; (3) beginning treatment before the age of 35; (4) a history of having attempted heterosexual intercourse; (5) dreams with manifest content depicting heterosexual interest or activity." The factors making sexual orientation change less likely were "a history of the mother having openly preferred the patient to her husband and a history of effeminate voice and gestures during childhood." Bieber further encouraged psychotherapists by recognizing the smaller

successes of psychotherapy. The experience of clinicians had shown that "even where homosexual patients have not shifted to heterosexuality, they have at least gained benefits from resolving interpersonal problems and other difficulties."[29]

Although Bieber did not go into much detail about the prevention of homosexuality, he stressed it. He believed the best approach to its prevention was "early detection of homosexual tendencies and public education. Most prehomosexual children exhibit characteristic problems and behavior. [Referring to boys] They tend to be inordinately fearful of physical injury; they are apt to avoid the scrambles and bruises in games of normal boys. ... Such boys are the ones other children recognize as different. They are called 'sissies' and are made the butt of peer group hostility." Bieber contended that if these preadolescents and adolescents entered into psychotherapy with their parents, it was quite possible for early treatment to "resolve the underlying problems, enough at least to prevent the consolidation of a homosexual adaptation. ... If a prehomosexual adolescent can be detected and treated before homosexual activity is attempted, prognosis for recovery is far more optimistic than if he is treated later." Bieber saw public school teachers along with parents, clergy, and physicians as the vanguard to detect and direct the prehomosexual child and his parents into psychotherapy.[30]

Lawrence J. Hatterer

Lawrence Hatterer provided clinical treatment to over 200 men with various involvements in homosexuality. Of the patients that Hatterer had follow up data ranging from one to fifteen years "forty-nine patients recovered [changed their sexual orientation], nineteen partially recovered, seventy-six remained homosexual."[31] In a book published in 1970 Hatterer provided detailed information on techniques useful to

therapists. A review of his information can be broken down into four broad areas: (1) evaluating the possible underlying causes of the homosexuality, evaluating the possibility of a successful heterosexual change, and determining the goals of an individual patient's treatment; (2) the role the therapist's attitude plays in treatment and the therapist's protocol with the patient; (3) equipping the patient for sustained change after therapy is completed; and (4) working with committed homosexuals. A summary of those four areas follows.

(1. Evaluating)

The goals the therapist and patient set depended on the patient. Additionally both the therapist and patient needed to know why the patient was seeking his goals. Of utmost importance for the patient with the goal of heterosexual change was a "conscious motivation to change in the direction of heterosexuality." Without a conscious motivation Hatterer predicted the patient would not be able to change through psychotherapeutic treatment. Another key factor for successful heterosexual change was early treatment. Although older patients had achieved change toward heterosexuality, "The younger the patient and the fewer his overt homosexual experiences in late adolescence and/or early adulthood, the better the prognosis."[32]

Hatterer recommended that therapists assess several determinants that could have been causal factors of the homosexuality or could be indicators of a successful treatment. In Appendix 1 Hatterer provided twenty pages of assessment guidelines using fourteen different variables. Each variable listed characteristics that were rated highly treatable, moderately treatable, or palliation. The variables examined motivation, diagnostic

factors, and historical factors from homosexual fantasy to family relationships, ego, self-image and social factors, desired goals, and the patient's reaction to therapy.[33]

(2. The therapist)

Hatterer advised the therapist treating a male patient with a homosexual condition to express optimism toward the heterosexual change possibility at the appropriate times. The therapist in many instances has to overcome the pessimism of the patient "from superficial, inaccurate, and pessimistic psychiatric literature." Hatterer found that "The most positive of all therapeutic approaches is for the therapist to treat the patient on a man-to-man basis . . . thus communicating his sense of respect for the patient acknowledging all areas of his intact maleness. . . . A nonerotic exchange of warmth can be enormously helpful." A therapist should encourage the patient's attempts at maleness and his efforts to establish appropriate female contact. Specifically, "the therapist must support any and all of his attempts to free himself from a binding relationship with his mother, sisters, or other dominant females in his life." While Hatterer recommended a therapist express a "tolerant, quiet, nonpunitive, and neutral reaction" towards a male "patient's stereotyped expressions of femaleness," he alternately advised the therapist to "interpret and discourage a patient's transference distortions," which would result in the recreation of an unhealthy mother-son/father-son relationship.[34]

In communication during therapy Hatterer advised the therapist to tell the patient early in treatment "that all homosexual imagery will not disappear and that he should not be discouraged by reappearances of homosexual attractions during therapy and later in life." The patient should be informed "that his problem is not solely a sexual one" and "he will never know every factor that contributed to the development of his particular

brand of homosexuality." Suggested realistic encouragement included conveying the evidence that specialized therapists reported "23 percent to 28 percent of the motivated patients totally capable of a heterosexual readaptation." Other suggested communications to motive the patient were "discussions of the slim possibilities of success for any permanent homosexual relationship and the frequently damaging consequences of a homosexual lifestyle." "Finally, the therapist has to be neutral with regard to the patient's ultimate choice and adaptation. He has to assure the patient that the responsibility for the choice is his and his alone."[35]

(3. Sustaining change)

Sustaining a heterosexual adaptation is the barometer of success for this type of psychoanalytic therapy and Hatterer devoted a section of his book to discuss methods a patient could use to sustain change and overcome pitfalls that he may face. Hatterer began the section by telling the therapist that the most effective way he can help a patient sustain change is to make him aware of "what specific historical, environmental and interpersonal dynamics trigger his particular form of homosexuality. . . . He should be reassured that he can discover and use the knowledge of the specific trigger mechanisms of his homosexuality at the very time that they take place." The many possible trigger mechanisms discussed by Hatterer reflected the complexity and multiple causal factors of homosexuality. By imparting this knowledge to the patient the therapist helped the patient thwart his impulsive fantasy, which in turn helped sustain change.[36]

Hatterer emphasized that in the final stages of therapy the therapist needed to continue to inform the patient who has actively practiced homosexual behavior for "a significant period of his adult life" that his past homosexual consciousness cannot be

totally removed. Relapses can occur during therapy and the patient may question "his decision to become heterosexual . . . A therapist obviously cannot allow himself to become entrapped in the patient's ultimate decision to become heterosexual. The decision is the patient's. Patience has to be a by-word. Without patience, the patient will expect a more complete removal of every vestige of his homosexuality too soon and not arrive at reasonable goals before terminating therapy."[37]

(4. The committed homosexual)

Hatterer's last chapter discussed therapy with homosexuals who did not come to a therapist to change their homosexual adaptation. It was Hatterer's observation that once men had lived in the homosexual subculture for three or more years, they "consciously declared their commitment to a homosexual way of life." The majority of these committed homosexuals in Hatterer's study did not wish to change to a heterosexual adaptation. Hatterer told the therapist that it was his responsibility to determine whether the emotional problems the committed homosexual sought corrected were related to his homosexuality or incidental to it. Of those who did not wish treatment for homosexuality "few, if any, who did come for treatment were completely devoid of difficulties related to their homosexuality. A therapist cannot ignore the relatedness of their homosexuality to these other problems." Some of the "interpersonal problems and psychodynamics" that appeared most frequently in Hatterer's committed homosexual patients were: "chronic rejection, separation, and/or abandonment of one homosexual by another after a transient contact or a temporary or long-standing relationship; . . . the inability to tolerate the promiscuous and transient patterns of depersonalized sexual behavior so prevalent in men committed to homosexual adaptations; . . . problems occur in establishing a balance

between and sustaining submission and dominance or passivity and aggressivity, that is, male-female role-playing in the committed homosexual's relationships. . . . They often result in sado-masochistic patterns of behavior between homosexual partners which generally threaten or even destroy one partner or the other; . . . Many committed homosexuals are highly vulnerable to exploiting others or to being exploited." Hatterer observed in some of his committed male homosexual clients paranoid reactions due to their "unconscious and conscious response to society's behavior and attitude toward homosexuality;" and addictions "to homosexual preoccupations and practices."[38]

Hatterer identified problematic reactions a committed homosexual may develop from the homosexual subculture he has attached himself to. The most common being: "guilt over depersonalized, degraded, and excessive humiliating sexual practices; fear of and simultaneous need to court danger in pursuit of sexual activity; development of cynical attitudes, cruel humor, and hostile, sadistic, and/or masochistic behavior; total inability to sustain any emotional contact or to be loyal or honest in interpersonal relationships; inability to tolerate any aspect of the 'establishment' and/or authority; and an inability to relate to women on any level."[39] These are areas in which Hatterer believed psychotherapy could help the committed homosexual. Hatterer implied that the homosexual that seeks a heterosexual adaptation would also need to work through these problems, if they were present. Hatterer's philosophy was professionally objective; to help the homosexual seeking psychoanalytic therapy whether the patient's goal was to change to a heterosexual adaptation or just to overcome a crisis in his life.

Charles W. Socarides

In his 1968 book *The Overt Homosexual* Charles Socarides emphatically stated that "there is no question that at the present time we have sufficient evidence as a profession to demonstrate that homosexuality can be cured or at least, in most cases, its symptoms and suffering greatly alleviated by medical psychoanalysis." [40] Socarides reported that of the strongly motivated homosexual patients he had treated four to five times a week, over 50 percent changed their sexual orientation to heterosexual.[41] Of the total sample of overt homosexuals that Socarides treated approximately 35 percent "developed full heterosexual functioning and were able to love their other-sex partner."[42] "The major difficulty in treating homosexuality has been the misconception that this disorder was of hereditary origin, the patient commonly believing that he 'was born that way.'"[43]

Like Lawrence Hatterer and Irving Bieber, Socarides emphasized that early psychoanalytic treatment increased the probability of "therapeutic success and prevention of further maladaptive processes. Adolescence is a highly favorable time to undertake psychotherapeutic measures to combat homosexual behavior despite the serious technical difficulties ... At this stage we can more readily undo recent overt homosexual behavior, redirect urges toward heterosexuality, reduce fear and guilt as regards heterosexual strivings and thereby begin to establish a firm basis for rewarding sexual maturity."[44]

Socarides explained, "the selection of patients with homosexual symptomatology is no different from the selection of all patients for psychoanalytic therapy. The two major considerations are the presence of a feeling of guilt on the part of the patient for the unconscious wishes experienced under the guise of homosexuality and that psychoanalytic treatment must be voluntarily undertaken. The absence of conscious guilt

does not mean that the patient does not suffer guilt ... Once seen as an internal conflict the patient is at last on the path toward resolution of his homosexuality and no longer can view himself as the victim of society's attitudes and judgments."[45]

Socarides continued, "[P]sychoanalysis is the treatment of choice for this disorder. Both preoedipal and oedipal anxieties can be relieved through the revival of infantile memories and traumatic states and the reintegration of the individual achieved. Treatment of preoedipal damage requires in addition to the uncovering techniques of psychoanalysis, educational and retraining measures, more intensive supportive interventions and modifications in the handling of transference, resistance, and regression." In the sessions what the psychoanalyst "attempts to do is to mobilize the patient's feelings and fantasies which accompany his sexual contacts and masturbation. ... In the male homosexual, therefore, we will see that there was once a very strong attachment to the first heterosexual object, the mother. He must re-experience and understand the early frustrations, intimidations and fixations, give up his attachment to his mother and transfer his libidinal interest to other women. Before this aim could reach fruition all developmental phases would have to be investigated including his identification with the father (analyst) in the transference. Analysis of the homosexual patient is global, a total analysis of the personality at all stages."[46]

In *The Overt Homosexual* Socarides spent considerable discussion on different transference situations the psychoanalyst would face treating a homosexual patient. The most universal was the male patient transferring his feelings toward his father to the male analyst. This would occur naturally as infantile memories and traumatic states of childhood were relived in the analyst's office. The analyst had to be aware of what

transference feelings were taking place in his patient. Although the emotional damage that initiated a gender identity dysfunction usually occurred "in the earliest mother-child relationship ... the importance of the father to the child's psychological development cannot be overestimated. To the boy he is the model for masculine identification, giving him a feeling of security in relation to the environment. For the girl it is the father's love which creates a model for heterosexual love in adulthood. ... The patient's turning to heterosexual relationships often coincides with a strong positive transference. In the positive transference the patient is able to identify himself with the good father and thus achieve in the transference what he had been unsuccessfully trying to achieve in homosexual relationships ... Then through an identification with the good father he can feel stronger and new possibilities in life appear."[47]

"The female homosexual, even more than the male homosexual, suffers from intense feelings of inferiority and self-depreciation which may be completely unconscious and result in a proportionately intense reaction-formation of superiority and self-aggrandizement. Therefore, her initial hostility toward the therapist may be quite powerful and the analyst must be prepared for this from the start, not allowing it to impair or disrupt the beginning therapeutic alliance. This hostility also has another source, the feelings of rejection and banishment by the father. ... The female homosexual will enact in the transference her relationship to the father much more vividly than the male homosexual and, upon finding she is not rejected, will put the analyst to the test by attempting to act out directly with him her reawakened oedipal wishes ... Such acting out can become a crucial making or breaking point for the therapy if the analyst does not interpret the meaning of her erotic and dependency demands before they have attained an

unsustainable peak of intensity. If not interpreted early enough the patient can then claim a new humiliation at the hands of the analyst (father) when these demands are not met by him. Very seldom are such importunate demands for direct libidinal gratification made of the analyst by the male homosexual patient."[48]

Both Socarides and Hatterer were straightforward in their guidelines for psychoanalysts treating homosexuality. Their information was based on their research and clinical experience. It was not an easy task to treat problems related to homosexuality, but it was being done successfully by many psychoanalysts and sexual orientation change was occurring in a significant number of cases. Other published studies of psychotherapy being used to change homosexual orientation to heterosexual showed varying success. A. Ellis reported 44 percent of his homosexual clients changing sexual orientation in 1956, M. Ross and F. Mendelson 20 percent in 1958, R.R. Monroe and M.L. Enelow 12 percent in 1960, P. Mayerson and H. Lief 40 percent in 1965, and L. Ovesey only 3 percent in 1969.[49]

Each individual's homosexuality was unique in itself, based on any number of causal factors, and a psychoanalyst needed the expertise to adjust his treatment to those factors. Each psychoanalyst was unique in their understanding of homosexuality and their skill in psychotherapy. The psychoanalyst's expertise and judgment were vital because there was "no guarantee that two homosexual patients or any two individuals with the same symptomatology will react similarly to the same technical procedure."[50]

Combined group and individual therapy

Elizabeth Mintz

Psychologist Elizabeth Mintz used a combination of group therapy and individual therapy for her homosexual patients. When Mintz wrote her essay on 10 homosexual patients she was treating in the early 1970s, five of the ten patients were still in treatment. Of those five, "one lost interest in homosexuality" and was enjoying "satisfying heterosexual relationships." Three of the other four still in treatment were "moving toward heterosexuality, but with considerable anxiety and conflict." Of the five who had already terminated their treatment, two "accepted themselves as homosexuals," two were "enjoying heterosexuality," and one remained in conflict.[51] .

Mintz's observations of the 10 male homosexual patients that remained in her treatment for at least two years was insightful and offered another alternative approach to the treatment of homosexuality before 1973. Mintz's psychotherapy involved group therapy once a week and individual therapy once to three times a week. The most unique aspect of her group therapy was that the groups always included heterosexual men and women. Preferably two homosexuals at a time were part of a larger group session. Mintz intentionally informed the homosexual patients "that she would make no attempt to 'cure' the homosexuality . . . It would be the patient's choice whether or not he would attempt to alter his homosexual adjustment."[52]

The advantages of the group therapy with heterosexual men and women were noted by Mintz. Usually, the group accepted "homosexuality in a matter-of-fact way as just another human problem. . . . Within the protection of the group as a whole, the homosexual patient then has a chance to explore what social disapproval means to him and how he handles it." A frequently noted rationalization that Mintz observed from male homosexuals was "that homosexuality is a different but equally normal way of life, or

even that it is esthetically superior. Groups usually demolish such a rationalization with a forcefulness that the therapist might hesitate to use." An example used by Mintz was of a late teen youth who claimed he was "so delicate and gifted that for him the heterosexual way of life was inappropriate." This young man shared this feeling with his mother and both "Mother and son used his homosexuality to maintain their intense mutual dependency. When the group assailed his claim that homosexuality was somehow precious and superior, the patient's tie to his mother began to weaken, and he developed growing interest in girls."[53]

Other advantages of this type of group therapy were that they often provided the environment where a male homosexual could for the first time "relate to people on the basis of qualities other than gender and sexual preference. . . . Such experiences help the homosexual man to recognize that his identity involves more than being 'a homosexual.'" Mintz also saw this type of group therapy bring out "conflicts centred around the oedipal desire for the mother and fear of the father, especially if the group is conducted jointly by a male and female therapist." Another dynamic of group psychotherapy was its ability to create a "corrective emotional experience." One example Mintz gave was of a homosexual man in his early thirties "who as a child had been ridiculed and labeled a sissy by the neighborhood boys." Through the praises of a heterosexual man in the group, this homosexual man "was able to heal one of the wounds to self-esteem which had contributed to his acceptance of the homosexual role in life."[54]

Mintz had a significant number of homosexuals who dropped out of therapy before two years and they were not included in her essay. She did say that a high proportion of these men held the attitude that their homosexuality was inevitable, because

they were "the victim of tragic or stifling childhood circumstances. In extreme cases, such a man may insist that he is completely helpless to struggle against the effects of his wicked, unwise, or overprotective parents."[55]

Of those homosexuals who sought therapy and chose to accept their homosexuality and adjust to it, Mintz stated that "in general, the homosexual adjustment – like any other – seems more satisfying if anxieties can be diminished and self-knowledge deepened." She acknowledged that there could be "some justification" for helping a patient adjust to his homosexuality rather that "face the deep anxieties behind his homosexuality," if the patient is "so close to psychosis that no defense can be safely relinquished."[56]

Normal variant psychotherapy

I have labeled this therapeutic approach as "normal variant" because the therapists who used this approach believed homosexuality to be a normal variant of human sexuality. Consequently, they emphasized the injustice homosexuals faced in society and generally ignored the etiological and clinical science on homosexuality. Some of these therapists rejected the etiological data simply by calling it insignificant. Typically, they believed that the destructive aspects of the homosexual life were the result of society's persecution of homosexuals rather than the psychopathological patterns related to homosexual etiology. Many normal variant psychoanalysts did not believe a homosexual should be helped to change their sexual orientation, even if that was the patient's desire. The treatment success of normal variant psychotherapy was the homosexual accepting his homosexuality without anxiety or guilt. Most normal variant

psychotherapy emphasized the support aspect of psychotherapy. The psychoanalyst or counselor supported the homosexual attractions of the individual. Normal variant psychoanalysts continued down the theoretical path established by Magnus Hirschfeld.

Magnus Hirschfeld

As a medical professional Magnus Hirschfeld was an early pioneer of the normal variant psychotherapy of homosexuality. Hirschfeld was a homosexual himself and led a German gay-rights organization in the first decades of the twentieth century.[57] In a book he wrote in 1914 Hirschfeld discussed his adaptation therapy which was based on his underlying premise that homosexuality was an innate condition and therefore it cannot be cured. Hirschfeld wrote, "Our first concern is to set the homosexual man or woman at ease. We shall explain that homosexuality is an innate drive, incurred through no fault of the patient, and is not a misfortune in and of itself, but rather becomes so as a result of the unjust evaluation which it comes up against, causing morally fine homosexuals (and we do not only include the abstinent) to 'suffer more wrong than they commit.' We shall further explain that the misfortune of being homosexual is often exaggerated, for many in no way perceive it as such, and that homosexuality alone does not stop one from becoming an able human being and a socially useful citizen. Even though now this is accomplished with considerable difficulty. We shall demonstrate this through historical examples, and then discuss the wide extent of homosexuality in the past and present, in order to free the patient who feels extremely isolated from the torturing experience of loneliness . . . The depressing attempts at sexual relations with the opposite sex should be given up, as should the idea of marriage, which, apart from its lack of consideration for the partner, can only worsen one's own situation."[58]

Key elements in Hirschfeld's homosexual "adaptation therapy" were his list of "worthwhile books" he advised his patients to read, which presented philosophies that valued and encouraged homosexual love. He encouraged the patient to make "contacts with homosexuals of high intellectual caliber," and advised those who had not acted on their homosexual desires to indulge in homosexual activity, "particularly in cases where the suppression of all sexual desire has caused grave neurotic disturbances." To support his prescription of homosexual activity Hirschfeld described a man with severe headaches that caused him to lose "all joy in living." When the man admitted his homosexual inclinations and acted on them the homosexual orgasm took away his headaches and the man subsequently "radiated well-being."[59]

Much of the rest of Hirschfeld's adaptation therapy was advising the patient on how to live in the world as a committed homosexual. He offered patients advice on how to tell their parents and relatives about their homosexuality, on workplace difficulties, and on relationship problems with other homosexuals. Hirschfeld's foremost advice to homosexuals was for them to engage in "regular, intensive work, whether manual or intellectual."[60]

Magnus Hirschfeld founded the world's first Institute for Sexology in 1919, "organizing it into four departments: Sexual Biology, Sexual Medicine, Sexual Sociology, and Sexual Ethnology." Live exhibits at the Institute included "whips, chains, and other sexual torture instruments" used by Hirschfeld's patients in therapy. Hirschfeld conducted the first survey of homosexuality from the "sexual deviants referred to him by the courts" and "Hirschfeld publicly advocated sex between consenting individuals, including adult sex with older children."[61] From the beginning the social justice view of

homosexuality was tied directly to the new academic field of sexology and the minority promoting adult/adolescent sex.

Ralph Blair

In the late 1960s the emerging normal variant philosophy of homosexuality argued that the only pathological aspect of homosexuality was society's disproval of it. This position was not held by many mental health or academic professionals before 1973. One of those who did hold that view was Hendrik Ruitenbeek who served as the chairman of the Board of Trustees for the Homosexual Community Counseling Center in New York City during the early 1970s. This counseling center used a supportive psychotherapy to help homosexuals adapt to their homosexuality. An important aspect of this counseling center's psychotherapy was indoctrination into gay politics. It was a support therapy similar to Hirschfeld's work fifty years earlier in Germany.

The director of the Homosexual Community Counseling Center in the early 1970s was psychoanalyst Ralph Blair. Like Hirschfeld, Blair openly defended his homosexuality as an innate feature of his personhood and was an activist for homosexual rights. Blair's argument for using normal variant adaptation therapy was "that in the absence of sound etiological knowledge and . . . the evidence of the natural occurrence of homosexual phenomena throughout the mammalian class of animals and . . . the difficulties, if not the impossibility, of trying to eliminate a sexual orientation with which many persons can live productive and happy lives, it makes much sense to attempt to enable homosexuals to become more self-actualizing individuals – whatever they may then do sexually."[62]

Although Blair dismissed decades of clinical evidence that showed homosexuality was often a symptom of a psychological disorder, a casual observation of Blair's adaptation therapy showed a similar rationale to the reparative philosophy of psychotherapy; helping homosexuals to overcome their psychological problems whatever sexual orientation they may choose. But from Blair's essay conclusion it was obvious that as a therapist he rejected the concept of a homosexual choosing the goal of changing their sexual orientation, and he accused the psychoanalysts who helped homosexuals change their sexual orientation of "immoral" medical practice. Blair wrote in 1972, "Increasingly, however, it is believed by many therapists that such recommendations of 'cure' are unrealistic and even immoral, and attention is being given to helping homosexuals to live a more self-actualizing homosexual life and to changing societal attitudes and environmental features which have made being a homosexual so difficult. Even the 'healers' among the therapists will begin to find their objectives even more difficult to reach since what they have always admitted was so very necessary to their effecting 'cures' – high motivation to change – is just that which the growth of gay pride is revising the outlooks of increasingly numbers of people."[63]

Ralph Blair had done his research. He understood that motivation to change was not only a key factor for changing sexual orientation through psychotherapy, it was a key factor for altering any behavioral condition through psychotherapy. His strategy as a gay activist and normal variant psychoanalyst was to take away the homosexual's motivation to change their sexual orientation, and he used his professional position as a therapist and counselor to achieve that objective. Gay political indoctrination seemed to be a key ingredient to the "self-actualizing" goal of Blair's normal variant psychotherapy. From

Blair's and Ruitenbeek's viewpoint conflicted homosexuals gained greater benefit from social and political involvement in the gay movement than from time spent with therapists searching for the causes of their homosexuality and other conflicts. Blair taunted the reparative psychotherapists with his strategy and was convinced that the growth in gay pride would eliminate most individual homosexual's motivation to change. Blair's colleague Hendrik Ruitenbeek articulated the homosexual community and normal variant slant to its logical conclusion. It was the parents who viewed homosexuality as a disorder that were in need of psychotherapy, "rather than the homosexuals themselves!"[64]

Richard C. Robertiello

Psychiatrist Richard C. Robertiello's 1973 essay "A More Positive View of Perversions." is a good example of how the normal variant psychotherapy worked in a variety of situations. Hendrik Ruitenbeek described Robertiello as "a new sound in this field, which is badly needed."[65] The essay began, "Traditionally psychoanalysts have viewed perversions as neurotic symptoms that require treatment. Though I agree they are no doubt neurotic symptoms, the requirement for their treatment, in my view, should be based on the degree of subjective discomfort they cause the patient." Robertiello saw perversions as a compromise in an individual's character that fulfilled an unfulfilled need; possibly preventing the individual from doing something worse. From that rationalization Robertiello's goal was not necessarily to stop the patient's perversion, but to prevent the patient from doing something worse. Therefore, he encouraged many of his patients to accept their perversion, "since I think it is the best his ego can do at this point."[66]

The most detailed example of Robertiello's psychotherapy involved an immigrant man whom he counseled for four years. The initial reason the patient saw Robertiello was because he was concerned about his homosexual activity. For years the patient had rationalized to himself that it was easier to find homosexuals to perform fellatio on him than to find a girlfriend, and he was worried that he might be a true homosexual. Robertiello took his patient through psychoanalytic psychotherapy and both he and the patient became aware of several hidden conflicts from his childhood. After working through these conflicts the immigrant confronted his mother and brother about childhood traumas, then married and became a father. Later on a turn of events caused the man to develop a "new symptom." The now married immigrant began going to public rest rooms where homosexuals meet in order to watch them engage in sexual acts, sometimes suggesting sexual acts to them and occasionally exposing himself to them. Robertiello reasoned that this new perversion was an acceptable symptom of the patient's anger and under the control of his ego, so Robertiello encouraged the patient to accept this perversion even though the patient wanted to be rid of it.[67]

Another example Robertiello gave was how he encouraged a "happily married woman who has a need for an extramarital relationship" to continue in and accept her affair, because it fulfilled a need the woman had for adoration. A third example Robertiello gave was of a young man who felt he was not adequately cared for by his mother. Robertiello encouraged the young man to accept his perversion of occasionally picking up "a teenager and then take very good care of him, including feeding him, bathing him and performing fellatio on him." According to Robertiello, "In all instances these perversions are safe, not self-destructive, not dangerous, not truly compulsions or

irresistible impulses but indulgences which do not interfere with the patient's lives or their social, marital or professional relationships."[68] Robertiello concept of judging culturally aberrant sexual behavior by the "degree of subjective discomfort" it caused the individual to experience would be an argument used to remove homosexuality from psychiatry's list of disorders.

Robert Lindner

Robert Lindner's psychotherapy techniques were similar to Robertiello, but rather than seeing homosexuality as a pathological compromise, Lindner viewed homosexuality as "a reaction-pattern of rebellion" against the "sex-conformance pressure" of society. Interestingly, Lindner believed that eliminating society's sex-conformance pressure could possibly eliminate homosexuality, which he observed as the "source of immense quantities of unhappiness and frustration to large numbers of individuals."[69]

One of Lindner's homosexual patients was a man named Ralph. Lindner described him as one of the most tormented men he had ever met. For years Ralph had tried to suppress his same-sex attractions. When he finally succumbed to them in his thirties, he tried to rid himself of his homosexual behavior by getting married, which was doomed from the start. He went back to his homosexual behavior while married and was living in two worlds. Each homosexual affair increased his distress. Ralph was referred to Lindner by his physician after what appeared to be a coronary attack was "diagnosed as a hysterical episode."[70]

"In the analysis Ralph finally faced and acknowledged the truth about himself. He recovered his identity, lost the shame and guilt that had ruined his life so far, and began to rebuild his personality. His tension disappeared and a remarkable change overtook

him." Ralph became free of the "elaborate defenses he had had to maintain in order to hide from himself and preserve a fiction." He became more creative at work and repaired his marriage. Ralph's wife was able to accept a new norm of sexual morality that tolerated his homosexual infidelity. Ralph's main source of sexual satisfaction was in his homosexual liaisons, yet he was, according to Lindner, a "considerate husband" to his wife and an "excellent father." Ralph also used his new sexually liberal philosophy to become a discrete gay activist.[71]

George Weinberg

In 1972 heterosexual psychiatrist George Weinberg dismissed the pathological family environment causation theories of homosexuality as "misinformation" and "popular folklore." Although Weinberg did not offer any evidence to discredit the environmental causation theories, he did offer a theory to explain the distress many homosexuals had. His new theory of "homophobia" was a leap forward in the evolution of normal variant therapy.[72]

Weinberg called homophobia "a disease." Its causation was "the dread of being in close quarters with homosexuals – and in the case of homosexuals themselves, self-loathing." Weinberg maintained that homophobia was a "conventional American attitude" held by the majority. From Weinberg's perspective society's distress over homosexuality was the problem to overcome, not homosexuality itself. According to Weinberg, the foremost underlying cause of homophobia was "the present tradition around homosexuality" that stemmed from "explicit prohibitions against homosexuality in the Bible." Other listed causes of homophobia included "the fear of being homosexual

oneself, ... repressed envy, ... they are seen as constituting a threat to one's value," and "the thought of persons without children reawakens their fear of death."[73]

Weinberg contended that American culture's prejudice against homosexuality was pressed upon children through its Judeo-Christian morality. Therefore, adolescents who discovered that they had same-sex attractions initially felt guilt and contempt for themselves. According to Weinberg that initial self-degradation was the beginning of the homosexual's problem, because "the flight into guilt is not only corrosive and fraudulent. It does not work."[74]

Weinberg's treatment for homosexuality was to help homosexual's overcome their attitudes of homophobia. He did this by helping his clients "identify all behavior springing from the attitude and discontinue it." Healthy for Weinberg was defined as the client overcoming their prejudice against homosexuality. Weinberg's therapy had several similarities to Hirschfeld's adaptation therapy. First, Weinberg viewed homosexuality as a potentially healthy sexual orientation variation. Second, like Hirschfeld, Weinberg believed it was necessary for the healthy homosexual to abandon the heterosexual ideal as a model for their life. Third, Weinberg's and Hirschfeld's therapies gave homosexuals confidence in their sexual attractions. Fourth, both therapies emphasized advice to homosexuals on how to tell their parents and family members that they were homosexual. [75] Weinberg's treatment of homophobia was an advanced method of helping homosexuals adapt to accepting and living with their homosexuality. Homophobia was a theory that legitimized homosexuality and made the accusation that belief in Judeo/Christian sexual morality was a psychopathological disease.

Weinberg's treatment measures had a connection to the gay activist movement. He reiterated the advice of gay activists, who told conflicted homosexuals "to go to the big cities, where there are thousands of homosexuals living happily and without guilt." Weinberg recommended that parents of homosexuals talk to gay activist leaders, attend their meetings, and read their literature. In his 1972 book Weinberg quoted gay activist Frank Kameny as saying, "The homosexual has a right to remain homosexual, and in fact a moral obligation to do so, in order to resist immoral prejudice and discrimination." Weinberg's own words of resistance to reorientation change claimed that a homosexuals attempt to change their sexual orientation "is an assault on your right to do what you want so long as it harms no one."[76] Weinberg acknowledged that he was a frequent writer in New York City's gay magazine, *Gay*. Nowhere in Weinberg's landmark book that introduced the concept of "homophobia" was there any support for an individual who desired to change their sexual orientation.

Conclusions

In his 1963 anthology on homosexuality normal variant advocate Hendrik Ruitenbeek stated that Edmund Bergler's clinical work was "psychoanalytic nonsense."[77] Included in Ruitenbeek's 1963 anthology was a 1949 essay by Sandor Rado that hypothesized the causes of homosexuality as either a reparative function, a situational lack of the opposite sex, or related to a search for sexual variety. Bergler had treated those troubled by their homosexuality as a disorder of the reparative type. He was successful. The "psychoanalytic nonsense" that Ruitenbeek discounted in one sentence, he acknowledged legitimate by reprinting Sandor Rado. A motive for Ruitenbeek to

include Rado's essay was that Rado believed the reparative patterns of sexual perversions were not harmful to society and should not be considered crimes.

Not very much is available on the personal history of Hendrik Ruitenbeek. It appears that he was a discrete gay activist, choosing to conceal his homosexuality so that his bias would not be taken into consideration. In his 1973 anthology on homosexuality Ruitenbeek turned his criticism on Irving Bieber and Charles Socarides with the statement, "The far fetched conclusions they draw from seeing about a hundred homosexuals are simply appalling."[78] Ruitenbeek knowingly skewed the facts. The Bieber study alone involved 77 psychoanalysts and analyzed 106 homosexuals. Although the number of homosexual clients Socarides helped was not public knowledge, Socarides presented many case histories of homosexuals before 1973. Ruitenbeek neglected to mention that Lawrence Hatterer had analyzed 200 homosexual clients himself and Edmund Bergler consulted almost 500 homosexuals.

Ruitenbeek offered no evidence in his two anthologies on homosexuality to disprove the clinical evidence that showed homosexuality was often the result of a psychopathological condition that could be corrected. Some of the essays in Ruitenbeek's anthologies actually supported the position that homosexuality was a curable disorder. Elizabeth Mintz's data in Ruitenbeek's 1973 anthology substantiated the work of other reparative psychotherapists by demonstrating that when underlying childhood traumas were resolved through psychotherapy methods a significant number of homosexuals changed their sexual orientation. It is a significant irony that Ruitenbeek would claim that "Bieber and Socarides base their beliefs on unsupported or at least inadequate

evidence,"[79] then include in the same anthology Mintz's data providing more evidence to support the beliefs of Bieber and Socarides.

The best examples that Ruitenbeek presented to support normal variant psychotherapy was Robert Lindner's case of Ralph and Richard Robertiello's three cases. Both Lindner's and Robertiello's effectiveness relied on the client's ability to accept their sexual perversion as normal behavior. Judd Marmor's 1965 anthology on homosexuality also had little of substance to support normal variant psychotherapy for homosexuals. His best evidence to support normal variant psychotherapy was the research of Evelyn Hooker and her argument that homosexuality was not necessarily psychopathological.

George Weinberg became one of the biggest critics of reorientation therapy in the early 1970s. Weinberg argued that a psychoanalyst's insistences on exploring the motivations of an individual's homosexuality "are almost sure to arouse misgivings, especially since the patient's life must be going badly for him or he would not have come for help of any kind. The psychoanalyst, by stressing the importance of understanding the origin of the homosexuality, conveys the idea that the inquiry itself should be a prerequisite for pursuing a homosexual life."[80] Weinberg continued this argument by accusing psychoanalysts of attempting to convince their homosexual clients to change their sexual orientation through the deception of attributing all the difficulties their homosexual clients had to their homosexuality.

Yet, Weinberg, following in the steps of Magnus Hirschfeld, was himself attributing most all the difficulties of homosexual patients to society's prejudice against homosexuality. Weinberg was a psychoanalyst that was not concerned with understanding the origins of his homosexual patients. He appeared to have empathy for

the homosexual who built his identity around his homosexuality, but little or no empathy for the individual whose homosexuality was unwanted and who sought the opportunity to change his sexual orientation

Weinberg criticized the varied follow-up periods that reorientation therapists arbitrarily used to confirm a client had changed their sexual orientation. Weinberg argued that by not having stopping times "*before* an experiment is begun," psychoanalysts can terminate their study whenever their "findings look as good as they will ever look."[81] His insinuation was that homosexuals were not really changing their sexual orientation. Having stopping times before a psychotherapeutic case study was begun was not typical of any psychotherapeutic study. Psychotherapeutic successes of all types varied in degrees of success and varied in how long it took clients to obtain a degree of success. This argument of Weinberg's against the record of successful reorientation therapy did not invalidate reorientation therapy successes.

The success rate of reorientation therapy was documented in the area of 25 to 35 percent, and those that succeeded usually had times when homosexual attractions reemerged. Weinberg called reorientation therapy a failure if the client's homosexual desires returned intermittently. That standard of never having fantasy of past unwanted behavior was not required of other psychotherapy treatments. For example, psychotherapeutic success rates of 25 to 35 percent for depression and alcoholism were considered reasonable success rates and a patient's success was not considered a failure if the patient later experienced intermittent tendencies of depression or desire for drugs. The success would be judged on how the patient responded to the intermittent thoughts and feelings.

Weinberg was probably the first to articulate the idea that reorientation therapy caused harm to homosexuals. For the majority of homosexuals who were not able to change their sexual orientation, they were out more than just time and money, according to Weinberg. The total cost of the failed therapy included the effects of the therapy's acute distress, which was almost certain to cause clients "to dislike themselves more than ever for being homosexual, after the treatment." Weinberg advocated that "Homosexuals should be warned. First of all, the venture is almost certain to fail, and you will lose time and money. But this is the least of it. In trying to convert, you will deepen your belief that you are one of nature's misfortunes."[82]

While this may have been the case for some clients, many others who were not able to change their sexual orientation benefited from reparative psychotherapy. Bieber documented that reparative psychotherapy produced positive benefits "even where homosexual patients have not shifted to heterosexuality." Clients who were not able to change their sexual orientation "at least gained benefits from resolving interpersonal problems and other difficulties."[83] Hatterer outlined a detailed list of "interpersonal problems" and "problematic reactions" a homosexual may have that could be helped with reparative psychotherapy even when the homosexual was committed to a homosexual identity or was unable to change his sexual orientation. Some of these problems and reactions included: "guilt over depersonalized, degraded, and excessive humiliating sexual practices; fear of and simultaneous need to court danger in pursuit of sexual activity; development of cynical attitudes, cruel humor, and hostile, sadistic, and/or masochistic behavior; total inability to sustain any emotional contact or to be loyal or honest in interpersonal relationships; inability to tolerate any aspect of the

'establishment' and/or authority; and an inability to relate to women on any level."[84] Hatterer saw all of those problems related to the individual's homosexuality.

Weinberg also criticized the concept that homosexuality could be prevented. He argued with questions. "Why, if the parents are causal, do some children 'contract' homosexuality and other's do not?" The reorientation experts "warn that the best time to catch incipient homosexuality is when children are between the ages of three and ten. But what are parents to do?"[85] The reorientation experts had advice for parents that could help their children adjust and identify with their biological gender. Bieber suggested the child and the parent enter into psychotherapy to uncover the source of the child's lack of identification with its biological gender. The implication was that the parents were of utmost importance for the conflicted child to develop a healthy heterosexual identity. Questions could be asked of Weinberg's objection to the clinical science of preventing homosexuality. Shouldn't parents be made aware of behavior in their child that may be a sign the child is not developing a heterosexual identity? Shouldn't parents have the opportunity to help a gender conflicted child develop a heterosexual orientation? Shouldn't parents be able to prefer a heterosexual identity for their child?

In the early 1970s George Weinberg, Hendrik Ruitenbeek, and Ralph Blair were part of a small minority who advocated and practiced a normal variant psychotherapy based on the principle that the homosexual life was as healthy as the heterosexual life. They were small in number but they were linked to a growing gay political movement throughout the United States. They rejected the existing cultural morality. They rejected the etiological data on homosexuality. They rejected the evidence of changed sexual

orientations. Many even rejected homosexuals who wanted to change their sexual orientation. Equality with heterosexuality was their social cause and that trumped the existing clinical science. With their accusations and theories Weinberg, Ruitenbeek, and Blair helped build the foundation for normal variant psychotherapy of homosexuality.

Edmund Bergler, Irving Bieber, Lawrence Hatterer, and Charles Socarides had proven that homosexual orientation could be changed in similar percentages to other behavioral disorders of the addictive type. Case after case showed that homosexuality was a psychopathological condition caused by psychological wounding in childhood. Their beliefs were based on the scientific method. The hypothesis that homosexuality was often a reparative adaptation came from Sandor Rado's observations in the 1940s. In the 1940s and 50s Edmund Bergler tested that hypothesis treating the reparative adaptation of homosexuality as a form of "psychic masochism" stemming from childhood trauma. By exposing the reparative function that homosexuality served and working the patient through the unresolved childhood trauma, the patients would often no longer need the reparative function of homosexuality. Many of his patients were able to develop heterosexual orientations. With a hundred sexual orientation changes from homosexuality to heterosexuality Bergler turned Rado's hypothesis into a theory.

The Rado theory was then tested and substantiated by the work of Lawrence Hatterer, Irving Bieber and his associates in the Society of Medical Psychoanalysts, Charles Socarides, Elizabeth Mintz, and others. Advances were made in understanding the causative factors of homosexuality and how childhood traumas that continued in the unconscious adult mind resulted in pathological behavior. Methods of treatment of homosexuality progressed. Major breakthroughs in understanding and treating

homosexuality occurred in the fifteen years before 1973. The homosexual condition that was once seen as untreatable was now treatable.

Through psychotherapy reparative psychoanalysts sought to help the individual homosexual who wanted to change his sexual orientation as well as the homosexual who did not want to change their sexual orientation. Their concern was for the individual homosexual; to improve their life. They observed factors that made a sexual orientation change more likely, the most important being motivation. All firmly believed that it was the patient's choice whether or not they sought to change their sexual orientation, and they all believed that heterosexuality would give the patient the most satisfying life. Bieber, Socarides, and Hatterer offered guidelines and advice to other psychoanalysts treating homosexuals. They built their practice on clinical science and the scientific method. They were the leading psychiatric authorities on homosexuality in 1973.

Notes

[1] Hatterer, *Changing Homosexuality*, 57.

[2] Bieber et al, *Homosexuality – A Psychoanalytic* Study, 15.

[3] Katz, *Gay American History*, 140, 153-4.

[4] Liebman, "Homosexuality, Transvestism, and Psychosis," 170-3, 201-207.

[5] Glass and Jognson, "Limitations and Complications," 170.

[6] Perloff, "Hormones and Homosexuality," 57-8.

[7] Feldman and MacCulloch, *Homosexual Behavior: Therapy*, 15. This information was originally published in *Homosexuality, 3rd. edition*, by D. J. West, London: Penguin Books, 1968.

[8] Urban and Ford, "Behavior Therapy," 1217-9.

[9] Feldman and MacCulloch, *Homosexual Behavior: Therapy*, 10.

[10] Ibid., 22-45.

[11] Ibid., 65-73, 94.

[12] Ibid., 50, 53, 86, 90.

[13] Bieber, "Sexual Deviations. II: Homosexuality," 973.

[14] Mack and Semrad, "Classical Psychoanalysis," 304.

[15] Stewart and Levine, "Psychoanalysis and psychoanalytic psychotherapy," 1196, 1201.

[16] Ibid., 1207-11.

[17] Ibid., 1212-4.

[18] Rogers, "Client-Centered Psychotherapy," 1225-7.

[19] Stewart and Levine, "Psychoanalysis and psychoanalytic psychotherapy,"1215.

[20] Bergler, *Homosexuality: Disease or Way*, 195-6.

[21] Ibid., 188, 192-3, 209-10.

[22] Ibid., 33-4.

[23] Ibid., 238-49.

[24] Ibid., 247-8.

[25] Ibid., 219.

[26] Ibid., 187-8.

[27] Bieber, "Sexual Deviations. II: Homosexuality," 972.

[28] Ibid., 971, 3.

[29] Ibid., 973.

[30] Ibid., 972.

[31] Hatterer, *Changing Homosexuality*, viii.

[32] Ibid., 57, 59, 60.

[33] Ibid., 445-64.

[34] Ibid., 86, 88, 89, 92.

[35] Ibid., 86, 88, 94, 95, 126.

[36] Ibid., 186, 187.

[37] Ibid., 263, 264.

[38] Ibid., 393-403.

[39] Ibid., 404-5.

[40] Socarides, *Overt Homosexual*, 4.

[41] Bayer, *Homosexuality and American Psychiatry*, 37.

[42] Socarides, Homosexuality A *Freedom Too*, 102.

[43] Socarides, *Overt Homosexual*, 210.

[44] Ibid., 80.

[45] Ibid., 216.

[46] Ibid., 211, 220-1.

[47] Ibid., 226-7.

[48] Ibid., 225.

[49] Satinover, *Homosexuality and the Politics*, 186.

[50] Socarides, *Overt Homosexual*, 222.

[51] Mintz, "Overt Male Homosexuals," 182.

[52] Ibid., 182-3.

[53] Ibid., 183-4.

[54] Ibid., 185-8.

[55] Ibid., 184.

[56] Ibid., 184-5.

[57] Bullough, *Before Stonewall*, 2-3.

[58] Hirschfeld, "Adjustment Therapy," 151.

[59] Ibid., 152.

[60] Ibid., 153.

[61] Reisman, *Kinsey: Crimes & Consequences*, 21, 300-1. Some of the information came from Christopher Isherwood's autobiography *Christopher and His Kind, 1929-1939*. Isherwood was a pederast and wrote three novels about life in Berlin which were used as the basis of the stage production and movie *Caberet*.

[62] Blair, *Etiological and Treatment Literature*, 38.

[63] Ibid., 40.

[64] Ruitenbeek, "Introductory Essay," 14.

[65] Ibid., 147.

[66] Roberteillo, "More Positive View," 176, 9.

[67] Ibid., 177-9.

[68] Ibid., 179-80.

[69] Lindner, "Homosexuality and the Contemporary," 59.

[70] Ibid., 64-6.

[71] Ibid., 66-7.

[72] Weinberg, *Society and the Healthy*, 48, 92.

[73] Ibid., Preface, 4-5, 9, 11-2, 16-7.

[74] Ibid., 9, 74-6, 78.

[75] Ibid., Preface, 1, 83-4, 88, 112-9.

[76] Ibid., 85, 104, 121, 123, 143.

[77] Ruitenbeek, Introduction to *Problem of Homosexuality*, xii.

[78] Ruitenbeek, Introduction to Part II of *Homosexuality: A Changing Picture*, 147.

[79] Ibid.

[80] Weinberg, *Society and the Healthy*, 29-30.

[81] Ibid., 62.

[82] Ibid., 62-3, 142.

[83] Bieber, "Sexual Deviations. II: Homosexuality, 973.

[84] Hatterer, *Changing Homosexuality*, 404-5.

[85] Weinberg, *Society and the Healthy*, 94, 143.

Chapter 4

The Kinsey Sexual Revolution

"Kinsey, a medical layman, undertook the impossible and fantastic feat of attempting to equate – and without reservation – heterosexuality and homosexuality."[1]

(Edmund Bergler, 1957)

Opening note

An American sexual revolution movement was birthed in 1948 with the publishing of his book *Sexual Behavior in the Human Male*. Funded and promoted by the influential Rockefeller Foundation, Alfred Kinsey was able to propagate an amoral philosophy regarding sexual behavior that still has wide influences in the culture today. From Kinsey's perspective morality was not scientific and therefore irrelevant to the study of human sexuality. This argument masked Kinsey's real motivation. Kinsey biographer James H. Jones, Ph.D. wrote, "However much he talked about science's need for data, this was not his primary motivation. Again, his research sprang from a private agenda shaped by personal politics. Decades of inner turmoil had transformed Kinsey into a rebel, a man who rejected the sexual mores of his age. He meant to change the

public's thinking on sexual matters. Convinced the cold hard facts alone would persuade the public to develop more tolerant sexual attitudes, Kinsey was determined to provide those data."[2]

In actuality, Kinsey's statistics on homosexuality were far from reality. They really cannot be called science. A scientific study should yield results that can be repeated and verified within a few percentage points. Kinsey's 10 percent statistic of male homosexuality in the American male population was 500 to 2000 percent off. Later studies would show that male homosexuality in America was somewhere between less than one percent to a maximum of two percent of the American male population. Kinsey's estimate of male homosexuality among college students was even worse. As Jones stated, Kinsey's work was an agenda. Yet, Kinsey's statistics and philosophy were used as evidence that homosexuality was not a disorder. In addition Kinsey's work minimized the consequences of pedophilia and was instrumental in the founding of America's academic discipline of sexology, which in turn produces sex education curriculum for American children.

The Kinsey saga before 1973 and its legacy

Alfred Kinsey's academic career began in zoology and his early interest was collecting and studying gall wasps, reportedly up to four million wasps.[3] Kinsey began his foray into human sexuality when he asked and was allowed to teach a class on marriage at the University of Indiana in 1938. Kinsey used the class to collect interviews on the student's sex lives and their genital physiology. It was not long before Alfred Kinsey had secured funding from the National Research Council and the Medical

Division of The Rockefeller Foundation for studies on human sexuality. The Rockefeller Foundation funding of Kinsey's research began in 1942 and ended in 1954.[4] In the first half of the twentieth century The Rockefeller Foundation was in the business of funding projects geared to promoting the type of liberal social reform Kinsey sought.[5]

Kinsey's volume on male sexuality was published in 1948 and the volume on female sexuality in 1953. Both volumes had massive publicity campaigns preceding their releases funded by The Rockefeller Foundation and sometimes American tax dollars.[6] The findings of Kinsey shocked America and forced the public to question what was sexually normal. Citing Kinsey, *Life Magazine* published an article in August of 1953 declaring that 50 percent of men and 40 percent of women will be unfaithful after marriage.[7] The most enduring Kinsey statistic was that "ten percent of his sample reported that they had been more or less exclusively homosexual for at least three years between the ages of eleven and fifty-five," leading the public to believe that 10 percent of the American male population was homosexual. Another statistic from Kinsey's study showed that 37 percent of males had had physical contact with a man to the point of orgasm between adolescence and fifty-five.[8] Homosexuals were encouraged by Kinsey's statistics that their sexuality was normal.

Kinsey touted his statistics as "a progress report from a case history study on human sex behavior" representing "an accumulation of scientific fact completely divorced from questions of moral value and social custom."[9] Kinsey's Male volume included tables on pre-adolescent erections and orgasms including this statement, "32 per cent of boys 2 to 12 months of age, more than half (57.1%) of the 2- to 5- year olds, and nearly 80 per cent of the pre-adolescent boys between 10 and 13 years of age (inclusive)

came to climax."[10] This data came from unidentified "observers." Other findings by Kinsey reported that molestation of girls generally had harmless consequences. Of the 1075 females interviewed by the Kinsey team who were sexually approached in childhood; Kinsey found "only one clear-cut case of serious injury done to the child."[11] The public was also told by the Kinsey team that sexually transmitted diseases were insignificant because "the medical techniques which are now available can prevent overall disease from becoming a matter of much social importance."[12]

Kinsey called his "accumulation of scientific fact" a "taxonomic" effort. The statistics and conclusions were just a process of collecting and classifying information. Kinsey wrote in the introduction to the *Male* volume that "The transfer from insect to human material is not illogical, for it has been a transfer of a method that may be applied to the study of any variable population, in any field."[13] Kinsey argued that the biological, psychological, psychiatric, and sociological studies on human sexuality before his own were based on samples that were too small for the generalizations that they made. He also argued that other published studies on sex confused "moral values, philosophic theory, and scientific fact."[14]

Kinsey's team accumulated data on pubic hair, masturbation, nocturnal orgasms, heterosexual activity, homosexual activity, sexual contacts with animals, erections, time to reach orgasm, and even data on the size of female clitorises, but Kinsey seemed most intrigued by homosexuality and aberrant sexual behavior. Early in Kinsey's sex interviewing career, when he was still teaching the marriage course and had accumulated only 570 sex histories, he already had made six trips to Chicago to record sex interviews with homosexuals. At that time he had "a half-dozen centers in the city from which he

could make contacts." It was during this time that Kinsey wrote to his close friend Michael Voris (who died in May of 1940) that he had "forty [homosexual] histories out of Chicago who have had first-hand experience with a total of about 12,000. You can figure the average. Several with 2000 and 3000 each. ... Now have a total, from all sources, of 120 H____ histories."[15]

Kinsey's interviewing quests to document homosexuals and their activities included a number of trips to New York City. When Kinsey was given funds by the University of Indiana to hire cinematographer Bill Dellenbeck. Kinsey associate Wardell B. Pomeroy, Ph.D. stated that Dellenbeck's first assignment was to accompany Kinsey to interview homosexuals in New York City and observe a homosexual orgy. Kinsey had obviously gained the confidence of these homosexuals, because they not only allowed him to observe but also record their sexual activity on film. Dellenback recalled that during the filming of homosexual sex sessions Kinsey was "much more unobtrusive in his manner than usual." Kinsey "would move quietly around the room, never intruding, occasionally whispering a direction to Bill." [16] The University of Indiana was unaware that Kinsey and his team were filming human sexual acts and evening staging sexual encounters for filming on campus, only Kinsey's inner circle knew of it.[17]

In 1972 Pomeroy revealed that while Kinsey was alive they filmed twenty homosexual couples and ten heterosexual couples in sexual activity, along with "about twenty-five males and females engaged in masturbation." At least one of the homosexual couples invited to Bloomington to be filmed was from New York. During a sex observing trip to New York Kinsey was intrigued that "one of the partners had an orgasm of such intensity that he was in a frenzy of release, quite unconsciously beating the other man

around the shoulder with his clenched fists." Pomeroy stateed the purpose of bringing the couple from New York was, "as always, of getting as much range and variety as possible in his sampling."[18]

Kinsey found it difficult to get the sexual histories of students at colleges and universities because as Pomeroy explained, "the religious and scientific biases of administrators or faculty could operate more freely against him than they did at his Indiana base."[19] That was not the case at prisons where Kinsey found easy access. By 1946 Kinsey, Pomeroy, and associate Paul Gebhard "had interviewed about 1,400 convicted sex offenders in penal institutions scattered over a dozen states." Just before the publication of the *Male* volume Kinsey and Pomeroy interviewed 199 sexual psychopaths at the Metropolitan State Hospital in Norwalk, California. Pomeroy recalled that Kinsey was anxious to talk to them and "learn how they were different from other people."[20] In the prisons the Kinsey team "simply sought out sex offenders and, after a time, avoided the more common types of offense (e.g. statutory rape) and directed our efforts toward the rarer types."[21] According to colleague Paul Gebhard "Kinsey did not view the inmates as a discrete group that should be differentiated from people outside; instead, he looked upon the institutions as reservoirs of potential interviewees, literally captive subjects. This viewpoint resulted in there being no differentiation in our 1948 volume between persons with and without prison experience."[22]

In his effort to change society's sexual norms Kinsey claimed that scientists should be the authorities who make society's sexual norms because sexual orgasm was needed for physical health and sexual practices involved hygiene. His argument was summed up in a lecture he gave early in his study of human sexuality, "The resolution of

erotic arousal, the relation of erotic stimulation and response to physical health, and the possibility of ignoring, suppressing, resolving, or sublimating such arousal are first of all questions of physical and mental hygiene, and their resolution must lie in the laboratory and science classroom, and not in the chair of philosophers ... or moralists ... Scientists must have the right to decide."[23]

Pomeroy stated, "Kinsey numbered himself among those who contended that, as far as so-called molestation of children was concerned, a great deal more damage was done to the child by hysteria."[24] In Kinsey's amoral philosophy there was nothing necessarily wrong with adult/child sex. Kinsey rationalized that both parties benefited if they had a sexual release, and if the child did not enjoy the experience, Kinsey did not see any significant damage done to the child. Kinsey was scientifically right in stating that adult/child sex is a taboo that is "culturally conditioned." All sexual taboos are in some respect culturally conditioned.

Kinsey's data on pre-adolescent climax in his 1948 volume came from "the histories of adult males who have had sexual contacts with younger boys and who, with their adult backgrounds, are able to recognize and interpret the boys' experiences." Kinsey relied on nine adult males for his information. Some of these homosexual male pedophiles and pederasts were "technically trained" by Kinsey or other academics on what to observe and how to keep dairies and records, which were eventually sent to Kinsey.[25] Pomeroy wrore that one such person they interviewed "had had homosexual relations with 600 preadolescent males, heterosexual relations with 200 preadolescent females, intercourse with countless adults of both sexes, with animals of many species, and besides had employed elaborate techniques of masturbation. ... His grandmother

introduced him to heterosexual intercourse, and his first homosexual experience was with his father. ... I will add that he was a college graduate who held a responsible government job." Pomeroy also claimed that this person's history "was the basis for a fair part of Chapter Five in the Male volume, concerning child sexuality."[26]

After Kinsey died his team published a book on sex offenders in 1965 arguing the same amoral adult/child sex principle. One of the arguments in the book stated, "The horror with which our society views the adult who has sexual contact with young children is lessened when one examines the behavior of other mammals. Sexual activity between adult and immature animals is common and appears to be biologically normal."[27] In the Kinsey paradigm if the sexual activity occurred in the animal world and occurred regularly in the human world, the Darwinist scientific world needed to defend it as normal sexual behavior. Kinsey wrote to a homosexual graduate student, "concerning my study in Chicago, you must have learned that I am absolutely tolerant of everything in human sex behavior."[28]

The impact Alfred Kinsey had on American culture is astounding. Kinsey's original team included Wardell Pomeroy, Clyde Martin, and Paul Gebhard. Some of the others to come through the early Kinsey Institute and shape a new sexual paradigm were John Gagnon, Martin Weinberg, William Simon, Alan Bell, and John Money. Wardell Pomeroy became the dean and a director of The Institute for the Advanced Study of Human Sexuality in San Francisco. The main requirement for a student to be accepted into this San Francisco sex institute was that they not have "traditional preconceptions about sexual mores." Other directors at the San Francisco sex institute had ties to *Hustler* magazine. Under Pomeroy's guidance, much of the scholarly training at the San

Francisco Sex Institute involved watching and sometimes the making of erotic films. The San Francisco Sex Institute also trained students to design and implement sex education curriculum for American's schoolchildren.[29]

Pomeroy served as president of the Society for the Scientific Study of Sex (SSSS) from 1966 to 1968.[30] According to Kinsey researcher Judith A. Reisman, Ph.D. Pomeroy was also involved in the early years of the Sex Information & Education Council of the United States (SIECUS). These organizations laid the groundwork for the accreditation of sex education teachers. Reisman stated that SIECUS came right out of the Kinsey Institute and sought "to teach Kinseyan ideology as sex education in our schools." The original seed money for SIECUS came from the Playboy Foundation.[31]

Kinsey himself contributed to England's Wolfenden Report that in 1957 that "recommended the legalization and licensing of obscenity, homosexuality, and other activities previously understood to be perversions."[32] The Wolfenden Report was then cited by American gay activists and their supporters as evidence that homosexuality should not be treated as a perversion.[33]

Shortly after Kinsey's *Male* volume was published the Rockefeller Foundation gave funds to the American Law Institute's effort to create a "Model Penal Code." The resulting Model Penal Code was filled with Kinsey ideology and reasoning. A Kinsey, Jonathan Gathorne-Hardy called the Model Penal Code of 1955 "virtually a Kinsey document." In one part of the code "Kinsey was cited six times in twelve pages."[34]

The American Law Institute Model Penal Code (ALI-MPC) was soon "taught by many unsuspecting law professors in America's most prestigious law schools."[35] Laws throughout the country were changed based on the ALI-MPC and Kinsey statistics.

Imbedded throughout was Kinsey's ideology that children were naturally sexually active, adult/child sex was usually consensual and harmless, homosexuality and other sexual aberrant behaviors were normal, and sexual offenders were not likely to repeat their offences.

Reisman used the online legal research service *Westlaw* to find the extent that Kinsey was cited in legal cases and law review journals from 1982 to 2000. Roughly 650 citations were connected to "Alfred Kinsey" compared to 92 citations connected to the recognized sex research team of Masters and Johnson. When Reisman combined the *Westlaw* citations with those in the *Social Science Citation Index* and the *Science Citation Index* she found "a total of approximately 5,796--compared to about 3,716 for Masters and Johnson."[36]

As the American homosexual rights movement emerged "it immediately acknowledged Kinsey as a friend" and "cultivated warm relationships" with Kinsey and his colleagues at Indiana University.[37] The 10 percent figure of homosexual males in the general male population was promoted extensively. As new studies showed the 10 percent figure to be inaccurate, the new statistics were ignored in the same way the etiological evidence of homosexual psychopathology would be ignored by those seeking to normalize homosexuality.

In the mid-1950s Edmund Bergler found that many of his homosexual clients had welcomed Kinsey's fallacies as a moral guide. He documented bisexual husbands using Kinsey's statistics and philosophy to tell him that there was nothing wrong with their homosexual activity outside their marriage relationship. One of Bergler's clients told him, "I know of a lot of fellows who turned to homosexuality because Kinsey convinced

them." Bergler suggested that "Kinsey may be held responsible for the creation of a new category of young homosexuals: the 'statistically induced' type." The Kinsey statistics and morality were being used by individual homosexuals to justify their homosexuality, by experienced homosexuals to seduce sexually confused young men, and by the homosexual rights movement to argue for a legitimate minority status. [38]

Criticism of Kinsey before 1973

Psychiatrist Edmund Bergler was a contemporary of Alfred Kinsey and an early authority on both homosexuality and Kinsey's research. Bergler coauthored a medical journal critique of Kinsey's work in 1954 exposing many of the errors in Kinsey's research.[39] In 1957 Bergler would write, "Kinsey, a medical layman, undertook the impossible and fantastic feat of attempting to equate – and without reservation – heterosexuality and homosexuality. Totally lacking in psychiatric knowledge, this biologist used a simple yardstick for recognizing normality ... For this biologist the unconscious seems nonexistent. Nonexistent, too, are cultural standards. And if one objects, the objections are dismissed as mere evidences of a detrimental influence of Judeo-Christian cultures – a concept apparently beneath contempt. Or the objector is more moralistic than the Church, or against 'science' as Kinsey understands it."[40] Bergler called Kinsey's statistics on the frequency of homosexuality "statistical fairy tales based on preconceived prejudices."[41]

Irving Bieber took issue with Kinsey's normal variant view of homosexuality in his 1962. "Kinsey's assumption of normalcy is based on the argument of frequency though, in fact, frequency as a phenomenon is not necessarily related to absence of

pathology."[42] Bieber went on to give the example that a high percentage of people get colds in a year, yet colds are a pathological condition. Decades later Socarides gave a better example using human sexual behavior. Studies on incest claimed that 25 percent of all young women in American "have been sexually tampered with by their own fathers." Socarides argued that using Kinsey's logic would give normalcy to incest,[43] which was actually what Kinsey ideology implied.

Socarides also pointed out that "psychoanalysts comprehend the meaning of a particular act of human behavior by delving into the motivational state from which it issues." Kinsey's conclusions on homosexuality based "simply because of its frequency of occurrence is to the psychoanalyst scientific folly."[44] Abram Kardiner, pointed out the uselessness of Kinsey's statistics in 1954. "[S]ince Kinsey does not and cannot enter upon motivation in his statistical studies ... [they] leave us quite stranded when we try to understand what they mean"[45] Even Robert Linder, who shared Kinsey's contempt of American culture's sexual norms, wrote that Kinsey's statistics "have nothing to do with sexual inversion and homosexuality. ... Nevertheless, the impression they produced on the public mind was the misleading one of confusing outlet with inclination."[46]

Kinsey's 1948 estimate of active homosexuality in "males who belong to the college level" was 16 percent for those in latter adolescence to less than 10 percent for those between the ages of 21 and 25.[47] Pomeroy wrote that the Kinsey team "had calculated the homosexual incidence at college age to be about 20 percent" for males.[48] One of the earliest efforts to verify Kinsey's prevalence of homosexuality was a survey of 200 male college students by a Drs. Phyllis and Eberhard Kronhausen in Holland. The Kronhausens' survey published in 1960 "found that only one-half of one percent could be

considered homosexual." The Kronhausen's did read the fine lines in the Kinsey report and discerned that Kinsey did not specifically refer specifically to college students, but to college age men.[49] Nevertheless, Kinsey's statistics on homosexually in the U.S. college male population differed from reality by 2000 to 4000 percent.

Some knew of the Kinsey statistical shortcomings before his *Male* and *Female* volumes were published in 1948 and 1953. Noted psychologist and humanist, Abraham Maslow, Ph.D. wrote in 1942 that "any study in which data are obtained from volunteers will always have a preponderance of high dominance people and therefore will show a falsely high percentage of non-virginity, masturbation, promiscuity, homosexuality, etc., in the population."[50] Maslow personally warned Kinsey of the error of volunteer study, and when Kinsey disagreed the two of them did a test using five classes that Maslow was teaching at Brooklyn College. When the test proved "the volunteer error" Kinsey ignored it, "refused to publish it and refused even to mention it in his books."[51]

Kinsey's chief statistician was original team member Clyde Martin. Martin had "no professional or practical statistical background or training." Kinsey's original team members Wardell Pomeroy and Clyde Martin "were both young, inexperienced, and without doctorates or published academic work."[52] Kinsey dominated them and molded them. Rockefeller Foundation administrator Warren Weaver was continually frustrated by Martin's lack of expertise. Weaver wrote in his Desk Diary on May 7th of 1951, "In his own diary record of a visit to Kinsey in July 1950, Dr. Gregg said, under the heading of personnel: 'Past and present needs remain unsatisfied in point of ... statistics.' This fault – this admittedly absolutely basic fault – existed in the project in 1942, it has existed ever since, there is no promise whatsoever that it will cease to exist – and we do nothing

about it."[53] The Rockefeller Foundation knew of gross statistical error in the Kinsey studies, yet continued to fund it and then promoted its findings with a highly organized media campaign.

Statistician Paul Sheatsley and sociologist Herber Hyman wrote in *An Analysis of the Kinsey Reports* in 1954 that "one of the most telling criticisms of [Kinsey's] first report was that no one could tell how good or bad his sample actually was because nowhere was there any systematic account of the distribution of the 5,300 males in terms of such factors as age, religion, etc."[54] No one was able to discern the background of the males to verify the research's accuracy or attempt to duplicate its findings. Clyde Martin would later write a letter to the 1990 Kinsey Institute director June Reinisch acknowledging the statistical mess he helped create. He told her,"I am certain there wasn't a code to designate which of the case histories were included in the male volume or used in computing prevalence data. ... It is confusing even now since the basic sample is nowhere well described."[55]

Page 6 of Kinsey's *Male* volume states that the Kinsey males sample size was about 6300 and "about 5300 of these are the white males who have provided the data for the present publication." After reviewing Kinsey's Male volume University of Chicago statistician W. Allen Wallis wrote in 1949, "The largest total I have noticed (often the totals are not shown, but have to be computed) in any of the tables that appear to cover all of the white males is the 4,120 shown distributed by religion in Table 41, p. 208. This same table shows 4,940 males distributed by occupation. ... In general, very little is revealed in the statistical data about the number of males covered in the volume."[56]

Kinsey achieved his statistics showing high levels of homosexual behavior in American by choosing to study males from establishments that would be more prone to homosexual behavior. He sought out subjects from prisons and gay bars. He would give lectures in college classrooms, presumably with his slant of the normalcy of aberrant sexual behavior, and then ask the students if they wanted to volunteer to be in a study on sexual behavior. Psychiatrist Charles Socarides commented that Kinsey's "sampling techniques broke all the rules for building a model of the U.S. population."[57]

It is statistically possible that half the male sample used in Kinsey's *Male* volume consisted of convicted sex offenders, sexual psychopaths in a correctional institution, practicing pedophiles, and practicing homosexuals. Of his 6300 total male sample size around 1,400 were convicted sex offenders in jails and prisons and 199 were sexual psychopaths at the Metropolitan State Hospital in Norwalk, California. Most of the data on child sexuality came from pedophiles who had not been caught and kept diaries that were given to Kinsey. In addition Kinsey spent considerable effort seeking out homosexuals in the homosexual underworld communities of Chicago, New York, Indianapolis, Peoria (Illinois), and Gary (Indiana).[58] At the end of 1940, approximately eight years before Kinsey's *Male* volume was published, Kinsey had already amassed over 450 homosexual histories.[59] No one will ever know the actual percentage these groups represented in the statistics from the *Male* volume. Nor will anyone ever know what percentage of the male heterosexual sample came from his prison interviews.

Many critics of Kinsey shared English anthropologist Geoffrey Gorer's viewpoint published in 1955. "The fundamental criticism which, to my mind, invalidates a remarkable amount of industry and perseverance, is that, by Dr. Kinsey's implicit

standards, sex becomes a quite meaningless activity, save as a device for physical relaxation – something like a good sneeze. … The concept of love is completely omitted from the analysis of sexual behavior … as though all orgasms were identical and total. … Though many people do engage in sexual activities without love, to assume that the presence or absence of love is irrelevant is surely a grave departure from common sense. … behind the 'scientific' smoke-screen of statistical tables, graphs, codes, and rebarbative language there is continuous propaganda for more, and more varied, sexual 'outlets' as physiologically good in themselves. There is even the stupendous claim that taxonomic studies of behaviour should be the basis for laws."[60]

University of Pennsylvania sociologist Albert Hobbs was an outspoken critic of Kinsey's attempt to replace the cultural norms of sexuality with his amoral philosophy. Hobbs described Kinsey's philosophy as "scientism," which he defined as "a belief that science can furnish answers to all human problems, makes science a substitute for philosophy, religion, manners, and morals." Scientism uses a variety of techniques "to create the delusion of scientific verity when it does not exist, and to give the impression that limited findings have general application."[61]

"Advocates of scientism," Hobbs declared, "have long endeavored to mold the lives of people and to change society according to their preconceived notions." … "Professor Kinsey's book provides a good illustration of scientistic attempts to modify human behavior and to change moral standards. Wide and uncritical profession acceptance of the statements contained in it indicates both the extent of gullibility in academic minds and the pathetic eagerness of people to accept almost anything which seems to provide scientific justification to abandon principle and moral standards." … "it

seems quite obvious that this book was directed at a mass audience rather than at a restricted professional audience. ... the principal purposes served by the mass of statistics are to awe the audience, to confound the untrained critic, and to provide an impressive façade of scientific authoritarianism. ... because the simple and basic data most essential to scientific evaluation were omitted by the authors."[62]

Hobbs continued his critique, "The senior author of the Kinsey Report explicitly denies making value judgments, and holds high his passion for 'facts' in direct contradiction to numerous evaluations and interpretations which rest on inadequate data or no data at all. These evaluations form a fairly consistent pattern which reveal an effort to do more that present 'facts' of sexual behavior." ... "Presentation of *mores* and moral codes in contrast to 'normal mammalian behavior' seems designed to leave readers with the impression that behavior which is in conformity with the mores is unjustified, 'wrong,' or 'a rationalization,' while behavior which is in accordance with 'normal mammalian practices' is justified, 'right,' 'normal,' or 'realistic.'" Hobbs observed that liberal academia's embrace of the Kinsey book was similar to the fable where the emperor's advisors praise the beauty of his majesty's invisible clothes. As long as the data supported their "predilections," they would "use it to 'reform' society regardless of its scientific validity."[63]

By 1953 when Hobbs wrote his book on the influence of scientism he had witnessed a tremendous impact from Kinsey's first book. "Despite the patent limitations of the study and its persistent bias, its conclusions regarding sexual behavior were widely believed. They were presented to college classes; medical doctors cited them in lectures; psychiatrists applauded them; a radio program indicated that the findings were serving as

a basis for the revision of moral codes relating to sex; and an editorial in a college student newspaper admonished the college administration to make provision for sexual outlets for students in accordance with the 'scientific realities' as established by the book."[64] Alfred Kinsey had truly started a sexual revolution using scientism.

A United States Congressional investigation into non-profit foundations created by big business was held in 1954 and chaired by Republican B. Carroll Reece of Tennessee. The Rockefeller Foundation's support of Alfred Kinsey's research was discussed in this investigation known as the Reece Committee. Rene A. Wormser was the general counsel for the Reece Committee. He stated in a book written in 1958, "Most mysterious and disturbing was how the investigation of the Kinsey data was thwarted by a combined effort of Republicans and the Democrats in that administration ... Hays particularly."[65]

According to Wormser Democratic Congressman Wayne Hays went into a "steaming rage" demanding to see the entire Kinsey file. Congressman Hays threatened the committee's research director, Norman Dodd, "that he would oppose any further appropriation to our Committee unless the Kinsey investigation was dropped." To appease Congressman Hays, Norman Dodd gave Congressman Hays the entire Kinsey file.[66]

Albert Hobbs' book on scientism had been published the year before the Reece Commission and Hobbs testified before the Reece Committee. Hobbs referred to Kinsey's data as "pseudoscientific" with the intent and possibility to "seriously affect public morality." Wormser also recorded that their Committee was concerned with Kinsey's evaluation that molestation of children by adults is objectionable "primarily

because we have become conditioned against such adult molesters of children, and that the children who are molested become emotionally upset, primarily because of the old-fashioned attitudes of their parents about such practices, and the parents (the implication is) are the ones who do the real damage by making a fuss about it if a child is molested. Because the molester and here I quote Kinsey, 'may have contributed favorably to their later sociosexual development."[67]

The Reece Committee did conclude the Rockefeller Foundation funded Kinsey Reports were "deliberately designed as an attack on Judaic-Christian morality." According to Wormser "the valuable material in the Kinsey file never saw the light of day." Looking back at the Reece Committee professor Carroll Quigley wrote that those who controlled the foundations being investigated were big political campaign contributors and "closely allied" to the "most respected newspapers in the country." The result of that influence on the Reece Committee was a watered down report that was quietly buried.[68]

Kinsey exposure after 1973

In the 1990's a wealth of information on Alfred Kinsey and his research became public knowledge. Two authors, James H. Jones and Jonathan Gathorne-Hardy, with access to the Kinsey's files at Indiana University wrote two separate biographies on Kinsey. The Family Research Council produced a documentary on the Kinsey team's child sexual abuse in 1994 and the British Yorkshire Television research team broadcast their own documentary on Kinsey in 1998 called *Secret Histories: Kinsey's Paedophiles*. Researcher and scholar Judith A. Reisman, without access to Indiana University's Kinsey

files, used the available material on Kinsey to expose Kinsey's fraudulent work and document Kinsey's crimes and consequences in 1998.

Reisman was the first to expose the child sexual abuse used and approved of by the Kinsey team. Although the 1948 *Male* volume had tables on adolescent and preadolescent sexual climaxes and stated the data came from "adult males who have had sexual contacts with younger boys,"[69] no one before Reisman had openly challenged the morality or legality of this research. In March of 1981 Paul Gebhard, a Kinsey associate and successor to Kinsey in the role of Kinsey Institute Director, responded to Reisman's request for information on the tables on child orgasms. Gebhard informed Reisman "that the children in Kinsey's tables were obtained from parents, school teachers, male homosexuals, and that some of Kinsey's men used "manual and oral techniques" to catalog how many "orgasms" infants and children could produce in a given amount of time."[70]

When Reisman presented Gebhard's reply to the attendees at the Fifth World Congress on Sexology in July of 1981 she was initially surprised that they were not outraged as she was by this research. Some attendees were concerned that some of the children were used without their consent, but in general Riesman's paper and presentation was condemned because many sexologists, including the international executives of the conference, "wholeheartedly agreed that children could, indeed, have 'loving' sex with adults."[71] Reisman quickly realized that she was addressing an "entire field of sex research therapy and education [that] relied on Kinsey's human sexuality model for authority, and I was there to tell his key disciples Kinsey was a fraud."[72]

Through her research Reisman discovered that one of Kinsey's sex collaborators was the documented Nazi and convicted German spy George Sylvester Viereck. In the 1990s Reisman teamed up with the British Yorkshire Television research team and flew to Berlin to see if they could find any other Nazi collaborators. They uncovered a German national scandal that tied Alfred Kinsey to a child molester. In 1957 the Berlin press had been filled with stories linking Alfred Kinsey with the accused pedophile Dr. Fritz von Balluseck. Von Balluseck was accused of sexually abusing and murdering a 10 year old child, and as his past was brought to light it shocked Germany. Von Balluseck had raped and sodomized his own children and possibly hundreds of other Jewish, Polish, and German children. According to German news sources von Balluseck was a Nazi commander of a small Polish town during World War II and warned the children he targeted, "It is either the gas chamber or me."[73]

Dr. von Balluseck compiled four diaries of his sexual activity with children 9 to 14 years old, recording the smallest detail and sending the information regularly to Alfred Kinsey. Von Balluseck stated in the trial that "Kinsey himself asked me for that."[74] Neither Indiana University nor the Kinsey Institute would provide any evidence to the FBI that Kinsey knew anything about Dr. Fritz von Balluseck's sexual activity with children. While Kinsey was still alive the FBI had sought von Balluseck's sexual diaries, but Kinsey would not provide them. According to Paul Gebhard both he and Kinsey sympathized with von Balluseck. Gebhard was quoted by Reisman, "the poor paedophile ... had his reputation destroyed."[75] Von Balluseck was convicted of child sexual abuse, but acquitted on the murder charge. After he served his sentence he continued his correspondence with Paul Gebhard.[76]

All through 1957 while the German press was reporting the scandal that German serial child molester von Balluseck had been recording his activities for years and sending the diaries to Alfred Kinsey, the American press chose not to share this controversial news with the American people. The question arises: were the same political forces that deflated the Reece Commission's investigation of Kinsey in the 1950s also responsible for keeping this damning information on Kinsey quiet?

The British Yorkshire Television documentary *Kinsey's Paedophiles* uncovered a lot of information on Kinsey's questionable research. Paul Gebhard told a British interviewer that Kinsey sought out pedophiles in prisons and that he had gotten pedophile organizations in America and England to cooperate with his team.[77]

The "college graduate" described by Wardell Pomeroy as holding "a responsible government job" and having "had homosexual relations with 600 preadolescent males" and "heterosexual relations with 200 preadolescent females"[78] was identified as U.S. federal government land surveyor Rex King.[79] The Yorkshire documentary revealed that Kinsey's mentor and colleague Robert Dickinson had trained Rex King "how to measure things, and time things, and encouraged him to."[80] Kinsey biographer Jonathan Gathorne-Hardy stated that Kinsey's wife typed eight or nine volumes of Rex King's journals before 1945.[81] Gathorne-Hardy also revealed that Kinsey "was deeply affected by five paedophile headmasters who ... had ... loving relationships with young adolescent boys of twelve or thirteen."[82]

Kinsey biographer James Jones was not supportive of Kinsey's use of pedophiles. In the Yorkshire Television documentary he talked about the Kinsey *Male* chapter on childhood sexuality. Jones stated, "Many of his victims were infants and Kinsey in that

chapter himself gives pretty graphic descriptions of their response to what he calls sexual stimulation. If you read those words, what he's talking about is kids who are screaming. Kids who are protesting in every way they can the fact that their bodies or persons are being violated."[83] Jones then addressed the Kinsey Institute's claim that the children used in Kinsey's research did not complain. "How did they know they didn't complain? The person who was rendering that information is the same person who abused them. It seems to me that they have as much credibility as a rapist would have, saying that the victim enjoyed the rape."[84]

In his biography of Alfred Kinsey James Jones revealed, through an interview with Kinsey aide Vincent Nowlis, that Kinsey had considered Rex King "a scientific treasure," because "privately, Kinsey had long believed that human beings in a state of nature were basically pansexual. Absent social constraints, he conjectured, 'natural man' would commence sexual activity early in life, enjoy intercourse with both sexes, eschew fidelity, indulge in a variety of behaviors, and be much more sexually active in general." Kinsey seemed to have equated himself with Charles Darwin and through Rex King Kinsey believed he "had discovered his 'missing link.'" On a personal level Kinsey had spent "much of his life feeling guilty and constrained, he admired Mr. X [Rex King] as 'a hero' because 'the guy had the courage and the ingenuity and the sexual energy and the curiosity to have this fantastic multi-year odyssey through the Southwest and never get caught.'"[85]

The Yorkshire Television documentary was able to locate and interview one of the children used in Kinsey's research data. Esther was around sixty-four years old at the time she was interviewed. Her grandfather had met Alfred Kinsey in a biology class in

1922. Both her grandfather and father sexually abused her starting at the age of four years old in 1938. At the peak of the sexual abuse period she remembers her father pulling a paper from a brown envelope and reading her some questions. There was a word she did not understand – orgasm. "My father explained to me what an orgasm was. And he asked me to let him know when there was an orgasm. He always looked at his watch … he said, he had a deadline to meet and you had to send [the paper] away. So he put it in this envelope and I have never seen it since."[86]

Esther remembered at least one time that a movie camera was running.[87] This memory is significant because Paul Gebhard admitted to Reisman that the Kinsey team not only had notes from parents who sexually experimented with children, but also a few instances of cinema.[88] At one time Esther met with Alfred Kinsey in the accompaniment of her father. Kinsey asked her if she was happy and if she loved her daddy. She was told before hand by her father "to be very nice to this man, that he was a very famous man."[89] Esther responded according to what her father had told her to say - she affirmed to Kinsey that she was happy, and her response seemed to satisfy Kinsey.[90] When Esther was an adult she went to a psychologist to help her cope with the sexual abuse that she had endured. She recalled the visit, "I found Kinsey's lies coming right back at me. And then I realized that the Kinsey Institute is teaching the psychologist, I just got through paying money to see!"[91]

During the filming of the Yorkshire Television documentary *Kinsey's Peodophiles* the director of the Kinsey Institute was John Bancroft. Bancroft was asked by a British reporter what contribution the Kinsey's tables on male child orgasm had "'actually contributed to science's understanding of sexuality in children?' Bancroft

replied that it showed that boys 'before puberty were capable of experiencing more than one orgasm, whereas, after puberty that is not the case.' Otherwise, he said, Kinsey's child sex data have been scientifically 'irrelevant.'"[92] Kinsey's child sex data may have been irrelevant to scientific truth, but it was very relevant to psychology and the new discipline of sexology. Reisman discovered at the Fifth World Congress on Sexology in July of 1981 that many sexologists at the conference "wholeheartedly agreed that children could, indeed, have 'loving' sex with adults."[93] As an adult Esther went to a psychologist for help to resolve the sexual abuse she endured as a child and her psychologist reiterated Kinsey's dogma on child abuse to her.

Conclusions

Kinsey's statistics and philosophy were used as scientific evidence by those who sought to change the status of homosexuality in the American Psychiatric Association (APA) and in the culture. At the February 1973 presentation of the request to remove homosexuality's status as a disorder before the APA's Nomenclature Committee, the gay contingent chose to invite two prominent Kinsey disciples to bolster their case, Wardell Pomeroy and Alan Bell. Pomeroy cited sections of the 1948 *Male* volume and urged the Nomenclature Committee "to acknowledge homosexuality as a normal variant."[94] Charles Silverstein was "chosen by the gay contingent to prepare a statement outlining the gay critique of the psychiatric orthodoxy." He started his presentation "with the early work of Evelyn Hooker, Alfred Kinsey, and Ford and Beach."[95]

Before his death in 1956 Alfred Kinsey founded the Kinsey Institute at Bloomington, Indiana, which would later be renamed the Kinsey Institute for Research in

Sex, Gender and Reproduction. Kinsey was following in the footsteps of homosexual advocate Magnus Hirschfeld who had "established the world's first Institute of Sexology in Berlin" in 1919.[96] Hirschfeld had been very effective in changing societal norms in Germany by using his status as a physician to persuade the German public to accept his theory that homosexuality was something a person was born with, and therefore it should be accepted as equal to heterosexuality. Like Hirschfeld, Kinsey used his status as a scientist to persuade the American public that homosexuality was normal and should be accepted as equal to heterosexuality. Similar to Kinsey, Hirschfeld had "publicly advocated sex between consenting individuals, including adult sex with older children."[97]

Alfred Kinsey created a new field of study in America called "sex research" and "ordained a new high priesthood to carry that research forward, all disciples of Kinsey."[98] The new field of sexology in America looked at sex from an amoral physiologic perspective void of the psychological aspects of sex and cultural norms. It called its perspective scientific. Yet the purpose of the new field of sexology was to change the culture's norms. The evidence supports Judith Reisman's assessment that "the new academic disciple of sexology is a shaman's trade; its claim of sound methodology is hokum. No sensitive-or sensible-person, including a scientist, who understands the dynamics of marriage, real human love, and the absolute trust and commitment they require, would propose or participate in perverse studies such as those conducted by Alfred Kinsey and his team."[99]

Yet this new field of sexology grew even while the tenets of Kinsey's sexual philosophy were discredited time and time again. Kinsey Institute associates like Wardell Pomeroy, Alan Bell, John Gagnon, William Simon, John Money, and Paul Gebhard, as

well as Kinseyan philosophy were influential in the Society for the Scientific Study of Sex (SSSS) and the Sex Information & Education Council of the United States (SIECUS). Classes and degree programs at universities were instituted and directed by those influenced by Kinsey. Wardell Pomeroy became the dean and director of The Institute for the Advanced Study of Human Sexuality in San Francisco (IASHS). The curriculum at IASHS included "analysis of the Kinsey reports; how to create 'sex education curricula'; child sexuality (taught by Dr. Pomeroy); 'forensic sexology'; and teaching students how to give expert-witness court testimony favoring obscenity, pornography, and reduced penalties for sex crimes."[100] On the other American coast a young homosexual activist named Deryck Calderwood was able to institute an accredited sexology degree program through the New York University Health Department's School of Education in 1964.[101]

IASHS in San Francisco was one of the first in academia to use cinema of sexual activity in the college classroom to desensitize sexology students to aberrant forms of sexual behavior,[102] the same process that pornography plays in desensitizing an individual. The use of sexually explicit images to desensitize students became know as Sexual Attitude Restructuring or SAR. The pornographic images of SAR were even introduced in the training of medical students due to the influence of the new American field of sexology. Vernon Mark, professor at Harvard Medical School, wrote, "Kinsey seems to have provided the impetus for showing sex movies to medical students."[103]

In Kuhn's theory some paradigm shifts in scientific fields emerge in the mind of a man immersed in crisis. Kinsey was a man immersed in a crisis over sexuality. Biographer Jones wrote, "Following the publication of *Sexual Behavior in the Human*

Male, Kinsey attempted to build a private world that would provide the emotional support he needed. Within the inner circle of his senior staff members and their spouses, he endeavored to create his own sexual utopia, a scientific subculture whose members would not be bound by arbitrary and antiquated sexual taboos. What he envisioned was in every sense a clandestine scientific experiment, if not a furtive attempt at social engineering: unfettered sex would be the order of the day."[104] According to Jones the experiment for Kinsey resulted in a loss of sexual desire for his wife and the development of an addiction to sadomasochistic homosexual sex.[105]

Kinsey did not live to see the post-1973 paradigm shift in the American Psychiatric Association and how the normal variant view of homosexuality changed the profession and the culture, but he was responsible for laying a significant part of the foundation of the post-1973 paradigm shift.

Notes

[1] Bergler, *Homosexuality: Disease or Way*, 177.

[2] Jones, *Alfred C. Kinsey*, 513.

[3] Pomeroy, *Kinsey and the Institute*, 16.

[4] Ibid., 80-2.

[5] Reisman, *Kinsey: Crimes and Consequences*, 25-8.

[6] Ibid., 37.

[7] Ibid., 219.

[8] Bayer, *Homosexuality and American Psychiatry*, 43.

[9] Kinsey, Pomeroy, and Martin, *Male*, 3.

[10] Ibid., 175-180.

[11] Reisman, *Kinsey: Crimes & Consequences*, 107-8. The quote was referenced from *Sexual Behavior in the Female* by Alfred Kinsey, Wardell Pomeroy, Clyde Martin, and Paul Gebhard, page 122, Philadelphia and London: W. B.Saunders, 1953.

[12] Ibid., 127. Reisman quotes Kinsey's *Female*, page 327.

[13] Kinsey, Pomeroy, and Martin, *Male*, 9.

[14]Ibid.

[15] Pomeroy, *Kinsey and the Institute*, 62-4.

[16] Ibid., 174-5.

[17] Ibid., 174, 186.

[18] Ibid., 176-7.

[19] Ibid., 144.

[20] Ibid., 211-2.

[21] Reisman, *Kinsey: Crimes & Consequences*, 50. This quote is from *Sex Offenders* by Paul Gebhard, John Gagnon,
Wardell Pomeroy, and Cornelia Christenson, 31-3, New York: Bantam Books, 1965.

[22] Ibid.

[23]Ibid., 36. The quote is from a 1940 lecture that was documented in *Kinsey: A Biography* written by Cornelia V. Christenson and published by Indiana University Press in 1971.

[24] Pomeroy, *Kinsey and the Institute*, 207-8.

[25] Kinsey, Pomeroy, and Martin, *Male*, 177.

[26] Pomeroy, *Kinsey and the Institute*, 122.

[27] Reisman, *Kinsey: Crimes & Consequences*, 225. Quoted from *Sex Offenders* by Paul Gebhard, John Gagnon, Wardell Pomeroy, and Cornelia Christenson, 54, New York: Harper and Row and Paul B. Hoeber, Inc., 1965.

[28] Pomeroy, *Kinsey and the Institute*, 78.

[29] Reisman, *Kinsey: Crimes & Consequences*, 170-2.

[30] The Society for the Scientific Study of Sexuality, "Society Founders and Past-Presidents."

[31] Reisman, *Kinsey: Crimes & Consequences*, 102, 170, 172, 176-7.

[32] Ibid., 279.

[33] Ibid.

[34] Ibid., 188. Reisman quote of Jonathan Gathorne-Hardy was from his book *Alfred C. Kinsey: A Life - Sex The Measure of All Things*, London: Chatto & Windus, 1998, 449.

[35] Ibid., 187-9, 196.

[36] Ibid., 205.

[37] Bayer, *Homosexuality and American Psychiatry*, 45.

[38] Bergler, *Homosexuality: Disease or Way*, 7, 51, 90-2, 183-4, 291.

[39] Ibid., 183.

[40] Ibid., 177.

[41] Ibid., 68.

[42] Bieber et al, *Homosexuality – A Psychoanalytic Study*, 304.

[43] Socarides, *Homosexuality – A Freedom Too*, 64.

[44] Socarides, *Beyond Sexual Freedom*, 116.

[45] Ibid., 144. Quote originally published in *Sex and Morality* by Abram Kardiner, New York: Bobbs-Merrill, 1954.

[46] Linder, *You Must Conform*, 36.

[47] Kinsey, Pomeroy, and Martin, *Male*, 630.

[48] Pomeroy, *Kinsey and the Institute*, 208.

[49] Reisman, *Kinsey: Crimes & Consequences*, 100-1.

[50] Ibid., 55. The quote is originally from the article "Self-Esteem, Dominance ... and Sexuality in Women" written by Abraham Maslow and published in *The Journal of Social Psychology*, 1942, 16: 259-294.

[51] Ibid., 56. The quote is by Abraham Maslow from a letter he wrote to Amram Scheinfeld dated April 29, 1970 and on file in the Archives of the *History of American Psychology*, University of Akron, Ohio.

[52] Ibid., 30.

[53] Ibid., 39, 44.

[54] Ibid., 90. The quote is from "The Scientific Method" by Paul Sheatsley and Herber Hyman in the anthology *An Analysis of the Kinsey Report* edited by Donald Porter Geddes, 98, New York: Mentor Book, 1954.

[55] Ibid., 52. The quote is from a private letter from Clyde Martin to Kinsey Institute Director June Reinisch dated December 31, 1990.

[56] Ibid., 51. Quote taken from "Statistics of the Kinsey Report" by W. Allen Wallis in the *Journal of the American Statistical Association*, December 1949, No. 248, Vol. 44, 463-484.

[57] Socarides, *Homosexuality - A Freedom Too*, 69-70.

[58] Kinsey, Pomeroy, and Martin, *Male*, 16.

[59] Pomeroy, *Kinsey and the Institute*, 75.

[60] Gorer, "Nature, Science, and Kinsey," 51-7.

[61] Hobbs, *Social Problems and Scientism*, 17, 41.

[62] Ibid., 83, 91-3.

[63] Ibid., 95, 97, 100-1.

[64] Ibid., 93.

[65] Reisman, *Kinsey: Crimes & Consequences*, 269-70, 273-4. The quote is from the book *Foundations* by Rene Wormser, New York: The Devin-Adair Company, 1958.

[66] Ibid.

[67] Ibid., 272. Quotes from *Foundations* by Rene Wormser, 102-3.

[68] Ibid., 270, 275, 321. The quote from Carroll Quigley was from page 950 of his book *Tragedy and Hope*, New York: Macmillan, 1966.

[69] Kinsey, Pomeroy, and Martin, *Male*, 177.

[70] Reisman, *Kinsey: Crimes & Consequences,* xxii.

[71] Ibid., xxii-xxiii.

[72] Ibid., xxiii.

[73] Ibid., 165-6.

[74] Ibid., 166. The court record was taken from the German publication *Neusss Deutschland*, May 17, 1957.

[75] Ibid.. 165.

[76] Ibid., 167.

[77] Ibid., 135.

[78] Pomeroy, *Kinsey and the Institute*, 122.

[79] Reisman, *Kinsey: Crimes & Consequences*, 135,164.

[80] Ibid, 164. The quote from the British Yorkshire Television documentary *Kinsey's Paedophiles* was from Clarence Tripp who worked as Kinsey's photographer.

[81] Ibid., 136.

[82] Ibid.

[83] Ibid., 135.

[84] Ibid., 136.

[85] Jones, *Alfred C. Kinsey*, 512-3. The quotes used by Jones were from Vincent Nowlis, an assistant who worked for Kinsey.

[86] Reisman, *Kinsey: Crimes & Consequences*, 151.

[87] Ibid., 152.

[88] Ibid., 78.

[89] Ibid., 151.

[90] Ibid., 182. The reference is in note 45.

[91] Ibid., 152.

[92] Reisman, *Kinsey: Crimes & Consequences*, 168. Reisman obtained this quote from the complete transcript of John Bancroft's interview with Tim Tate on the 21st of July 1998.

[93] Ibid., xxii-xxiii.

[94] Bayer, *Homosexuality and American Psychiatry*, 117.

[95] Ibid., 117-8.

[96] Reisman, *Kinsey: Crimes & Consequences*, 21.

[97]Ibid.

[98] Ibid., 253.

[99] Ibid., 67.

[100] Ibid., 81.

[101] Ibid., 170.

[102] Ibid., 81-2.

[103] Ibid., 79. Reisman's quote form Vernon Mark was from *The Peid Pipers of Sex*.

[104] Jones, *Alfred C. Kinsey*, 602-3.

[105] Ibid., 603-4.

Chapter 5

The Philosophical Storm Leading Up To 1973

"In defining heterosexuality as normal and homosexuality as

abnormal,

what is the basis for our judgment?"[1]

(Thomas Szasz, 1970)

From sin to sickness

"Historically, it is to be noted that the government of the erotic life is among the primary requisites for the establishment of human communities, and that the chief business of most if not all of the agencies that dominate the collections of men we call societies is the control of the sexual instincts."[2] There is a lot of truth in this statement by philosopher and psychologist Robert Lindner. Every culture has its own norms of sexual behavior even if the norm is anything goes. Sexual norms vary between nations and even within local communities that exist as melting pots of ethnic and behavioral based cultures.

In general, ancient cultures were ambivalent on the sexual choice of males when they assumed the active penetrating role, but viewed a man being sodomized as a disgrace. Hence, it was a practice in some ancient cultures for the losing warriors in a battle to be sodomized by the victors. Even in Hellenistic Greece when homosexuality was legal and pederasty was considered by some elites to be the highest form of love, the adult male citizen who allowed himself to be sodomized "suffered a diminution of civil rights."[3] In about 1400 B.C the Jewish culture through the Law of Moses declared homosexual behavior a "detestable" sin punishable by death.[4] The Jewish law was unique in antiquity because both roles in the homosexual act were considered to be equally detestable.

Centuries later in about 55 A.D. the Apostle Paul reiterated for Christianity that homosexual behavior was a grievous sin comparable to adultery, drunkenness, greed, and slander. The Christian message Paul preached called for behavioral and psyche change, not civil punishment.[5] During the Renaissance period of human history when Christian priests had substantial political power and dictated European moral norms, homosexuals were often punished more severely than other designated sinners. For example, during the thirteen, fourteenth, and fifteenth centuries when Spain had a church/state government the punishments for homosexual behavior included castration, stoning to death, being burned alive, and confiscation of property.[6]

As western culture moved out of the Renaissance and into the period called the Enlightenment, scientists and physicians became increasingly more influential. In many respects they began to replace the cultural and political positions that the priests of the Renaissance period held. Many abnormal human behaviors that were considered an

abandonment to sin or related to demons during the Renaissance period would be reclassified during the Enlightenment period as diseases or mental illnesses. During the eighteenth century behaviors such as alcoholism, drug addiction, seizures, suicide, and sexual perversions became classified as medical disorders in the developing scientific and medical communities.

The reclassification of many aberrant behaviors from sin to sickness occurred in a turbulent time of cultural transformation. The Enlightenment period of history produced articulated concepts of individual liberty, democracy, socialism, capitalism, religious freedom, freedom of speech, and the rights of man. In this same time period Darwin presented his theory of how mankind might have evolved from other forms of life through a process of natural selection. His theory of evolution gave the atheist, the agnostic, and the religious antagonist a godless creation theory to build other godless theories, philosophies, and worldviews such as humanism. Many of these components became factors in the new philosophies on human sexual behavior.

Is homosexuality a psychopathological condition?

Western clinical science continued to distance itself from biblical morality in the twentieth century. Whether certain sexual behaviors were considered to be sin was of no interest to clinical science. The ultimate goal of clinical science was to help the patient. In order for the medical professional to help the patient with behavior deemed a sexual disorder it was of utmost importance to determine if the abnormal or destructive behaviors were a psychopathological response or symptom. Psychopathology and neuroses were seen as similar in that they both were disorders caused from internal

distress. What differentiated the two classifications was that the psychopath tended to release his internal distress by acting out his impulses and the neurotic kept his internal distress bound up inside. The *Comprehensive Textbook of Psychiatry* 1967 edition stated that "The theory of neurosis is central to psychoanalytic concepts of psychopathology."[7]

In 1955 Robert Lindner defined psychopathological behavior as "when, for any reason, a person regresses in his behavior to infancy, when he expresses infantile aims and seeks their realization by infantile techniques."[8] From both these definitions psychopathology was not an illness like cancer or the measles, but it was a disorder. Lindner described the psychopathic personality as "a form of disorder that renders its victims essentially antisocial, conscienceless, inclined to violence in behavior and liable to loss of identity in the group."[9]

In the godless atmosphere of science homosexuality could not be clinically or culturally equal to heterosexuality if it were a psychopathological condition. Thus for any group trying to make homosexuality culturally equal to heterosexuality in modern times, they would have to convince the public that it was not a pathological disorder. Early in the twentieth century German physician Magnus Hirschfeld was one of the first gay activists to argue that homosexuality was not disorder. The foundation of Hirschfeld's argument was a genetic hypothesis justifying homosexuality. Hirschfeld believed that homosexuality was not a disorder or psychopathological condition because homosexuals were born that way. [10] If homosexual desires were something an individual was born with, they would not be disguised neurotic symptoms. Hirschfeld promoted his ideology by founding the world's first sexology institute.[11]

The developer of psychotherapy, Sigmund Freud, categorized homosexuality with bestiality and pedophilia as a "deviation in respect to the sexual object."[12] Obviously, a sexual deviation with a person of the same sex, an animal, or a child is the acting out of an impulse. If the acting out is the result of internal distress it would be categorized as psychopathological according to Lindner's definition. Freud and the other medical professionals who saw the homosexual condition as a disorder did so based on clinical evidence and not from a moral philosophy. Their professional opinions were amoral in relation to sexual behavior. Freud wrote these words to an American mother of a homosexual in 1935, "Homosexuality is assuredly no advantage, but it is nothing to be ashamed of, no vice, no degradation, it cannot be classified as an illness; we consider it to be variation of the sexual function produced by a certain arrest of sexual development."[13] According to Freud this "arrest of sexual development" was an impairment found along a human sexuality growth continuum which led to heterosexual behavior. From Freud's assessment homosexuality could not be classified as an illness, but it could be a disguised neurotic symptom.

Sandor Rado took the psychopathological aspects of homosexuality to a more provable and useful level. He hypothesized that homosexuality was often a reparative response stemming from an individual's internal conflict which resulting from childhood trauma in the parent-child relationship. Rado saw the homosexual adaptation as psychopathological in these situations, but he did not think all homosexual behavior was psychopathological in the sense that it was a reparative impulse.[14] As noted earlier Rado believed that homosexual behavior could be the result of situations where there was a lack of opportunity for heterosexual behavior or the result of desires for variation.

Robert Lindner also believed homosexual behavior could be either a psychopathic impulse or merely a culturally related choice. From his own observations Lindner believed some men had entered into the homosexual lifestyle because of homosexual propaganda that promised "mystery, excitement, and magic." Yet, Lindner's description of the classic psychopath etiology is eye-opening. "For most psychopaths the initial hurt to the ego grows out of the erotic triangle: mother, child, father. Because, for numerous reasons, a proper and proportionate image of the father is not absorbed, all that in later life stems from the father in Western culture - authority, precept, custom, morality - is fated to be rejected with hate. ... In most instances the mothers (or their substitutes) contribute equally to the making of this human deviate. ... In case after case, a tale of seduction on the mother's part; not necessarily a sexual seduction, but rather an emotional binding of the child to the mother, a desperate overindulgence that arises from her anxiety ... [For the psychopath] to satisfy ordinary needs, it henceforth became necessary for him to select erotic objects, and to do erotic deeds, as far as possible removed from the cherished but forbidden maternal image. ... It expresses itself mainly by perversions to avoid guilt, but it only succeeds by this kind of expression in achieving more guilt. ... Often, in the attempt to avoid the incest prohibition, it takes a homosexual form; but it is done, even here, with an object of convenience rather than choice, and consummated at white heat with violence and contempt for the other person."[15] Lindner's typical psychopath etiology is basically identical to the typical homosexual etiology arrived at by Irving Bieber and the Society of Medical Psychoanalysts. Linder saw homosexuality as a psychopathologic symptom if it was related to an "initial hurt to the ego" that resulted in a perversion to avoid guilt.

By 1973 many psychiatrists who adhered to Sandor Rado's reparative theory of homosexuality had successfully helped homosexuals change their sexual orientation to heterosexual. They all believed homosexuality to have psychopathological origins related to childhood trauma. They helped their clients resolve their inner conflict, the inner pain and rejection related to neuroses. Often the resolution achieved in psychotherapy removed the unwanted homosexual desires and attractions of the client, which reinforced the psychoanalyst's belief that homosexuality was a neurotic symptom for those clients.

By the late 1960s gay activist were drawn to arguments claiming the psychopathologic labeling of homosexuality was a mistake, because new relativist philosophies rendered the clinical science on homosexuality irrelevant. Frank Kameny was considered by many to be the most important gay leader in this time period. A small but vocal group of mental health professionals and researchers provided the philosophy and theories to discount the 1973 paradigm that homosexuality was a disorder or symptom of a disorder. Some of the more prominent professionals espousing this view were Judd Marmor, Robert Seidenberg, Thomas Szasz, Richard Green, Hendrik Ruitenbeek, and George Weinberg.

Most of the academics and mental health professionals who argued that homosexuality was not a psychopathological disorder did not present alternative evidence; they simply invalidated the current clinical evidence with philosophical accusations. This example by normal variant stalwart Robert Seidenberg illustrates the tactic. "The countless volumes that have been written by the 'experts' on the subject of homosexuality turn out to be justifications for society's prejudices against an 'erotic minority.' They contain nothing different from what religion and the conventional

wisdom have always been saying. The experts continue to prove that the homosexual is 'sick,' 'regressed,' 'immature,' 'polymorphous perverse,' 'orally fixated,' and forever doomed by his 'passive, feminine identification.' With all of this, it is a wonder that the poor fellow can make it to the nearest bar." ... "The relevant question is not what makes homosexuals, or what to 'do' with them, but rather, what makes society persecute them."[16] The hypocrisy of Seidenberg's statement lies in his blatant prejudice. In the same paragraph where he criticizes society's past prejudices, his own prejudice leads him to discount "countless volumes" of objective evidence.

Many gay activists and some mental health professionals wanted to believe that researcher Evelyn Hooker had proven that homosexuality was not a psychopathologic condition. Evelyn Hooker had set out as the goal of her research to show that homosexuality was not necessarily pathological. She sought out "normal homosexuals" for her research; those who were content with their homosexual orientation and were not in psychotherapy. Hooker became friends with homosexual activist leaders in Los Angeles who in turn provided her with what they considered normal homosexuals. Her premise was that if she could find one homosexual who was not considered psychopathic, then homosexuality was not necessarily a psychopathological condition.[17]

She concluded from her study of 30 homosexuals and 30 heterosexuals that homosexuality cannot be assumed to be a psychopathological disorder, because she documented homosexuals who did not have psychopathic disorders according to three personality tests - the Rorschach, Thematic Apperception Test, and Make-A-Picture-Story. Her conclusion was hailed as monumental by gay activists, but it really offered nothing new. Hooker's tests were not used to test whether homosexual behavior was a

psychopathic impulse, but rather sought to determine if normal homosexuals were as well adjusted to living in American society as were heterosexuals. [18] In addition Irving Bieber pointed out that "Neither Hooker nor the judges defined what they considered to be 'well adjusted.' At best, the term refers to a purportedly well functioning individual without gross visible symptoms. It does not preclude the presence of severe underlying psychopathology."[19]

Because a homosexual did not have a visible psychopathological disorder did not mean that the homosexuality was not a psychopathic condition or caused by psychopathological conditions related to childhood. The reparative function of the homosexual behavior, as Sandor Rado had pointed out, "may enable the individual to recapture his losses in function, pride, and social usefulness."[20] Hooker acknowledged that somewhat by stating that her Rorschach tests may not have been an adequate test. She even qualified her research, "Another way of looking at the data from the projective tests may be that the homosexual 'pathology' occurs only in an erotic situation and that the homosexual can function well in nonerotic situations such as the Rorschach." That theory would account for the normal personality tests of most of the homosexuals and fits right into Rado's reparative function of homosexuality.[21]

Two thirds of Hooker's homosexual group matched very closely to two thirds of the heterosexual group. The other third was remarkably different; more on the order of what clinical science had shown. The personality tests in the other third showed that seven of these nine homosexuals had a psychopathic condition. Their personality characteristics were described as "pseudo-normal, near-psychotic," "strongly destructive," "anal-sadistic," "very narcissistic," "incapable of guilt," and "regresses

easily into the infantile." It is important to note again that this was not a random sample of homosexuals, but homosexuals delivered to Hooker by gay activists in the local Mattachine Society. These activists knew that Hooker was trying to show homosexuality was not necessarily pathological and they provided her with the most stable homosexuals they could get. The other third of the heterosexual comparison group did not show the psychopathic nature of its homosexual counterpart.[22]

Hooker's research did not negate the fact that for many homosexuals their homosexuality was a symptom of psychopathology. Using the logic of Hooker's premise in reverse, if one homosexual is psychopathic and the psychopathology is related to the homosexuality, then homosexuality is at least sometimes a psychopathological condition. The clinical evidence showed that homosexuality was often a psychopathological condition.

As noted in the previous section Kinseyan reasoning was used frequently in the new rationale to undermine the clinical science that showed homosexuality to be a psychopathological condition. Kinsey ignored the psychological motivation in sexual behavior. He only documented what individuals did sexually and who they did it with. His rationale implied that if a sexual behavior was statistically significant, then it was not pathologic or something to be discouraged. Kinsey was tolerant of all sexual behavior, yet he was "intolerant of every other approach to sex research than his own."[23] That kind of bias was typical of the advocates who professed that homosexuality was not a psychopathological condition. They were quick to point out any bias that respected Judeo/Christian morality, yet were oblivious to their own amoral bias. They sought

tolerance in the form of creating equality between homosexuality and heterosexuality, yet were intolerant of those who believed heterosexuality should be held as the cultural ideal.

The challenge presented by Lindner and Szasz

Psychologist Robert Lindner was antagonistic toward Judeo/Christian cultural norms. He argued that the social temper that described the homosexual as "sick" instead of a "sinner" was "merely another maneuver, another device, to preserve the rigid sex morality of our sex denying society." Lindner was an early prophet of the new liberal morality. He argued that non-conformity had "become the major if not the only sin" of the 1950s. His message to the medical establishment was "our social order has been betrayed by the myth of adjustment to the extent that non-conformity and mental illness or disease have become synonymous."[24] Instead of the social order using religious leaders to coerce people to conform to norms set by religious doctrine, Lindner argued that the current social order was using medical professionals to coerce people to conform to norms set by the medical establishment. That was a radical declaration in 1956.

Lindner's views were marginal in the 1950s and 1960s, but they are an early example of the new moral rationale that would greatly influence the medical and academic establishments. What made Linder's writings so unique was that he articulated the beliefs behind his reasoning. Most dissenters of the Judeo-Christian norms of America did not share their own belief system. One of Lindner's basic assumptions regarding human nature was that "No man lives who does not, in one way or another, exhibit the operation of the religious need. Indeed, no man *can* live without some kind of religion, some sustaining faith, be it only a collection of self-made illusions or a set of

obsessive ideas and compulsive observances arising from his individual psychology."[25] Linder recognized what many of his contemporaries did not want to admit to. Their core beliefs were a faith. Not in a god, but a substitute religion none the less.

Lindner's own sustaining faith reflected his Darwinist belief system. To Lindner mankind existed in a prison of limitations that bound him from reaching god-like status. The three walls of this prison binding man, from Lindner's belief system, were (1) "the medium provided by nature" like having to breathe a certain mixture of air and eating specific substances, (2) mankind's "endowed equipment" like our limited strength, vision, and mental capacity, and lastly (3) mankind's "mortality", our limited lifespan. Lindner rejected all speculation of a God designing man in His image. He "identified the purpose of life with the purpose of evolution," Linder believed mankind's purpose was to endeavor to overcome the limiting prison mankind was in. "To break through this prison, to escape from it, is, I believe, the purpose of life and the design of evolution."[26]

Lindner saw the rebellious nature of mankind as an evolutionary temperament seeking to eventually overcome mortality, human physical limitations, and the earth's environment. This "rebelliousness appears to be the essence of man's nature, the theme of his life and meaning – if there is any at all – of his existence." Lindner argued that his belief system would give a child "a sense of the great and abiding mission of his life. Such an attitude, to my mind, replaces formal religion with something that is not only healthier psychologically, but of far more spiritual value."[27]

From this belief system Lindner's sympathetic interest in the "plight of the homosexual" was directly related to his revelation that society unjustly punished those who did not conform to its norms. Although he saw homosexual behavior at best related

to sex-repression and an unproductive counter-rebellion, he saw society's hostility toward homosexuality as an inflexibility that refused to accommodate "the restless, rebellious nature of the human animal."[28]

Lindner's lasting philosophical legacy was his direct influence on Thomas Szasz. Psychiatrist Thomas Szasz took Lindner's perspective that non-conformity had become synonymous with mental illness to the next philosophical level. Szasz argued that just as the Church in medieval society supplied ideology that brought repression by the state, today "the Scientific Establishment supplies the ideology" for State sponsored repression. In 1970 to the dismay of many psychiatrists Szasz made a compelling argument that the involuntary placement of so-called mental patients into an asylum was the equivalent of the Inquisition's persecution of so-called witches. Szasz argued, "Today, the institutional psychiatrist accuses the citizen of mental illness and diagnoses him as psychotic; he then turns him over to the court – that is the State – and he is committed to a prison called a mental hospital."[29]

"The alcoholic, the addict, the homosexual – all these and many more are said to be mentally ill. Our foremost psychiatrists and highest judges tell us so." According to Szasz, the institutional psychiatrists, like the inquisitors, punished their subjects under the guise of helping them. "The psychiatrist is saving the 'patient' from drug addiction, homosexuality, suicide, and a host of other terrifying 'mental illnesses' even though, again, the victim makes it unmistakably clear, by word and act, that he does not wish to be saved."[30]

Although Szasz made widespread accusations his main charge was against institutional psychiatry which generally treated unwilling patients. He tended to separate

institutional psychiatry from contractual psychiatry which treated patients who voluntarily sought help. While Szasz saw institutional psychiatry as repressive, he stated at times that contractual psychiatry was a human service of great value. At other times Szasz included contractual psychiatry in his broad condemnations of psychiatry, especially on the treatment of homosexuality. Because Szasz imparted his distaste of societal norms in his condemnation of institutional psychiatry, he too became a leader of the new morality.

Szasz's views on homosexuality showed his own bias. He referred to the biblical story of the two angels appearing as handsome young men in ancient Sodom as the "earliest account in human history of the entrapment of homosexuals ... These agents of the Biblical vice-squad wasted no time punishing the offenders." Szasz inferred that the God of Israel was unjust in entrapping the men of Sodom who sought to anally rape the two angels in the form of young men, to the same degree that he thought it was wrong for government agents to entrap men seeking homosexual contacts in public places. It is an interesting point of view that revealed his contempt of American's Judeo/Christian morality and police entrapment of public homosexual sex.

From the mid 1700s to the beginning of the twentieth century psychiatry considered masturbational insanity an illness. Szasz saw "no significant difference between the former persecution of masturbators and the present persecution of homosexuals or alcoholics." Homosexuals, alcoholics, drug addicts, and suicidal people, according to Szasz, were "medically stigmatized and socially persecuted individuals."[31] Ending the social persecution was of more importance to Szasz than any etiological evidence of psychopathology or benevolent efforts to help those individuals.

Szasz ignored and rejected the etiological evidence of homosexual causation. He mocked psychiatrists like Bieber who from clinical experience described behavioral patterns of children who would likely become involved in homosexuality. He ignored the fact that many homosexuals sought contractual psychiatry for help because they did not want to be homosexual. He accused psychiatry of "torturing" the homosexual under the ruse of helping him.[32] Szasz presented a good argument that institutional psychiatry was an agent of the State and then without evidence or logically sound premises came to the conclusion "that psychiatric opinion about homosexuals is not scientific proposition but a medical prejudice."[33] The conclusion did not follow from his institutional psychiatry premises. His argument used bait and switch trickery. He gave facts regarding institutional psychiatry's transgressions and made a conclusion that included contractual psychiatry. He had not shown that homosexuality was not a disorder. Szasz's conclusion was his own prejudice, but most of his peers were confused by the bait and switch tactics.

Szasz did push the medical establishment against a philosophical wall and he used the pressure to argue that homosexuality as well as alcoholism, drug addiction, racism, and suicide were not mental illnesses. Psychiatrists, according to Szasz, created the concept of mental illness and were acting as "agents of social control."[34] Lost in Szasz's accusations was the logical conclusion that if mental illness was only a created concept then not only was institutional psychiatry not needed, but contractual psychiatry was not needed either, which Szasz supposedly valued.

Szasz's contributed another philosophical argument used by Judd Marmor to undermine a basic assumption of the Bieber group. Szasz argued that heterosexuality should not be accepted as a social value because of its biological value. "We delude

ourselves," Szasz wrote, "if, because of its biological value, we accept heterosexuality as a social value. The jump from biological value to social value is the crux of human morality."[35]

Szasz described the role of psychotherapy as "a purely 'analytic' enterprise; the therapist's activity is limited to helping the patient learn about himself, others, and the world about him." From this premise Szasz argued that "the goal of converting homosexual to heterosexual conduct" was "incompatible" with psychotherapy, because it would be an attempt "to change the patient's values."[36]

The weakness in Szasz's argument is best illustrated when compared to the other disorders Szasz associated homosexuality with – alcoholism, drug addiction, and suicide. If it was incompatible with psychotherapeutic principles to have a goal of converting homosexual conduct to heterosexual, then the same argument applied to the goals of converting alcoholic conduct to sober conduct, drug use to activities that did not drug abstinence, suicidal actions to actions of life appreciation, because these goals would be attempts to change the patient's values. Szasz's argument was oblivious to the fact that the patient's values were what created the patient's goal to be heterosexual, sober, drug free, or non-suicidal. Helping a patient with a goal of changing their homosexuality, alcoholism, or suicidal thoughts was not incompatible with psychotherapy; it was the purpose of psychotherapy.

The contradictions in Szasz's logic and his bias were generally overlooked by mental health professionals. Yet, the main revelation from Szasz was not that medical organizations had replaced religious organizations as governmental agents legislating acceptable behavior. The main revelation was actually how much political power

psychiatrists held in western society. As Szasz articulated it, "Today, medicine is worshiped for promising, through its false prophets, the psychiatrists, moral tranquility on earth."[37] Some were aware of it before, but through Szasz all who read his arguments knew it. The mental health professionals who saw homosexuality as a disorder felt that their profession was created to help the individual, and generally agreed with Szasz that unwilling patients should not be forced to change their behavior. They were left in confusion for the most part by Szasz, wondering what role the mental health profession should play in determining cultural norms.

A minority of mental health professionals who believed homosexuality should be considered a normal variant were inspired by Szasz to use the mental health profession's political power to change the cultural norms to their particular philosophy. Szasz himself brought out the fact that "many psychiatrists have implied that the aim of psychiatry should be to replace morality by an ostensibly value-free mental health technology."[38] To bolster this claim Szasz quoted G. Brock Chisholm, a former director of the World Health Organization: "The reinterpretation and eventual eradication of the concept of right and wrong ... are the belated objectives of practically all effective psychotherapy. ... With the other human sciences, psychiatry must now decide what is to be the immediate future of the human race. No one else can. And this is the prime responsibility of psychiatry."[39]

While Szasz implied that Chisholm had crossed the line by acting as an agent of the state through the World Health Organization, Szasz's own moral philosophies mirrored G. Brock Chishom's vision of eradicating right and wrong moral behavior. If someone wanted to live as an alcoholic, let them, but more significantly Szasz implied that alcoholism was equal to sobriety, suicide to life, homosexuality to heterosexuality. In

these discourses Szasz awakened medical professionals to their political power in American culture.

The challenge presented by Weinberg

Psychiatrist George Weinberg used Thomas Szasz's philosophical arguments, but only applied them to homosexuality in his landmark book *Society and the Healthy Homosexual.* "Dr. Thomas Szasz has likened psychoanalysts to preachers. They are never more so than when arguing for sexual abstinence." Weinberg argued, "In the place of Hell used by preachers to frighten homosexuals, psychoanalysis warns homosexuals that they will suffer a dissolute life, an incomplete existence, and old age spent in misery." The truth, according to Weinberg, was that the experts who made these dire warnings were only guessing and too much had been staked on the "conjectures" of these experts.[40]

Weinberg offered a glimpse into his belief system. "But suppose that we, members of the human family, are truly unlike one another – we are unlike one another and the choices we make as individuals render us more unlike one another every day. Under this supposition, we are all deviates – each from the rest of us. In this sense, none of us can be more deviate than others, since *to exist is to be deviate.*" From that belief system Weinberg conjectured that "nature smiled" on the day of the first Gay Day parade in New York City, "perhaps because homosexuality is found everywhere in nature. Man is the only creature beneath the sun who condemns it." Weinberg rationalized, "Where a person is not harming himself and not harming other people, the assertion that he is psychologically sick is meaningless." This belief system also supported Weinberg's concept that the goal of changing homosexual orientation to heterosexual was in effect

the goal of "stamping out one aspect of human variety, one facet of human possibility – merely because it distressed us to think about that possibility."[41]

Weinberg used several broad premises about human behavior to build his arguments for homophobia and homosexuality's normalcy. One of those premises was: "Once an attitude is formed, in some cases at least, it may not be dislodged by evidence alone."[42] The situational application that Weinberg referred to was psychoanalysts who thought of homosexuality as a disorder, upon meeting healthy and happy homosexuals, they still considered homosexuality a disorder.

A second general premise Weinberg presented emphasized how an individual's actions influence their beliefs. "Once a person acts on any belief – in this case, disdain for homosexuals – among the outcomes is that he makes the belief seem righter than ever. This principle is, I think, more important than any other in psychology. After holding numerous beliefs, we choose to act on certain of them, and by so doing we make them seem more reasonable."[43]

In defense of the "homophile movement" Weinberg argued that the gay rights movement was only seeking permissibility not preferability. Weinberg claimed that virtually no one maintained that homosexuality was preferable to heterosexuality. The "cornerstone" creed of the movement by homosexual activists was that "there should be no proselytizing for any sexual orientation as preferable. … Gay liberation implies freedom from having to align oneself in sexual preference with dictates from anywhere."[44] In actuality there were many homosexuals who believed homosexuality was superior to heterosexuality, but that was never the core of the debate. The division in the mental health profession and in the culture was whether homosexuality should be

considered just as healthy and normal as heterosexuality. Homosexual activists were not just asking for permissibility, they were asking for equality of sexual status.

The new morality

The worldwide moral direction suggested by G. Brock Chisholm and implicitly shared by Alfred Kinsey, Thomas Szasz, George Weinberg, Hendrik Ruitenbeek and others was a belief system founded on relativism. In this belief system right and wrong are not absolute, but dependant on culture and the individual, and each culture and individual is reasoned to be equal in their right to define right and wrong. From this reasoning came a value-free moral imperative. No individual or force should determine right and wrong for another person, because each individual should have the right to determine right and wrong for themselves, unless of course the person was harming another person – the harm principle qualification.

The emerging new morality reflected the value-free attitude the psychoanalyst needed with a patient in psychotherapy. It was this clinical non-judgmental approach to personal behavior that the Szasz, Weinberg, and Ruitenbeek sought to project into a national morality. Antagonistic toward the existing Judeo/Christian cultural norms, the new sexual morality mirrored the early moral imperatives of German gay activist Magnus Hirschfeld. It was championed by Alfred Kinsey, and shared by Pomeroy and the discipline of sexology.

Both sides of the psychopathology debate on homosexuality believed that the punitive laws against homosexuals were excessive or totally unwarranted. Reparative psychoanalyst Lawrence Hatterer called the laws that treated homosexuality as a crime

"antiquated."[45] Normal variant psychoanalyst Judd Marmor argued that other than indecent acts in public or the seduction of minors, "When, however, homosexual behavior takes place in private between consenting adults, it should not be even the law's business."[46] There was support across the broad spectrum of psychoanalysts to help remove the criminal penalties for homosexual behavior between consenting adults in private, but only a small minority wanted to make homosexuality equal to heterosexuality.

The reparative psychoanalysts sought the removal of criminal sanctions against homosexual behavior because they believed in individual sexual liberty in private environments, and they believed homosexuals as a group with a psychological based disorder were being unjustly persecuted. Normal variant psychoanalysts also believed homosexuals were unjustly persecuted, but they did not see homosexuals as having a disorder. They viewed homosexuality as equal to heterosexuality because they believed there was no right and wrong sexuality. To the normal variant coalition criminal sanctions against homosexuality were wrong because their relativist belief system reasoned that homosexuality was equal to heterosexuality.

From a moral relativist perspective psychoanalyst Richard Robertiello encouraged a wife to continue in her extramarital affair, encouraged a homosexual man to seduce young men, and encouraged a married man to frequent public bathrooms to watch homosexuals engage in sexual acts and expose himself to them.[47] It was all relative and just another expression of sexuality. This was the type of counseling that was needed in America's sex-denying culture according to normal variant advocate Hendrik Ruitenbeek. George Weinberg's relativist philosophy led him to argue that to help a

person with unwanted homosexual attractions change their sexual orientation was akin to an immoral act of "stamping out" a human sexual variety.[48] From a moral relativist perspective Robert Seidenberg ridiculed Charles Socarides' clinical research and suggested that homosexuals become the "new ecological cult-heroes," by renouncing the traditional family and not producing children in an already over-populated world.[49] Thomas Szasz came to that same conclusion suggesting "to lessen the danger of overpopulation, we might even advocate homosexuality over heterosexuality; this choice could be supported as a contraceptive technique, especially for women intellectually or artistically gifted, for whom the value of traditional feminine heterosexuality is a barrier to achievement."[50]

From ta relativist moral perspective normal variant psychoanalysts and counselors rationalized not telling clients with unwanted same-sex attractions that research showed homosexuality was often a reparative effort to overcome psychopathological parent-child relationships. They justified not telling clients with unwanted same-sex attractions that sexual orientation change was possible. Instead, those with unwanted same-sex attractions would be told by normal variant therapists to accept their homosexuality because it was a life equal to the heterosexual life. It was this moral relativist philosophy that would not only reshape the sexual morality of psychiatry and academia; it would redefine their mission.

Misrepresenting the opposition

Thomas Szasz had made the case for individuals with behavioral problems not being forced or even encouraged to change their ways, yet Szasz at one point in the same

book stated that psychiatrists had "the right to consider homosexuality a disease (however defined)." His argument in this instance was "If that concept helps them, they will be wealthier; if it helps their patients, the patients will be happier. Second, should psychiatrists have the power, through alliance with the State, to impose their definition of homosexuality as a disease on unwilling clients? I say: Of course they should not."[51] Judd Marmor agreed with Szasz "that there is not ethical or scientific justification for forcing such treatment on an unwilling homosexual."[52] Robert Seidenberg also supported the unwilling homosexual arguing that "conversion should no more be demanded of them in therapy than of a Jew or Catholic."[53]

One would assume from these writings that the reparative psychoanalysts forced the concept of sexual orientation change on unwilling clients. That was the picture normal variant advocates painted of the reparative psychoanalysts, but the facts showed otherwise. Prominent mental health professionals treating homosexuality as a disorder did not force sexual orientation change on their patients. Their homosexual patients voluntarily came to them seeking help. The patient determined whether or not they wanted to try to change their sexual orientation. Irving Bieber wrote this about his psychotherapy process: "I inform the patient that heterosexuality is desirable for many reasons to be elucidated as the analysis proceeds, but that he will neither be pushed nor tricked into it, that he will be the one to make sexual decisions, and that, as long as sexuality involves consenting adults, there is no judgmental bias or interest other than information necessary for the analytic work."[54] Charles Socarides wrote in 1968, "the selection of patients with homosexual symptomatology is no different from the selection

of all patients for psychoanalytic therapy." One of the main considerations was "that psychoanalytic treatment must be voluntarily undertaken."[55]

Before 1973 Lawrence Hatterer gave some of the most detailed guidelines to help psychoanalysts treat homosexuals. Regarding the patient/analyst relationship he wrote "The most important attitude a therapist can assume is to keep his mind open to the number of alternatives and ultimate goals for each patient. ... The patient incapable of and totally undesirous of adapting to heterosexuality will say just that, and he must be taken at his word."[56] Group therapist Elizabeth Mintz saw a significant percentage of her homosexual patients change their sexual orientation, and it was "entirely the patient's choice whether or not he would attempt to alter his homosexual adjustment."[57]Edmund Bergler had proclaimed in 1956 that homosexuality was now curable, but qualified this new breakthrough, "We can help only those who want to be helped."[58]

In reality, normal variant mental health professionals who devalued the homosexual patient's goal of heterosexuality were undermining the individual homosexual's right to determine his own fate. Some normal variant advocates refused to acknowledge that unwanted same-sex attractions and compulsive sexual activity imprisoned many homosexuals in an identity they did not want. They encouraged a client's homosexuality even though the client homosexual wanted it removed from their personhood. Psychoanalyst George Weinberg argued that for a homosexual to try to convert to heterosexuality was analogous to attacking his own sexuality – a self inflicted blow to his chance at intimacy.[59] Ralph Blair called attempts at helping clients with unwanted homosexual attractions "unrealistic and even immoral."[60] Gay psychologist

Charles Silverstein wrote that the psychotherapeutic group he worked with in 1973 "never agreed to a therapeutic contract to change sexual orientation, even if requested."[61]

Some normal variant psychoanalysts imposed their view that homosexuality was not a disorder on individual clients who felt their homosexuality was a disorder. Weinberg's theory of homophobia told those with unwanted same-sex attractions that an intolerant society had made them think their same-sex attractions were a disorder. According to Weinberg, the same-sex attractions were not the client's problem, society's condemnation of homosexuality was the root of their problem. There was no justification for normal variant psychoanalysts to ignore the advances made in changing sexual orientation and not help homosexuals who wanted to change their sexual orientation, but they chose not to help them. The actions of the normal variant psychoanalysts who would not help homosexuals change their sexual orientation were analogous to denying chemotherapy to a cancer patient seeking a cure or denying medication to a patient trying to overcome depression. Yet they were the ones accusing the reparative psychoanalysts of disregarding the will of their homosexual patients.

Another misrepresentation was that the mental health professionals who adhered to the reparative function of homosexuality supported criminal laws punishing consensual adult homosexuality. Again, the truth was the exact opposite. Leading reparative psychoanalysts sought to decriminalize consensual adult homosexual activity. In 1972 a task force on homosexuality led by Charles Socarides for the New York County District Branch of the APA "called for civil rights for homosexuals" at the same time it categorized homosexuality as "a disorder of psychosexual development." This was not a contradiction. Socarides explained, "I've always been in sympathy with some of the goals

of the gay rights movement. Discrimination hurts people, I don't care who they are. But if someone comes to me in pain because he's caught up in same-sex sex, I want to help him."[62] Lawrence Hatterer agreed that homosexuals were unduly persecuted. He wrote, "Homosexuality is one of the few diseases which the entire medical profession agrees is an emotional disorder, yet it remains punishable within the law."[63]

In 1972 a new philosophical argument to discredit the reparative psychoanalysts came from Richard Green. He offered no evidence to contradict the clinical science done by Bieber, Socarides and the other experts on homosexuality. Instead he accused the experts and the culture of "heterosexuality bias." Green claimed this bias must have affected the clinical science that showed homosexuality was a disorder and contended that because of heterosexual bias the clinical research on homosexuality should be dismissed. [64] The heterosexual bias accusation coincided with the Szasz accusation that psychiatry was upholding the Judeo/Christian morality of the culture and therefore psychiatry was a tool of the State. Green's argument was adopted by both gay activists and the normal variant mental health professionals. Green and his followers seemed to be blind to the fact that their own relativist biases created the so-called heterosexual bias.

Similar to Green's inability to see his own bias, George Weinberg was unable to grasp the reality that the biases he criticized in reparative psychoanalysts also applied to him. For instance, Weinberg's premise, "Once an attitude is formed, in some cases at least, it may not be dislodged by evidence alone,"[65] also applied to himself and gay activists. The evidence showed that for many healthy homosexuals the gay lifestyle did not lead to happiness, but to despair. The evidence showed that some homosexuals wanted to change their sexual orientation and were able to. Despite the evidence,

Weinberg's attitude against reorientation therapy was not moved. Similarly, Weinberg's important principle of psychology that when a person acts on a belief "the outcomes is that he makes the belief seem righter than ever," applied as much to gay identified individuals and their advocates as it did for those who disdained homosexuality. It was a principle that grew the gay rights movement. The more gay identified individuals acted in support of homosexual equality, the more they believed that homosexuality was equal to heterosexuality.

Gay activists and normal variant mental health professionals were not concerned about the bias a homosexual professional or gay activist might harbor in order to validate a homosexual identity, legitimize homosexual behavior, overlook pathological causal factors of homosexuality, deny evidence, or misrepresent the opposition. The possibility that a relativist belief system could cause them to be as bias as a religious zealot was also overlooked. In the early 1970s the charge of "heterosexuality bias" and the false accusations of forced conversion to heterosexuality were equally hypocritical, yet many bought into those messages.

Conclusions

There was significant philosophical agreement between the two factions who fought in 1973 over whether homosexuality should remain classified as a psychiatric disorder. For the most part the reparative psychoanalysts like Bieber, Socarides, and Hatterer were in agreement with the normal variant psychoanalysts that consensual adult homosexual sex in private places should not be a criminal offense. The normal variant psychoanalysts like Marmor and Weinberg also advocated that homosexuals should not

be discriminated against in employment and housing opportunities, and some of the reparative psychoanalysts even agreed with that perspective.

In the clinical setting there was total agreement from both the reparative and normal variant psychoanalysts that homosexual patients should not be forced to change their sexual orientation. Both groups also believed the therapist needed a value-free attitude toward the patient. This did vary somewhat though. The reparative psychoanalysts generally maintained a value-free attitude toward consensual adult sex, whereas the some of the normal variant psychoanalysts like Robertiello could hold a value-free attitude toward pederasty and infidelity.

On the surface another point of agreement between the reparative and normal variant psychotherapists was the principle that the sexual morality of the therapist should not to be imposed on the patient. The reparatvie psychoanalysts lived up to that principle better than the normal variant psychoanalysts for typically they would not try to alter the patient's moral convictions, but rather present the clinical evidence. Normal variant psychoanalysts, on the other hand, would attempt to change a homosexual's religious conviction if the homosexual believed that homosexuality was immoral behavior, because that was a key element of their support psychotherapy to lessen the homosexual's anxiety. A tactic regularly used was to introduce homosexual clients to the teachings of Troy Perry and the Metropolitan Community Church. Perry was a gay man and the church did not consider homosexual behavior sinful.

Obviously, there were significant disagreements between the reparative and the normal variant psychotherapists. The biggest disagreement was over whether homosexuality was a psychopathological condition, which was directly related to the

etiological evidence on the causation of homosexuality. The reparative therapists believed the etiological evidence supported the theory that homosexuality was either a psychopathological condition or a symptom related to a psychopathological parent-child relationship. The normal variant psychoanalysts like Hendrik Ruitenbeek and George Weinberg rejected all the etiological evidence along with the psychopathological labeling of homosexuality.

Until George Weinberg's creation of "homophobia" Evelyn Hooker's evidence and argument was the best the normal variant psychoanalysts had to counter the volumes of clinical science that showed homosexuality was often pathological, but her evidence did not support or prove that homosexuality was not a pathological condition. Indeed if homosexuality did serve a reparative function related to childhood trauma, then the reparative function allowed the homosexual to function in society. All Hooker's research did was suggest that some cases of homosexuality might not be a pathological condition.

Bieber and his reparative allies disputed Hooker's research well, but they did not adequately counter her philosophical logic. Hooker had argued that one homosexual free from psychopathology proved that homosexuality was not necessarily a psychopathological condition. The corresponding argument that reparative psychoanalysts should have used was that if one person's homosexuality is found to be a psychopathological condition or symptom, then homosexuality is, at least for an unknown percentage, a psychopathological condition or symptom. The reparative psychotherapists had a library of evidence showing that homosexuality was a psychopathological condition or symptom for many patients, but for the most part they ignored Hooker's philosophical debate.

Bieber and Socarides followed Sandor Rado's theory that homosexuality was a reparative function brought about by "the inhibition of standard performance through sexual fears and repressed yet overflowing rages," but they did not consistently recognize Rado's other theoretical causes of homosexuality: "situational" where there is a lack of the opposite sex; and "variational" where the person yields "to the desire for variation in performance."[66] The person involved in homosexual behavior for situational or variational reasons, who was propagandized by gay mythology, was probably not going to have psychopathology related to their homosexuality. If Rado was right, if Lindner was right, then homosexuality was not always going to be a psychopathological condition, but it was conclusively shown to often be a psychopathological condition. To their error the Bieber coalition did not stress this distinction.

Another area where the Bieber coalition dropped the philosophical ball was the issue of whether homosexuality should be considered a sexual preference equal in value to heterosexuality. Adhering only to a science based defense the Bieber coalition relied on the male and female anatomy as the foundation of their argument that heterosexuality should be the cultural norm. They had no response to Thomas Szasz's philosophical argument that the biological value of heterosexuality should not lead to a heterosexual social ideal. Bieber's coalition could have shown why biological value translates into social value. For example, men and women have different sexual organs designed to produce children which society depends on, so the biological function of heterosexuality has social value. Or all things being equally free of psychopathology, children develop best with both a mother and a father, so maintaining a heterosexual marriage ideal is a social value. Those are some lines of reasoning that could have been used.

While the Bieber's reparative coalition did not aggressively develop philosophical arguments or seek allies outside their profession, the normal variant mental health professionals did. The normal variant psychoanalysts did not want the norms of sexual behavior based on Judeo/Christian principles and the reparative psychoanalysts did not necessarily want the norms of sexual behavior to be based on religious principles either, even though they may have agreed with those principles. No allies were sought by the reparative mental health professionals to defend the principle that a nation's people have the right to define society's norms based on religious principle or tradition. That was the greater philosophical question, and yet, both sides avoided it. As elites in the culture, both sides acted like elites. The will of the people or the existing cultural norms meant little in this debate.

Robert Seidenberg and Thomas Szasz had taken the normal variant philosophy to its farthest extreme. They suggested that homosexuality could be part of the solution to the ecological problem of over-population; creating "new ecological cult-heroes." Seidenberg's euphoric representation of homosexual life was completely opposite from what the reparative psychoanalysts had learned from their clients. Seidenberg equated homosexual relationships with brotherly love, sexual encounters with true friendship, and he elevated homosexual relationships over heterosexual relationships. Seidenberg called the morality of the traditional heterosexual family an "indulgence of mindless reproduction," and he claimed the superiority of homosexual relationships because they did not have "the accepted oppression of women and the subjection of the young."[67] In truth, Seidenberg's portrayal of homosexuality was a fantasy of his own creation. Homosexual relationships were often filled with forms of oppression and subjection, but

the normal variant mental health professionals tactfully overlooked those facts. The reparative psychoanalysts could have defended the traditional family better, but they did point out the destructive aspects of the homosexual lifestyle.

Some in the mental health profession who sought to undermine the Judeo/Christian norms of America also latched onto the growing liberal interpretation of the First Amendment which argued that the separation of Church and State forbade the government from basing law on religious principles. The only laws they applied their Church and State interpretation to were the ones that they disagreed with. Ernest van den Haag argued in 1963 that America's "basic documents do not give our government the right to defend the social ethos."[68] This interpretation would become more widespread as time went on.

Even though Thomas Szasz supported the normal variant perspective and was antagonistic toward Judeo/Christian norms he did not take the position that the American government could not defend a social ethos based on religious principle. Szasz understood the "establishment clause" of the First Amendment to block "the official guardians of religious dogma from access to the police power of the State." Szasz also understood that "the concept of religion does not require a godhead. Buddhism, for example, is universally recognized as a religion, yet it is godless."[69] Lindner's Darwinist ethos was his religion. Other Darwinist philosophies, like relativism, were equivalent to religious philosophies, but few others discerned this reality.

Utilizing their relativist philosophy the normal variant medical professionals charged that efforts to change homosexual behavior were forms of persecution and prejudice. Thomas Szasz had argued that if a person was not harming others, their

behavior should not be considered a sickness. George Weinberg argued that if the person was not harming others or themselves, the behavior should not be considered "psychologically sick." Yet, as Szasz pointed out it was not only the homosexual that psychiatrists were trying to convert, it was the alcoholic, the drug addict, the suicidal, and the racist. Except for Szasz, the normal variant mental health professionals were not outraged that psychiatrists attempted to change the behavior of these other groups. They were not concerned that psychiatry upheld the Judeo/Christian ideals of sobriety, non-violence, the value of human life, and racial equality. At this moment in history it was only homosexual inequalities that spurred them to action. For Judd Marmor and the other leaders of the normal variant perspective removing homosexuality's status as a psychiatric disorder "was neither medical nor semantic, but moral."[70] Their partnership with gay activists was motivated, justified, and defined by a faith based in relativism.

While the normal variant psychoanalysts and their allies verbally assailed the work and motives of the reparative psychoanalysts, the Bieber/Socarides reparative coalition stuck to their etiological evidence and the biological function of heterosexuality. They could not imagine that their professional field would use Weinberg's creation of homophobia to replace decades of clinical research. No one on the reparative side of the issue consistently pointed out the hypocrisy of those who criticized the Bieber/Socarides coalition. When the Judeo/Christian norms of American culture were assaulted and a relativist moral code was promoted as a better alternative, no group organized to defend the cultures existing sexual norms or the people's right to have a voice in society's norms. The Bieber/Socarides coalition did not understand the greater philosophical war

that was being waged. They did not seek reinforcements from outside their profession. They used their clinical science position like a defensive bunker.

The first major victories of the normal variant perspective over the Bieber/Socarides reparative perspective took place in the National Institutes of Mental Health (NIMH) during the mid to late 1960s. Socarides wrote to the Director of the NIMH asking "to discuss some suggestions for a national program for the prevention and treatment of homosexuality and other sexual disorders." Besides his concern for adolescents and their families, three public awareness issues motivated Socarides. He wanted to "dispel the mystery" surrounding homosexuality, "dissolve the fear which attends any attempt at free discussion," and make the public aware that the medical profession considers homosexuality "a form of emotional illness or sexual immaturity." Socarides met with the Director's staff on February 3, 1965, but his proposal "was dismissed out of hand."[71]

About two years later Socarides was invited to be part of a lecture series before the Adult Psychiatry Branch of the NIMH. Socarides' lecture was "on the problem and treatment of homosexuality." After the series was complete "the Director of the NIMH appointed a Task Force on Homosexuality," but Irving Bieber and Charles Socarides were not invited to be on the task force. The appointed chairman of the task force was psychologist Evelyn Hooker. One of the three psychiatrists was Judd Marmor, and the Kinsey Institute for Sex was represented by Paul Gebhardt and collaborator John Money. Paul Gebhardt informed Socarides that psychoanalytic clinicians such as he and Bieber were purposely left off the task force because their "Freudian" approach was considered "professionally biased."[72]

Following Socarides' earlier suggestion the NIMH Task Force's 1969 report recommended "the establishment of a center for the study of sexual behavior." But nothing in the report mentioned that mental health professionals considered homosexuality a pathological condition in the form of emotional illness or arrested psychosexual development. What the report did ask for was "society's toleration and understanding of the homosexual condition and the gradual removal of persecutory laws against such activities between consenting adults."[73]

The triumph of the normal variant philosophy in the NIMH was the beginning of its ascension to dominance. Those appointed to the task force did not represent the mainstream mental health profession. Socarides' efforts to demystify homosexuality and have open discussions on homosexuality would not happen. By the late 1960s normal variant philosophies were motivating gay activists "to attack any psychiatrist or psychologist who dared present his findings as to the psychopathology of homosexuality before national or local meetings of psychiatrists or in public forums."[74]

Notes

[1] Szasz, "Legal and Moral Aspects," 132.

[2] Lindner, "Homosexuality and the Contemporary," 56.

[3] Socarides, *Beyond Sexual Freedom*, 102. The information was credited to *The Family in Classical Greece* by W. K. Lacey, Ithaca: Cornell University Press, 1968.

[4] Moses, "Leviticus," 18:22 and 20:13.

[5] Paul, "I Corinthians," 6:9-10.

[6] Szasz, *Manufacture of Madness*, 164.

[7] Mack and Semrad, "Classical Psychoanalysis," 304.

[8] Lindner, *Must You Conform?* 20.

[9] Ibid., 17.

[10] Bayer, *Homosexuality and American Psychiatry*, 21.

[11] Reisman, *Kinsey: Crimes & Consequences*, 21.

[12] Bieber, "Sexual Deviations. I. Introduction," 960.

[13] Freud, "Letter," 1.

[14] Rado, "An Adaptational View," 108-10.

[15] Lindner, *Must You Conform?* 104-7.

[16] Seidenberg, "Accursed Race," 159, 168.

[17] Hooker, "Adjustment of the Male," 142, 144, 160.

[18] Ibid., 145-50.

[19] Bieber, "Sexual Deviations. I. Introduction," 967.

[20] Rado, "An Adaptational View," 110.

[21] Hooker, "Adjustment of the Male," 159.

[22] Ibid., 148-50, 157-8.

[23] Pomeroy, *Kinsey and the Institute*, 70.

[24] Lindner, "Homosexuality and the Contemporary," 73.

[25] Lindner, *Must You Conform?* 82.

[26] Ibid., 140.

[27] Ibid., 186, 206-7.

[28] Lindner, "Homosexuality and the Contemporary," 79.

[29] Szasz, *Manufacture of Madness*, 63-4.

[30] Ibid., 123, 204.

[31] Ibid., 162, 168, 192.

[32] Ibid., 168.

[33] Ibid., 174.

[34] Ibid., 167-8, 174.

[35] Szasz, "Legal and Moral Aspects," 136.

[36]Ibid..

[37] Szasz, *Manufacture of Madness*, 275.

[38] Ibid., 221.

[39] Ibid.

[40] Weinberg, *Society and the Healthy*, 29-31, 143.

[41] Ibid., 22, 100, 138, 140.

[42] Ibid., 40.

[43] Ibid., 76.

[44] Ibid., 126-7.

[45] Hatterer, *Changing Homosexuality*, 129.

[46] Marmor, Introduction to *Sexual Inversions*, 18.

[47] Robertiello, "More Positive View," 176-180.

[48] Weinberg, *Society and the Healthy*, 138.

[49] Seidenburg, "Accursed Race," 164-5.

[50] Szasz, "Legal and Moral Aspects," 137.

[51] Szasz, *Manufacture of Madness*, 176.

[52] Marmor, Introduction to *Sexual Inversions*, 18.

[53] Seidenberg, "Accursed Race," 168.

[54] Bieber, "Clinical Aspects," 261.

[55] Socarides, *Overt Homosexual*, 216.

[56] Hatterer, *Changing Homosexuality*, 57.

[57] Mintz, "Overt Male Homosexuals," 182.

[58] Bergler, *Homosexuality: Disease or Way*, 52.

[59] Weinberg, *Society and the Healthy*, 66.

[60] Blair, *Etiological and Treatment Literature*. 38.

[61] Silverstein, "Wearing Two Hats," 19.

[62] Socarides, Homosexuality A *Freedom Too*, 77, 163.

[63] Hatterer, *Changing Homosexuality*, 129.

[64] Bayer, *Homosexuality and American Psychiatry*, 112.

[65] Weinberg, *Society and the Healthy*, 40.

[66] Rado, "An Adaptational View," 110.

[67] Seidenberg, *Accursed Race*, 162,164, 167.

[68] Haag, "Notes on Homosexuality," 299.

[69] Szasz, *Manufacture of Madness*, 178, 266.

[70] Bayer, *Homosexuality and American Psychiatry*, 64.

[71] Socarides, *Beyond Sexual Freedom*, 84-5.

[72] Ibid., 85-6.

[73] Ibid., 86-7.

[74] Ibid., 87.

PART II

THE 1973 PARADIGM SHIFT

Chapter 6

APA 1973 – How It Happened

"*Instead of being engaged in a sober consideration of data, psychiatrists were swept up in a political controversy.*"[1]

(Ronald Bayer, 1981)

Opening note

The homosexual movement took a radical turn in the late 1960s. In the 1950s and early 1960s homosexual leaders were content for the most part with the academic reclassification of homosexuality from culturally immoral behavior to a psychiatric/psychological disorder. The reclassification had improved the homosexual's standing in society, because he was no longer seen as a person in willful rebellion over society's norms. In the 1960s the homosexual was viewed by academia and much of society as a victim of his early family environment. Clinical science showed that the homosexual had not chosen his same-sex attractions. His psyche had been overpowered by a reparative effort to compensate for early childhood trauma that stymied his identity with the same-sex. The new social climate created by classifying homosexuality as a

psychiatric disorder was summarized by one of Robert Lindner's homosexual clients in the early 1950s, "You make a pass at a guy in the movies or john and right away you get a lecture on Freud. *Nobody slugs you any more!*"[2]

Many homosexuals began to want more in the 1960s. Many still believed they were born homosexual because they always felt different. Alfred Kinsey a Sc.D. in biology had told them that all sexual orientations were normal. Robert Lindner, a psychologist, and Thomas Szasz, a psychiatrist, told homosexuals that they were persecuted because they were different and that mental disorders were a fantasy made up by psychiatrists to justify their profession. By the early 1970s psychologist George Weinberg had presented his hypothesis that prejudice against homosexuality was a disease called homophobia and attributed the disorders associated with homosexuality to internalized homophobia. Another mental health professional, Richard Green, M.D., told homosexuals to ignore all the clinical evidence that showed homosexuality to be a psychopathological condition, because the psychoanalysts and researchers who produced it must have had a heterosexual bias. Although these arguments applied to many aberrant sexual behaviors and other deviant subcultures, it was the homosexual subculture that used these rationales in the 1960s to launch a subculture civil rights movement. A gay militancy emerged in the late 1960s and equality with heterosexuality became cause of the homosexual movement. By the end of 1973 homosexual militants had set the cornerstone of this new cause with a major political triumph in the American Psychiatric Association.

The rise of gay militancy

The American gay rights movement was originally called the "homophile movement." In the early history of the American homophile movement its most influential organization was the Mattachine Society. Founded in 1950 as a secret society it evolved into a national organization by the mid 1950s. The original organization kept a low public profile and was open to learning what clinical science revealed about homosexuality. The early leaders of this organization saw many benefits to homosexuality being classified as a disease rather than a crime. In an article written in the *Mattachine Review* Ken Burns, the chairman of the board of the Mattachine Society in 1956, stressed the importance of preventative family and social patterns to solve the problem of homosexuality. During those early years the Mattachine Society asked medical professionals like psychologist Albert Ellis, an author who viewed homosexuality as a phobic response and a curable condition, to speak at Mattachine Society conferences and contribute to the organization's newsletter.[3]

By 1960 the Mattachine Society had grown to include several regional councils and the tone of the homophile movement began changing. Albert Ellis, Edmund Bergler, Irving Bieber and other medical professionals who held the view that homosexuality was a disorder were now considered enemies by many in the homophile movement. In particular, Bergler's 1956 book, *Homosexuality: Disease or Way of Life*, outraged many homosexuals because he found homosexuals to be "injustice collectors" and Bergler assailed the work of Alfred Kinsey, an important ally of the Mattachine Society. The national leaders of the Mattachine Society were at odds with the more militant homosexual leaders. It made no sense to the national Mattachine Society leaders in the late 1950s to turn against their sympathetic allies in the medical profession. The same

medical professionals that saw homosexuality as a disorder were also working with the Mattachine Society to make homosexual behavior more acceptable to society. Because the national leaders feared that "some of its local groups might move in directions unacceptable to the parent organization, the local Mattachine councils were disbanded," and the "national organization lost much of its strength."[4]

When the national Mattachine Society disbanded the regional councils the leaders of the regional councils formed their own independent homophile organizations. These new organizations carried the Mattachine Society name with the addition of their geographical location.[5] In 1961 Frank Kameny was one of the founders of the independent Mattachine Society of Washington.[6] Kameny would become the homophile movements most influential leader in the 1960s; articulating both policy and strategy.[7] The Mattachine Society of Washington overwhelmingly adopted this bold policy statement in 1965: "The Mattachine Society of Washington takes the position that in the absence of valid evidence to the contrary, homosexuality is not a sickness, disturbance, or other pathology in any sense, but is merely a preference, orientation, or propensity on par with and not different in kind from heterosexuality."[8]

Frank Kameny led the effort in the homophile movement to discount the scientific and clinical evidence that showed homosexuality was or could be a neurotic or psychopathological disorder. He sought nothing less than society's full equality of homosexuality with heterosexuality. Kameny and the militant homosexuals used the arguments that Alfred Kinsey and Evelyn Hooker had formulated. The militant homosexuals knew that many homosexuals functioned quite well in their occupations and social life, so for them, that meant that they did not have a psychological disorder.

A pamphlet published by the Mattachine Society of Washington in 1966 featured various quotes by medical professionals giving their opinions that homosexuality was not a sickness. Some of the quotes denied that homosexuality could be changed. A quote by clinical instructor and former Kinsey cinematographer Clarence Tripp stated, "I know of not one single validated instance of any basic sexual change ever having been accomplished."[9] To the militant homosexual mind this statement invalidated the Bieber study, the clinical work of Edmund Bergler, Albert Ellis and others.

Psychologist Robert Lindner was also quoted in the pamphlet as evidence that homosexuality was not a sickness. The Lindner reference illustrated contempt for the traditional morality of the population. "It [declaring the homosexual mentally ill] may masquerade as a boon to the invert and a humanitarian modification of historic prejudice and hate: it is, in fact, but another way to obtain the conformance – this time in the area of sex-behavior – our dangerously petrifying institutions demand."[10]

Independent researcher Ronald Bayer summed up the militant homophile movement's medical case for normalcy as an illusion. The critics of the clinical science did not offer "empirical material" to support their positions. They gave opinions and offered philosophies that argued the culture demanded unreasonable sex conformance. But these professionals "possessed the aura of science – albeit social science," and the homophile militants would use those opinions to dismiss the clinical science.[11] The professionals and experts who were now being invited to homophile organizational gatherings were professionals who criticized the clinical science on homosexuality and the "illegitimate power of psychiatry."[12]

As the militant homophile movement evolved in the 1960s a new theme emerged that the therapeutic goal of curing homosexuality was itself "morally wrong."[13] The foundation of this perspective could be found in Robert Lindner and Thomas Szasz's argument that basically all mental illnesses were created by people in authority to punish and stigmatize non-conformance to despotic social standards. Using the Szasz philosophy, the militant homophile movement and its supporters argued that homosexuality had been labeled a psychological disorder only because it did not conform to the culturally accepted standards of sexual behavior. Because they assumed that homosexuality had been classified a psychological disorder solely on the basis of prejudice, they began to see any treatment to help a person overcome homosexuality as immoral, even if the individual sought the treatment.

Researcher Ronald Bayer's most profound observation during this changing of the guard in the homophile movement was on its shift of focus. While the early homophile movement of the 1950s sought to defend the individual homosexual and not the condition of homosexuality, the new militant homophile movement sought to defend homosexuality instead of the individual homosexual.[14] In plain English, the political cause of legitimizing homosexuality became more important than the individual homosexual. The only valuable homosexual in this militant movement was the one dedicated to the homophile cause; the rest were considered weak or even traitors. There was no place in the new militant homosexual subculture for the homosexual who found the homosexual life disingenuous or destructive. There was no place for the homosexual who would rather be heterosexual. The new militant mindset would come to argue "that homosexuals who attempted to change were not only foolish and misguided but

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renegades," and "that the goal of homosexual emancipation required of homosexuals that they, like Blacks, accept their identities rather than seek freedom through self-denial."[15]

As the militant homophile identity was being solidified Frank Kameny initiated the slogan "GAY IS GOOD" at a homophile conference in 1968, forever changing the homophile movement into the gay rights movement. The word "gay" had been used since the 1950s by homosexuals in the United States as a code word. Its original use to designate a homosexual came from the French word "gaie." In sixteenth century Paris the word "gaie" meant "whore" and later came to mean "homosexual."[16] In 1968 "gay" became a political movement. Kameny's resolution at the conference included these words, "BECAUSE many individual homosexuals, like many of the members of many other minority groups suffer from diminished self-esteem ... BECAUSE the Negro community has approached similar problems and goals with some success by the adoption of the motto or slogan: *Black is Beautiful,* RESOLVED: that it be hereby adopted as a slogan or motto for NACHO [North American Conference of Homophile Organizations] that GAY IS GOOD."[17] The stage was now set. Gay militants were officially identifying as an oppressed minority. They were not identifying with other oppressed sexual orientations like pedophilia, voyeurism, or fetishism. They chose to identify their sexual orientation, however misappropriate it was, with the Black civil rights movement.

The gay assault on psychiatry

The American gay rights movement began using militant tactics against psychiatrists in 1968. From then on wherever psychiatrists and psychologists gave

lectures with the point of view that homosexuality was a psychopathological disorder; they could expect to be the target of gay protests. At the 1968 American Medical Association's convention in San Francisco Charles Socarides gave a lecture on homosexuality. Gay activists leafleted the convention and demanded "that those who opposed the pathological view of homosexuality be represented at future conventions" and that members of homophile organizations be on panels discussing homosexuality. A similar protest happened at Columbia University when Lawrence Kolb of the New York State Psychiatric Institute led a panel on homosexuality at the university's College of Physicians and Surgeons.[18]

Although the gay rights movement officially adopted the slogan "gay is good" in 1968 and began its militant tactics in 1968, it prefers to see its birth in the June 1969 Stonewall Riots in Greenwich Village. After New York police raided a gay bar called the Stonewall Inn, the gay community took to the streets throwing bottles and pennies at police, starting fires in trash cans, and shouting "gay power" and "queen power." The rioting and bedlam went on for several nights and developed into a party atmosphere.[19] It was the first occasion that non-activist homosexuals had fought back from what they perceived as unjust harassment. It changed the mindset of many gay identified individuals and from that uprising came the first Gay Liberation Front organization. The new Gay Liberation Front was modeled after the more radical Black civil rights and anti-war organizations of the late 1960s. "Gay power" and "gay pride" became their slogans. One year after the Stonewall riots the Gay Liberation Front and its spin off, the Gay Activist Alliance, organized the first Gay Pride Week in New York City, highlighted by

the nations first gay pride parade. In the ensuing couple of years independent Gay Liberation Front organizations started to multiply across the United States.

The leaders of the militant gay rights movement expressed their anger at any authority that viewed homosexuality as a perversion, a sin, or a psychological disorder. In 1970 the American Psychiatric Association's (APA) convention in San Francisco was the target of gay rights groups. Psychiatrist Irving Bieber, the most prominent medical authority on homosexuality, was ridiculed by gay activists when he spoke during an APA panel discussion on homosexuality and even called a "motherfucker."[20] Bieber was visibly shaken by the personal attack. Because of his prominence and belief that homosexuality was a psychopathological condition, gay rights activists had labeled Irving Bieber "Public Enemy Number One."[21]

Another event at the 1970 APA convention on "issues of sexuality" was completely disrupted as gay activists demanded to be heard. The event was adjourned as the gay activists shouted accusations and read a list of their demands. Gay activists had disrupted the 1970 APA convention in San Francisco with guerrilla theater tactics, shouting, and profane language. They offered no evidence of their own to dispute the position that their sexual attractions and behavior came from a psychopathological origin. Their protest was based on their claim that homosexuals were an oppressed minority similar to Blacks in America.[22] It was an analogy full of holes, but the gay activists did not care about science, they had come to intimidate and promote their cause.

Despite the negative reaction of the psychiatrists to the tactics of the gay activists, one psychiatrist from Maryland agreed with the argument that the gay rights movement was analogous to the Black civil rights movement. Psychiatrist Kent Robinson met with

one of the gay organizers, Larry Littlejohn, to express his support for their tactics of disruption. Littlejohn was a gay activist and a gay sex pioneer in San Francisco. He had helped organize the cities first gay organization and "opened one of the cities first private sex clubs. He took some credit as one of the businessmen who introduced a whole generation of gay San Franciscans to the joy of orgy sex."[23]

Kent Robinson would become the early intermediary between the militant gay political movement and the APA. Robinson was informed by Littlejohn that the militant gay rights coalition wanted to present its own panel at the next APA convention. Robinson conveyed this message to APA leaders with the warning that the disruption of the 1971 APA convention would be much worse than what had happened in San Francisco, if the APA did not agree to this demand. The chair of the Program Committee for the 1971 APA convention, John Ewing, "quickly agreed" to allow the proposed panel as long a psychiatrist chaired the session. It only had taken the threat of disruption to succeed in intimidating the APA. Researcher Ronald Bayer noted: "That lesson would not be forgotten."[24] With colossal psychological irony, gay activists were told by the behavior of APA leaders that they "could get what they wanted from 'the shrinks' by using calculated violence and threats."[25]

The 1971 APA convention was going to be held in Washington, D.C. Kent Robinson was told by the gay activist he had met in San Francisco that the person he should work with in Washington was Frank Kameny. Despite the opportunity of having a militant homosexual panel at the next APA convention, Kameny and other gay leaders still thought it was necessary to demonstrate at the upcoming convention and even disrupt

it. "Kameny developed a detailed strategy for disruption, paying attention to the most intricate logistical details."[26]

The 1971 APA convention was in a two-fold predicament. Not only had the APA empowered gay activists, but by chance a large anti-war demonstration was going to take place in Washington, D.C. at the same time as the 1971 convention. Thousands of anti-war protesters were coming to Washington not just to demonstrate, but to shut the city down. It would be known as the May Day Protests and it resulted in the largest mass arrest in U.S. history. Because of the large anti-war protests scheduled to take place in D.C., the APA leaders decided against a strong visible security force and choose to "ride out" rather than prevent demonstrations against its position that homosexuality was a disorder.[27]

The planned disruption of the 1971 APA convention was coordinated to be on the same day that the anti-war protesters tried to shut down the streets of Washington – May 3, 1971. Gay activists stormed into the main activity and Frank Kameny grabbed the microphone telling the psychiatrists that they were the "enemy" and that "psychiatry has waged a relentless war of extermination against us." Other areas of the APA convention were accessed by forged credentials and the disruption spread to the exhibit area. Intimidation tactics were used to force a marketing display on aversion therapy techniques for homosexuality out of the exhibit area. From the psychiatrists viewpoint the actions of the gay activists resembled the tactics of "Nazi storm troopers." Militant homosexuals had once again used force to intimidate and silence those who dared think of homosexuality as a disorder.[28]

Even though Frank Kameny had led the gay activists who disrupted the APA convention, the panel featuring homosexuals hand picked by Frank Kameny went on as scheduled. The title of Kameny's panel was "Lifestyles of Non-Patient Homosexuals." Researcher Ronald Bayer observed that the very title of the panel "suggested a critique of both the diagnostic posture and the methodology of clinical research." Not surprisingly all the homosexuals on the panel rejected the clinical science that showed homosexuality was often a psychopathological condition. All the homosexuals on the panel expressed their "utter distain for psychiatry's claim that it sought to heal and aid the homosexual." They blamed the discipline of psychiatry for the social exclusions, rejection, and discrimination that they had endured as homosexuals.[29] "Some psychiatrists capitulated right on the spot. They pleaded with the gay panelists. 'Don't think,' they said, 'that we're *all* followers of Bieber and Socarides.'" Socarides would later comment on the actions of those who capitulated, "Many of them didn't know what they were doing. They didn't treat homosexuals."[30]

Bieber and the objective psychiatrists did not oppose the militant homosexual's forum, even though the gay militants would not allow them a peaceful forum at any gathering of medical professionals. Socarides explained, "We wanted to hear them out. And they gave us a pretty good preview of a line they would follow for the next 20 years." The homosexual panelists urged sympathetic psychiatrists in attendance to challenge the view that homosexuality was a disorder, and from that convention "a small minority inside the APA began laying plans to see how they could re-classify homosexuality – that is, take it off the APA's list of disorders."[31] The *Diagnostic and Statistical Manual of Psychiatric Disorders* (*DSM-II*) at that time in history listed

homosexuality with other sexual deviations as "non-psychotic mental disorders."[32] Kent Robinson assisted the gay leaders that year in their first attempt to present this demand to the APA leadership.[33]

Nothing came of the first demand by the gay rights movement to have homosexuality removed from the APA's list of disorders, but their presence was growing inside the APA. Kent Robinson was given the authority to make the "arrangements for a fully institutionalized gay presence" at the next American Psychiatric Association convention in Dallas. Gay activists were allowed their own display in the "scientific exhibition area," which they entitled "Gay, Proud, and Healthy." What a change a year had made. The panel on homosexuality Robinson organized included sympathetic psychiatrists along with gay activist Frank Kameny and lesbian activist Barbara Gittings. The sympathetic psychiatrists on the 1972 panel were Robert Seidenberg, Judd Marmor, and a disguised homosexual psychiatrist who called himself Dr. Anonymous. The panel verbally attacked the work of Charles Socarides and the other experts who treated homosexuality with an ultimate goal of sexual orientation change.[34]

Dr. Anonymous informed the audience that there were over two hundred homosexual psychiatrists at the convention and appealed to other homosexual psychiatrists to join in the effort to change psychiatry's attitude toward homosexuality. Frank Kameny issued a similar plea reiterating what he had written in a flyer that was being distributed by gay activists, "Psychiatry...has been *the* major single obstacle in our society to the advancement of homosexuals and to the achievement of our full rights, our full happiness and our basic human dignity. Psychiatry *can* become our major ally."[35]

Seidenberg was a philosophical disciple of Thomas Szasz. He brought to the panel the point of view that the psychoanalytic work of Socarides and Bieber was an attempt to justify "society's prejudices against an 'erotic minority,'"[36] By 1972 Judd Marmor had also come to adopt more of Szasz's philosophy. Marmor specifically attacked the work of Charles Socarides accusing him of "cruelty," "thoughtlessness," and a "lack of common humanity."[37] No one mustered the courage to challenge the prejudiced attitudes of Kameny, Seidenberg, Marmor or the other panelists, and Charles Socarides was not given an opportunity to defend himself or the clinical science that showed homosexuality was a disorder. The gay initiated panels were political spectacles at best, not sources of medical information.

Bieber, Socarides and many other reparative psychoanalysts agreed with many of Kameny's goals for homosexuals, but they couldn't renounce their own experience and research that clearly showed the homosexual life was anything but healthy for many homosexuals. It became clearer to the reparative psychoanalysts as the convention progressed that the professional minority allied with the gay activists were demanding "things that would hurt homosexuals in the long run, and subvert society in the process," and their tactics were not based in discussions of science, but rather through "intimidation and attack." Socarides would comment later, "We weren't ready for that."[38]

For Frank Kameny the 1972 APA convention was a triumphant victory. Bieber, Socarides and other psychiatric experts on treating homosexuality had been purposely left out of all the panels discussing homosexuality. The only views allowed on panels discussing homosexuality were those friendly to the gay point of view. Kameny had also become more diplomatic with his growing influence in the APA. The disruptive tactics

were generally absent at the 1972 convention and Kameny focused more on the strategy in his statements. Homosexuals were seeking civil rights, happiness and dignity, and psychiatry was denying homosexuals those rights. Gay activists had successfully intimidated not only the APA leaders, but even the psychiatric experts on homosexuality - Bieber, Socarides, and Hatterer. Militant gay leaders could gloat. "The tactical reliance upon disruption and force in earlier years had been vindicated."[39]

The bureaucratic charade

In October of 1972 a disruption of the Association for the Advancement of Behavior Therapy by the New York Gay Activist Alliance yielded unexpected results. The leader of the disruption was gay activist Ronald Gold. In his protest discourse he used the Richard Green argument that the medical profession had let its heterosexual bias influence its therapeutic stance. One of the mental health professionals at this conference was a member of the APA's Committee on Nomenclature, Robert L. Spitzer, M.D. of the New York State Psychiatric Institute. Spitzer, impressed with the passion and the arguments of Gold and the other gay activists, agreed to arrange "a formal presentation" before the nomenclature committee where the gay activists could present their viewpoint that homosexuality was not a disorder. Spitzer also agreed to sponsor a panel at the 1973 APA Convention with the focus on whether or not homosexuality should be listed as a psychiatric disorder.[40]

Ron Gold was chosen by New York Gay Activist Alliance to chair the committee of gay individuals making the formal presentation. "Jean O' Leary was appointed to make a presentation about how the illness theory of homosexuality had harmed people."[41]

Gay graduate student Charles Silverstein was chosen to address the "professional issues."[42] Independent researcher Ronald Bayer described Silverstein's presentation as "the gay critique of the psychiatric orthodoxy."[43] At the time Silverstein was the director of the Institute for Human Sexuality, a homosexual and bisexual counseling center in New York City.

Silverstein himself presented the research findings of Hooker, Kinsey, Ford and Beach, along with the opinions and philosophical arguments of Judd Marmor and Richard Green as evidence that homosexuality was not a disorder. Silverstein then argued that the misclassification of homosexuality as a sickness had served as justification for society's discrimination towards homosexuals. Researcher Ronald Bayer summarized Silverstein's presentation as a complete disregard of the "rich scientific literature" on homosexuality with the calculated intent of portraying the clinical evidence that homosexuality was a disorder as "'subjective,' 'unsubstantiated,' and a series of 'adult fairy tales.'"[44]

In addition to preparing the gay critique, "Silverstein enlisted a number of sympathetic psychiatrists and psychologists to address the committee with statements supporting the deletion of homosexuality from the *Diagnostic and Statistical Manual*" (*DSM*). On the eighth of February in 1973 the mental health professionals chosen by Silverstein argued before the committee to remove homosexuality from the *DSM*. One of those chosen by Silverstein was psychiatrist Seymour Haleck. Haleck cited in his statement before the committee that "scientific evidence was lacking to support the view that homosexuality was a developmental disorder." He argued that the "deletion of the

diagnosis of homosexuality is not only a humanistic step, it is dictated by the best scientific information available."[45]

Silverstein included in his panel entourage two mental health professionals with ties to the Kinsey Institute for Sex Research at Indiana University. Both men defended homosexuality as a normal variant of human sexuality. One of the two was Wardell Pomeroy. Following Kinsey's pexample, Pomeroy criticized the clinical homosexual population samples that psychoanalysts saw. He claimed that the homosexual seen in the clinician's office was not typical of the homosexual population. Pomeroy suggested that psychiatry should have accepted "the conclusions he and Kinsey had put forth twenty-five years earlier."[46]

The other Kinsey Institute person to address the nomenclature committee was Alan Bell, Ph.D. Bell was a research scientist at the Kinsey Institute and used his research and Evelyn Hooker's research to argue that "homosexuality 'fell within the normal range of psychological functioning.'"[47] Interestingly, Bayer's research of the "formal presentation" before the nomenclature committee did not document any of the presenters using George Weinberg's theories of homophobia or harm caused by reorientation therapy. Silverstein's record of the formal presentation suggests that Jean O'Leary may have used Weinberg's arguments in her presentation of how the "illness theory of homosexuality had harmed people."

Silverstein also gave some behind the scenes insight into the goals sought by the gay activists. Silverstein wrote, "some of us were after bigger game than that. Our intention was to attack the use of morality as the foundation for the diagnosis and treatment of outlawed sexual behavior. We wanted the whole house of moral cards to

collapse so that all forms of variant sexuality would be acceptable. While we did not mention it at the meeting, we wanted the American Psychiatric Association to drop what would later be called the paraphilias as a diagnostic category as well."[48]

None of the members of the Committee on Nomenclature were experts on homosexuality, so most of the arguments they heard were new to them. The committee members were impressed by "the sober and professional manner in which the homosexual case was presented to them."[49] As non-experts on homosexuality the committee was more of a judicial court than a scientific panel. They had heard one side of the case before them, but as the proverb wisely states, "The first to present his case seems right, till another comes forward and questions him."[50]

The leaders in the New York Gay Activist Alliance decided that the best way to capitalize on their meeting with the Committee on Nomenclature was to inform the friendly media. On the day after Silverstein's presentation to the Committee on Nomenclature an article in the *New York Times* proclaimed that "Psychiatrists Review Stand on Homosexuality." In the article the chairman of the Committee on Nomenclature, Henry Brill, M.D., acknowledged that "the psychiatric labeling of homosexuality had led to unwarranted discriminatory policies and attitudes," but some committee members "saw homosexuality as a 'central feature of a psychiatric problem.'" Brill told the reporter that "he hoped to present a statement on the appropriate direction of change in four months" at the 1973 APA convention. [51] Silverstein had succeeded in persuading the Committee on Nomenclature toward the gay viewpoint.

Needless to say Charles Socarides and Irving Bieber, the most prominent experts on homosexuality in 1973, were concerned and surprised that the Committee on

Nomenclature was seeking a quick response to the pleadings of gay activists and their allies. Their concern was heightened by the lack of experts on the committee and at how they had been excluded from the proceedings. Socarides and Bieber quickly formed an Ad Hoc Committee Against the Deletion of Homosexuality from the *Diagnostic and Statistical Manual.* Bieber wrote directly to the medical director of the APA and urged him to appoint a "balanced" special committee to review the declassification of homosexuality as a disorder. In the next couple of months the Association for Psychoanalytic Medicine and Institute for Psychoanalysis passed resolutions opposing any change to the classification of homosexuality in the *DSM-II.* In a related action the Executive Council of the American Psychoanalytic Association urged that any action to change the status of homosexuality be delayed because more study and debate was needed.[52]

Gay activists were also working within the APA. The Northern New England District Branch of the APA led by a closeted gay psychiatrist,[53] Lawrence Hartman, adopted a resolution prepared by the openly gay psychiatrist Richard Pillard in March of 1973. The resolution not only called for the deletion of homosexuality from the *DSM*, it also "asked for an end to the exclusively heterosexual orientation of sex education programs." Soon after the resolution was passed by the District Branch, the Branch's regional council also endorsed it.[54]

Although Henry Brill was chair of the Nomenclature Committee, Robert Spitzer had assumed the central role on the homosexuality debate before the committee. Spitzer was not an expert on homosexuality, but he suggested which clinical research and literature the committee would study and dominated "both the pace and the direction of

the committee's work. In fact it was Spitzer's own conceptual struggle with the issue of homosexuality that framed the committee's considerations."[55]

When the APA convention was held in Honolulu during May of 1973 Robert Spitzer fulfilled his promise to his gay activist friends and sponsored a panel discussion on homosexuality. The six member panel was visibly unbalanced. Only two panelists who viewed homosexuality as a disorder were on the panel as opposed to four panelists who claimed it was not a disorder. Proponents that homosexuality was a disorder included Charles Socarides and Irving Bieber. The opposing viewpoint was represented by gay activist Ronald Gold and three medical professionals - Judd Marmor, Richard Green, and Robert Stoller. The panel drew almost one thousand conference attendees. While Socarides and Bieber presented the clinical evidence, their opponents challenged the audience to adopt a cultural relativist philosophy that would no longer consider heterosexuality superior to homosexuality. Marmor argued, "It is our task to be healers of the distressed, not watchdogs of our social mores."[56]

Outnumbered four to two it was impossible for Socarides and Bieber to present both the clinical evidence and adequately point out the flaws in their opponents' philosophical arguments. In addition, Ronald Gold presented an example of an articulate homosexual who was not distressed by his homosexuality. His presence contradicted the conclusions derived from the clinical science. Gold made a passionate appeal to the attendees to change the disorder classification of homosexuality.

The panel discussion on homosexuality went well for the side with the numerical advantage. Later, while the convention was still going on Ronald Gold reasoned that if he introduced Robert Spitzer to more gay psychiatrists; it might put added pressure on him

to declassify homosexuality as a disorder. Spitzer agreed to go to a clandestine social gathering of gay psychiatrists. Gold's strategy worked. Spitzer became more confident of his position that being a homosexual did not necessarily hinder a person from functioning at a high level in society, and within one month after the convention he prepared his first proposal to declassify homosexuality as a disorder.[57]

Robert Spitzer's perspective of psychiatric disorders had evolved so that he now believed a diagnostic disorder required the person to show subjective distress or generalized impairment. This was the new perspective that psychiatrist Richard Robertiello advocated, but taken a step further. Robertiello advocated overlooking aberrant behavior and treating psychiatric patients solely "on the degree of subjective discomfort" the behavior caused the patient.[58] Spitzer advocated basing the terminology of psychiatric disorders on the degree of "subjective distress' and social impairment aberrant behavior caused individuals. He viewed homosexuals who were functioning well and satisfied with their homosexuality to be living with a "suboptimal" condition. He rationalized that the homosexuality in the gay identified individual was akin to celibacy, racism, vegetarianism, or religious fanaticism in otherwise well functioning people. These other life conditions were not considered mental disorders so homosexuality should not be considered a mental disorder either. According to Spitzer's reasoning only homosexuals who were troubled by their homosexuality and sought change should be classified as having a psychiatric disorder. Spitzer's recommendation called for the removal of homosexuality from the *DSM* category of "non-psychotic mental disorders" and the creation of a new classification of "sexual orientation disturbance" for those with unwanted homosexual attractions.[59]

Spitzer's philosophical reasoning mirrored Szasz's philosophy, except Szasz aligned homosexuality with alcoholism, drug addiction, and suicide. Certainly there were alcoholics and drug addicts who functioned well in society and were satisfied with their lifestyle, and one could even rationalize that if a person desired to commit suicide and succeeded, it solved any subjective distress they were suffering. But Spitzer did not apply his new philosophy to alcoholism, drug addiction, or even other aberrant sexual orientations. He did at a later time concede to Irving Bieber that if individuals with sexual voyeurism and fetishisms organized, psychiatry would be forced to consider removing them from APA's the list of mental disorders also.[60]

There was a bureaucratic development within the APA that was central to the reclassification of homosexuality in 1973. Several years earlier some politically active psychiatrists formed a political party within the APA called the Committee for a Concerned Psychiatry. Some of the leaders of this group were gay psychiatrists. "Their lobbying and their electioneering led to a seizure of the presidency and the chairs of the APA." Those they helped elect, particularly Alfred Freedman, John Spiegel and Judd Marmor, would play important roles in the APA's reclassification of homosexuality.[61]

In mid-1973 the APA president John Spiegel and its vice president Judd Marmor brought the Nomenclature Committee to a meeting at Columbia University with representatives of several gay activist organizations "to discuss the deletion of homosexuality from the APA's *Diagnostic and Statistic Manual*." The organizations represented included the Gay Activist Alliance, the Mattachine Society, and the Daughters of Bilitis. Spiegel and Marmor also used their executive power to bypass the

chair of the Committee on Nomenclature Henry Brill, by a creating a subgroup called the Nomenclature Task Force on Homosexuality headed by Robert Spitzer.[62]

At the same time Spitzer was drafting the nomenclature change on homosexuality he was working with gay activist Ronald Gold on an APA resolution in support of gay civil rights. The Spitzer proposals came out of the newly created task force and not from the Committee on Nomenclature as a whole. They "represented Spitzer's own effort to resolve what many APA leaders considered a 'hot potato.'" When the proposals were brought before the Committee on Nomenclature the committee unanimously supported the gay civil rights resolution, but were "completely divided" on the nomenclature change. Even though the Nomenclature Committee was divided on the nomenclature change and never formally approved the proposal it went on to the APA's Council on Research and Development.[63]

As elated as the gay activists were over the Spitzer proposal moving through the APA bureaucracy, they were not satisfied. Their goal was to bring homosexuality to equality with heterosexuality. Spitzer's new classification of "sexual orientation disturbance" did not bring complete equality and the gay activists were upset that Spitzer referred to homosexuality as "suboptimal." Ronald Gold sent a letter to the Council on Research and Development arguing that if some homosexuals are disturbed with their sexual orientation then the classification should also include heterosexuals who are disturbed with their sexual orientation and need a homosexual adjustment. Gold was now a leader in the National Gay Task Force and did not want to delay the council's vote or have the proposal subject to review, so he suggested to the council that they just delete homosexuality from the *DSM* without adding the new classification. Gold's request was

not heeded by the council and many gay activists remained skeptical of the Spitzer proposal.[64]

Henry Brill, whose leadership on the Nomenclature Committee had been compromised by Spiegel and Marmor, sent a cover letter with the Spitzer proposal stating that the Committee on Nomenclature was divided on the proposed nomenclature change and "caustically characterized Spitzer as being 'quite sympathetic' to the viewpoint of the 'Gay Liberation Group.'" Brill recommended to the APA Council on Research and Development that "a formal survey of a stratified sample of APA members be undertaken to elicit responses to Spitzer's nomenclature proposal." Brill's suggestion was rejected and the Council on Research and Development unanimously approved Spitzer's proposal at its October meeting. [65]

The APA Council on Research and Development claimed that its unanimous vote reflected its desire to follow established procedure of accepting the work of the committees it initiated. Appointed committees were supposed to be composed of experts using scientific methods of procedure, yet they knew there were no experts of homosexuality on the task force led by Spitzer.[66] The council had to have been aware that none of the prominent experts on homosexuality were even consulted by Spitzer's Task Force or the Committee on Nomenclature. Yet the council claimed its unanimous vote stood for scientific procedure.

The next bureaucratic step for the Spitzer proposal was the Assembly of District Branches. Gay activists tried again to alter the language of the status change. Working with the New England APA Region they put together a declassification proposal more suitable to their demand of equality, but they could not get support from the other APA

regions and the New England Region withdrew its alternate proposal from the Assembly's consideration. After passing the Assembly the Spitzer proposal went to the APA Reference Committee. On November 15 of 1973 the Reference Committee approved Spitzer's new diagnostic category for homosexuality and only one more hurdle was left, the APA Board of Trustees.[67]

The psychiatric experts on homosexuality had been left out of the process that reclassified homosexuality. Charles Socarides learned that a proposal to reclassify homosexuality was going to the APA Board of Trustees in November when a reporter called and asked him for a comment on the upcoming celebration party in December at the APA headquarters in Washington, D.C. The reporter referred to the approaching APA event as "the greatest of gay victories – the purging of homosexuality from the realm of psychiatry." Socarides was unaware of the Spitzer nomenclature proposal and was taken aback when informed that it had been approved by Council on Research and Development.[68]

Socarides and Bieber had been cast as villains by gay activists Ronald Gold, Charles Silverstein, and Frank Kameny. Mental health professionals Judd Marmor, Robert Seidenberg, Seymour Haleck, and Richard Green also cast Socarides and Bieber as villains; so did Kinsey alumni Wardell Pomeroy and Alan Bell. Socarides and Bieber's expertise was attacked by the coalition of gay activists and normal variant mental health professionals at every level of the reclassification process.

Early in the APA debate over homosexuality Charles Socarides had been authorized to lead a task force for the New York County District Branch of the APA to educate psychiatry and the public on homosexuality. "It was an impressive bunch, a

dozen experts affiliated with the major medical centers of New York City – the first all-psychiatric group ever to study homosexuality." The report they submitted at the end of 1972 advocated for homosexual civil rights, while at the same time classifying homosexuality as "a disorder of psychosexual development." Unfortunately for the Socarides task force, the president of the New York District Branch who had authorized the task force died in 1971 and the new Executive Committee of the Branch was now headed by gay psychiatrists. When the report came to the new Executive Committee they rejected it. The gay dominated Executive Committee would not let the report be read and they dissolved the task force.[69] Politics repeatedly trumped science in this debate.

Several psychiatric groups had tried to slow down the reclassification of homosexuality, but were opposed by gay psychiatrists with bureaucratic power. None of the committees in the reclassification process "ever called for a scientific, critical discussion between those who had been treating homosexuals and those who just thought that curing homosexuality by fiat would be the easiest way to help homosexuals gain equal rights under the law."[70] The committees and councils did not want any input from the psychiatrists who helped homosexuals change their sexual orientation, specifically, Socarides and Bieber. Although gay activists were consulted and brought to meetings, not one former homosexual was consulted or represented at the meetings. Committee after committee and council after council rubber stamped the Spitzer reclassification proposal.

When Socarides learned that Spitzer's proposal was going before the APA Board of Trustees he protested to the board that the reclassification of homosexuality was being railroaded "through without sufficient input from those in the profession who knew most about homosexuality." The board realized they could not justify reclassifying

homosexuality without hearing testimony from the psychiatric experts who opposed the reclassification, so they gave three psychiatrists five minutes each before the board at their December 15th meeting.[71]

Irving Bieber, Charles Socarides, and Robert McDevitt stated their opposition to Spitzer's proposed reclassification of homosexuality to a "bare quorum of the Board." First they expressed their "conviction that the nation repeal all persecutory laws against homosexuals," but they "insisted that there was no scientific evidence to justify removing the diagnosis of homosexuality as a psychiatric condition." Bieber expressed concern that the reclassification would "bring about an increase in homosexual experimentation among young men" who are confused about their sexuality. McDevitt told the board directly to its face that their desire to remove homosexuality from the *DSM* was motivated solely on "political and philosophical grounds," and would "create more despair than hope." Socarides argued that the proposed declassification change amounted "to a legitimation of same-sex sex" and "would lead to a general breakdown in society."[72]

Within minutes of the opposition's testimony the board voted thirteen to zero, with two abstentions, to approve Spitzer's reclassification of homosexuality. Homosexuality was now reclassified as a "sexual orientation disturbance" and this new classification applied only to those with unwanted same-sex attractions. According to the new classification those with unwanted same-sex attractions were to be "distinguished from homosexuality, which by itself does not necessarily constitute a psychiatric disorder." The board also passed the homosexual civil rights proposal that Spitzer had written with Ronald Gold. In the civil rights proposal the APA urged the ending of discrimination against homosexuals, the enactment of local, state, and federal civil rights

legislation guaranteeing civil rights protections by law, and the end of all criminal laws against adult sexual acts performed in private. "Eleven months after their first presentation before the Committee on Nomenclature, homosexual activists had succeeded in achieving their long-sought goal." [73]

One of the Board of Trustee members, John Nardini, later apologized to the three psychiatrists who had come to Washington, D.C. to present opposing opinions. Nardini told them that "The board was set up from the beginning to vote against you, no matter what you had to say. Your testimony was simply pro forma."[74] Socarides, Bieber, and McDevitt would have been better served if they had boycotted the board meeting and held their own press conference.

Five days before the board's December meeting the APA had issued a press release to inform reporters of an upcoming press conference with Robert Spitzer and APA president Alfred Freedman. The National Gay Task Force was also going to have representatives at the press conference; activists who had been involved in "pressing the APA to make the desired change." Ronald Gold sent the gay participants a memorandum urging them to stress the importance of the anticipated board decision, but to note their dissatisfaction with a new diagnostic category of homosexuality. Gold also wanted the participants to send a warning "that individual 'homophobes' would remain the subject of continued 'exposure.'" [75]

The press conference took place on December 16th at a cocktail celebration party the day after the Board of Trustees meeting. At the press conference the psychiatrists talked about politics and law, not about mental disorders. They voiced their opposition to criminal laws against homosexual sex between consenting adults and to the social

discrimination gays and lesbians endure. While the gay activists were delighted by the psychiatrists support, they made it clear that the APA's reclassification of homosexuality "was only a first step in their fight 'for equality.'" Their next targets were "sodomy laws, immigration restrictions, and child custody cases." They also informed the press that "they would start a campaign to purge school textbooks of any material that smacked of being 'anti-gay.'" Some of the gay activists at the press conference/cocktail celebration were National Gay Task Force leaders Howard Brown and Bruce Voeller, lesbian activist Barbara Gittings, and Frank Kameny. Someone asked Robert Spitzer "Aren't you afraid the gays will now take over the APA?" With a reported look of self-satisfaction Spitzer replied, "Look around you. They already have."[76]

The opposition's response

The New York Times covered the December 16th press conference with the headline "PSYCHIATRISTS IN A SHIFT DECLARE HOMOSEXUALITY NO MENTAL ILLNESS." A gay weekly magazine ran the headline "SICK NO MORE." A few weeks later the APA Board of Trustees sent text justifying their vote to the *Psychiatric News*. It consisted of a background paper by Robert Spitzer and conclusions to a 1973 book on homosexuality. The book was more sociological than psychological, focusing on what homosexuals did and not why they did it. Spitzer's paper argued that homosexuality was a normal human condition at one end of Kinsey's sexual orientation scale. It was not a disorder because it did not "regularly cause subjective distress" or "generalized impairment of social effectiveness or functioning." Spitzer offered no proof to back up his rationale, "no citations from anyone, nothing from the psychoanalytic

community." He ignored all the clinical science and text that showed the psychopathologic nature of homosexuality.[77]

It was surreal to Bieber, Socarides, and other reparative psychoanalysts that the leaders of the APA would ignore the evidence of clinical science. The opponents of the Board of Trustee's decision disagreed with Spitzer's reasoning that "social distress" should be the standard by which the presence of psychopathology was determined. "Indeed, it was the absence of such discomfort that often revealed the depths of pathology."[78] For example, a person with schizophrenia, depression, or volatile rage that is not discomforted by their condition and functions well in social situations would still have a great depth of psychopathology. In fact, they may have a greater depth of psychopathology than a person with the same condition showing distress.

The distinguished Abram Kardiner criticized the board's decision in the *Psychiatric News,* "If the American Psychiatric Association endorses one of the symptoms of social distress as a normal phenomenon it demonstrates to the public its ignorance of social elements." Kardiner predicted that in future generations the family would become the victim of this decision.[79] Another letter in the *Psychiatric News* from a psychiatrist stated the concern very bluntly, "The Board of Trustees has made a terrible, almost unforgivable decision which will adversely affect the lives of young homosexuals who are desperately seeking direction and cure."[80] In another letter Robert Goldstein accused the APA Board of Trustees of behaving "like a church council deciding on matters of dogma," and psychiatrist Harold Volh accused the Board of Trustees of inflicting grave harm on society and disgracing itself.[81]

Charles Socarides and Irving Bieber were not done fighting the reclassification of homosexuality yet. There was dismay and outrage in the psychoanalytic community across the country. The Ad Hoc Committee Socarides and Bieber had organized earlier used an APA by-law provision to directly challenge the board's decision. Socarides and Bieber circulated a petition at the January 1974 meeting of the American Psychoanalytic Association in New York. In two days 243 mental health professionals had signed the petition to bring the classification change of homosexuality to a vote of the APA membership.[82]

The provision in the APA by-laws that allowed for democratic redress against the APA leadership was intended for use in the corporate life of the APA. It was never intended to decide matters of science. Irving Bieber argued that although "he was unalterably opposed to democratic decision-making in matters of science; it was the Board of Trustees that had violated the standards of scientific inquiry."[83] The Spitzer proposal was the work of one man who knew little of the psychiatric science on homosexuality. The philosophies of Kinsey disciples and Szasz disciples had falsely been given scientific credibility, while the psychiatric experts on homosexuality and their clinical research were written off as prejudiced.

Politically the Board of Trustees was in a pickle. They all agreed that democratic votes in the organization "were appropriate for organizational policy questions and not for matters of science," but they "found that distinguishing between the two was not quite so simple." After much dissention it was decided that the Spitzer proposal would go before the APA membership as a referendum. The board saw the decision to allow the membership vote as the lesser political risk. What the board feared most was a possible

political unification of those who opposed the reclassification and those "who would consider rejection of the petition a high-handed infringement of their democratic professional rights."[84]

Gay activists immediately developed an aggressive strategy to back their allies in the APA. Through Kent Robinson gay activists recruited Judd Marmor's support for a statement supporting the reclassification of homosexuality. The gay activist strategy was to mail the statement to "all APA members urging them to vote for the nomenclature change." Marmor was the APA vice president at the time and running for president. At Marmor's suggestion Robinson contacted the other two psychiatrists running for the APA presidency and they also agreed to sign the statement. The statement defending the Spitzer proposal was written by Spitzer and gay activist Ronald Gold, and then signed by Marmor and the other APA presidential candidates, along with two vice president candidates. [85]

Researcher Ronald Bayer was intrigued by the strategy of the statement that Spitzer and Gold had written. The letter completely sidestepped the conflict over the classification of homosexuality, and sought support for the nomenclature change on grounds of "organizational and professional integrity." The statement included this summation, "we feel that it would be a serious and potentially embarrassing step for our profession to vote down a decision which was taken after serious and extended consideration by the bodies within our organization." The statement gave every indication that it was initiated and written by Marmor and those who signed it. At least one signer of the statement acknowledged that if the role of gay activists in conceiving

and writing the statement was made public, it "would have been the 'kiss of death'" for the reclassification of homosexuality.[86]

The National Gay Task Force sent out a fund-raising letter to their friends in mid-February seeking $2500 for the mailing to the members of the APA. It read, "The National Gay Task Force has obtained agreement from the three candidates for the presidency of the APA to sign a statement opposing the referendum, and our plan is to send this to the entire voting membership of 17,910 psychiatrists. ...WE NEED $2500." Potential contributors were told that contributions over $100 could be tax deductible if a check was made out to St. Mary's Episcopal Church.[87]

"The National Gay Task Force orchestrated the process of obtaining signed copies of the letter, purchased the necessary address labels from the American Psychiatric Association, and underwrote the full cost of the mailing." The letter intentionally did not reveal that it was written in part by Ronald Gold of National Gay Task Force or that the mailing was financed by the National Gay Task Force. The leadership of the APA knew of the letter, who wrote it, and how its distribution was financed. "They, as well as the National Gay Task Force, understood the letter as performing a vital role in the effort to turn back the challenge."[88]

Towards the end of February in 1974 Charles Socarides was made aware that the National Gay Task Force had purchased the APA's computerized mailing labels and called the medical director of the APA for an explanation. The medical director would not respond to any questions as to how a political organization could be allowed to use APA resources to influence a referendum that was supposed to involve a science based clinical classification. He would only tell Socarides that candidates running for office

could purchase the labels for electioneering purposes. Clearly, that was not what the labels were being used for. Harold Voth, a member of the Socarides and Bieber Ad Hoc Committee, wrote to the president of the APA that "The letter is written in such a way as to suggest that the signatories initiated it ... In my opinion this letter represents an act of fraud." The Socarides Ad Hoc Committee soon filed a formal complaint.[89]

The referendum went out to the APA membership on schedule defining the new "sexual orientation disturbance" classification and containing statements both supporting and opposing the new classification. Of the roughly ten thousand psychiatrists who participated in the referendum 58 percent favored the board's decision and 37 percent opposed it.[90]

Of those supporting the board's decision to reclassify homosexuality most bought into the illusion that the board's decision was the "result of the full scientific airing of the complex issues" that encompassed homosexuality. They tended to dismiss the opposition to the reclassification as social conservatives stuck in the Judeo/Christian morality of the general population. In contrast they viewed the liberal leadership of the APA as sophisticated, in tune with cosmopolitan values and weighing decisions on empirical research.[91] Of those who opposed the board's decision most believed the 37 percent vote against the reclassification of homosexuality showed that the reclassification was not based on empirical research, but was an attempt by APA leaders "to impose their own social values under the guise of science."[92]

The facts regarding the National Gay Task Force's involvement in the APA referendum were given to Chicago newspaper columnist Mike Royko, who in turn informed the public in April of 1974. He told the world that the letter sent to psychiatrists

signed by Judd Marmor and the other APA candidates for president "was a piece of gay movement propaganda. ... What the psychiatrists don't realize is that they were subjected to as shrewd a job of hidden lobbying as you'd ever see in Washington."[93]

In June of 1974 APA leadership created a special appointed committee to review the compliant the Socarides group filed regarding the direct participation of the National Gay Task Force in the referendum. It heard out the complaints of Socarides and his group, but did not allow them to confront the signers of the letter or Spitzer. None of the signers were even questioned by the committee. The committee's conclusion was that the signer's actions did not constitute unethical behavior, but it was "unwise." From Socarides' viewpoint the committee "swept this whole sorry issue under the rug."[94]

Later in the summer of 1974 a statement was published in the *Psychiatric News* signed by the Judd Marmor and the other signers of the controversial letter mailed by the National Gay Task Force. They acknowledged that they knew the National Gay Task Force had financed the mailing and that Robert Spitzer had written the text. They claimed that the statement was their views and denied "foreknowledge of the decision not to reveal the role of the Gay Task Force to the APA's membership."[95] They claimed their cooperation with the gay activists was not a dishonest act. In several ways the statement in the *Psychiatric News* was another political ploy. It did not acknowledge that gay activist Ronald Gold had written the letter with Spitzer, and the only way the signers could deny knowing that the Gay Task Force's involvement was being concealed, was if they signed the letter without reading it. Surely Marmor and the other candidates did not think the National Gay Task Force was going to put their organizations name on the return address.

At the end of 1973 homosexuality was no longer classified as a mental disorder by the American Psychiatric Association. Socarides, Bieber, and the reparative psychoanalysts had fought a good fight, but they were fighting with clinical science, while their opponents waged a philosophical war and had a political movement as an ally. Socarides reflected on the battle later, "We were sure of our position on clinical grounds. We didn't think we had to get political in order to bring most of the working psychiatrists in the country along with us."[96] The Socarides group had erred. They knew this battle had far reaching consequences, but they did not understand its epic political ramifications for the gay political movement. This political decision by the APA in 1973 to reclassify homosexuality would be the foundation stone that the gay political movement would build upon for decades to come.

Conclusions

In the 1960s Thomas Szasz's arguments made psychiatrists aware that their decisions had a large role in influencing the moral norms of the nation. For some it was a call to action. In the early 1970s a small group of psychiatrists joined with gay political activists in an effort to use the APA as a means to make homosexuality culturally accepted. Their main opposition was the clinical science that showed homosexuality was a psychopathological disorder. The offensive weapons in this battle were philosophical arguments and an army of militant gay activists. By the end of 1973 the APA was no longer the watchdog of society's Judeo/Christian norms as Judd Marmor had complained earlier in the year. Instead, the APA was now working with gay activists to create new cultural norms.

Heinz Lehman, a member of the Committee on Nomenclature with Spitzer, stated that the presentations by gay leaders and the new information on homosexuality he was privy to persuaded him to vote yes on the referendum vote reclassifying homosexuality. He claimed that those who "adhered to the conservative view" and voted against the referendum were not aware of the new key information.[97] For many psychiatrists unfamiliar with homosexuality most everything they learned was new to them, but it was not all new information. The Kinsey scale of sexual orientation that argued homosexuality and bisexuality were normal variants of human sexual behavior was from the 1950s, as were the Kinsey statistics. Evelyn Hooker's argument that homosexuality is not necessarily a psychopathological condition because many homosexuals function normally in society was also from the 1950's. Thomas Szasz's argument that mental illness was a myth created by mental health professionals was first published in 1961. The fact that many homosexuals who embraced their homosexuality could function well in society dated back to Magnus Hirschfeld in the 1920s.

What was new from the normal variant perspective of homosexuality in the 1970s was Richard Green's theory of heterosexual bias, George Weinberg's theory of homophobia, and Weinberg's charge that reorientation therapy was harmful to homosexuals. Was the Committee on Nomenclature blind to the homosexual bias of Charles Silverstein and the other homosexual activists? Were Weinberg's theories presented to the committee or to its members outside the formal meetings? These questions remain unanswered at this time. Probably of more importance, what was new in the early 1970s was the rise of gay militancy and the revelation that a significant number of psychiatrists were homosexual.

Lehman had been a judge in a courtroom that purposely heard only one side of the case before it. The conservative viewpoint barred from the debate was built upon information that had been substantiated with clinical research for a couple decades. Beginning with Sandor Rado's assessment in 1940 that homosexuality often served as a reparative function related to unresolved childhood trauma, significant psychoanalytic breakthroughs had been made in understanding homosexuality. Psychoanalysis in the 1960s offered real hope to those with unwanted homosexual attractions. Published reports by Edmund Bergler in 1956, Bieber in 1962, Socarides in 1968, and Hatterer in 1970 documented consistent sexual orientation change and revealed the underlying causes of homosexuality through the clinical records of their clients. This was the scientific method at work. New clinical evidence continued to support the theory that homosexuality was often a reparative function, a psychopathologic response to unresolved internal distress.

Spitzer and the Committee on Nomenclature heard presentation after presentation by gay activists, Kinseyan sexologists, and normal variant psychoanalysts. In addition the panels on homosexuality at the APA conventions of 1971 and 1972 consisted only of gay activists and their supporters. The 1973 APA convention pitted Socarides and Bieber against four opponents, one being a gay activist. Where were the former homosexuals, the clients for whom the gay life was destructive? They were never sought out by Spitzer and other APA leaders. Former homosexuals would probably have had to have a police escort to protect them from gay activists that considered them traitors to the cause of homosexual equality, but they were people psychiatry was supposed to help. One can only wonder how differently the panel discussions would have went if former homosexuals had been on the panels to counter the presence of the gay activists; former

homosexuals who had sought out psychotherapists and who had actually changed their sexual orientations. But their stories were never heard, never sought out by Kent Robinson, Robert Spitzer, the Committee on Nomenclature, or the APA leadership.

Looking back at 1973 Charles Socarides believed that many members of the APA were led to believe that reclassifying homosexuality would "protect homosexuals from a lot of abuse they were taking – from society in general, from the criminal justice system in particular."[98] Gay activists had convinced many with pleas and intimidation that the disorder status of homosexuality was harming them. Only the leaders of the reparative psychoanalysts, like Bieber and Socarides, separated the political issues from the medical science issues. To them the criminal justice issue was a civil law issue and political. The issue of what caused homosexuality and how to help those troubled by it was a psychiatric issue, and the clinical science supported their viewpoints. The leaders of the normal variant psychoanalysts, like Marmor, Seidenberg, and Silverstein, saw an opportunity to use the sentiment surrounding the criminal justice argument to change the societal norms on homosexuality. They were undeniably opportunistic.

The 1973 APA declassification of homosexuality was a classic case of Kuhn's paradigm shift in a scientific field. Tenets of the 1973 paradigm and the post-1973 paradigm on homosexuality were irreconcilable. The paradigm shift was a scientific revolution that changed the world with it. It offered future promise rather than past achievement. The paradigm shift was a story of bureaucracy and political intrigue more linked to political science and sociology than psychiatry. It was also the story of the gay political movement's biggest victory of the century.

Alfred Kinsey had sowed the seeds of a scientific organization embracing the normal variant view of homosexuality. In accordance with Kuhn's theory Kinsey had been personally conflicted over homosexuality. Judd Marmor and Robert Spitzer were equally conflicted over homosexuality, but in a different way than Kinsey. Kinsey's conflict over homosexuality seemed to be a personal demon. For Marmor and Spitzer the conflict was the gay activist's condemnation of psychiatry; the charge that psychiatry was harming homosexuals; and the evidence that the gay activists were articulate and functioned well in society. They believed the future promise of the paradigm shift would help homosexuals by easing their anxiety with the information that their homosexuality was not a disorder.

The ballots from the referendum were never independently verified and opposition leader Charles Socarides never asked who counted the ballots. Looking back, he questioned his lack of judgment for not insisting on an independent audit of the ballots, but "at the time, it didn't seem like a very gentlemanly thing to do."[99] Four years after the APA referendum on homosexuality the *Medical Aspects of Human Sexuality* journal sent out questionnaires to APA members asking them if they believed "homosexuality is usually a pathological adaptation, as opposed to a normal variation." Based on the first 2500 responses the survey showed that 69 percent of the APA members believed that "homosexuality is usually a pathological adaptation." 18 percent disagreed, while 13 percent were uncertain.[100]

In 1974 Gerald Davison addressed the Association for the Advancement of Behavior Therapy and argued that psychotherapists should not help homosexuals to change their sexual orientation. Davison was the president of the association at the time

and presented a gay political objective that would be strived for again and again in the future. In the speech Davison acknowledged that individual homosexuals might suffer from such a policy, but "homosexuals would benefit as a class."[101]

Researcher Ronald Bayer had observed a major shift of focus in the homosexual movement during the 1960s. It was closely correlated in time to when the homophile movement became the gay rights movement. From that point on the movement's priority was to defend the interests of the homosexual minority group over the interests of the individual homosexual. The gay movement going into 1973 had for some time devalued the homosexual who did not want to be a homosexual and openly attacked psychoanalysts who offered them the opportunity to change.

Bayer's historical record of the 1973 APA declassification of homosexuality alluded to a similar structural shift happening within the APA, but he did not explicitly point it out. But a structural shift did occur within the APA in 1973. It was a paradigm shift on homosexuality. While the proponents of the post-1973 paradigm saw the shift as benefiting a minority subculture that had been discriminated against, the disregard of clinical research undermined the professional integrity of the organization and psychiatry itself. In addition, the paradigm shift on homosexuality put the interests of the homosexual minority group over the interests of the individual homosexual, especially those struggling with unwanted same-sex attractions. By putting the political interests of a minority group over the psychological interests of the individual client it could be argued that the American Psychiatric Association was no longer a mental health organization dedicated to helping individuals with psychological disorders. At the 1972 APA convention in Dallas gay activist Frank Kameny produced a flier for the gay booth

in the scientific exhibition area. The flier urged psychiatry to become the major ally in the struggle for "our full rights, our full happiness and our basic human dignity."[102] In 1973 the APA became that major ally.

Notes

[1] Bayer, *Homosexuality and American Psychiatry*, 3.

[2] Lindner, *You Must Conform,* 63.

[3] Bayer, *Homosexuality and American Psychiatry*, 70, 74, 76-7. Bayer references the Ken Burns' statement to the article "The Homosexual Faces a Challenge" in the *Mattachine Review*, August 1956, page 25.

[4] Ibid., 78-81.

[5] Ibid., 81.

[6] Rainbow History Project, "Timeline of D.C. GLBT History."

[7] Bayer, *Homosexuality and American Psychiatry*, 81.

[8] Marshall, "Positive Policy," 4.

[9] Committee on Religious Concerns, "Is Homosexuality A Sickness?" 2.

[10] Ibid.

[11] Bayer, *Homosexuality and American Psychiatry*, 64.

[12] Ibid., 86.

[13] Ibid., 85.

[14] Ibid., 88.

[15] Ibid., 85-6.

[16] Socarides, *Homosexuality A Freedom Too*, 51-2.

[17] Bayer, *Homosexuality and American Psychiatry*, 90-1.

[18] Ibid., 92.

[19] Clendinen and Nagourney, *Out for Good*, 22.

[20] Socarides, *Homosexuality A Freedom Too*, 160.

[21] Bayer, *Homosexuality and American Psychiatry*, 102.

[22] Ibid., 102.

[23] Shilts, *Band Played On*, 431.

[24] Ibid., 103-4.

[25] Socarides, *Homosexuality A Freedom Too*, 160.

[26] Bayer, *Homosexuality and American Psychiatry*, 105.

[27] Ibid., 104-5.

[28] Ibid., 105-6.

[29] Ibid., 106-7.

[30] Socarides, *Homosexuality A Freedom Too*, 161.

[31] Ibid., 161-2.

[32] Bayer, *Homosexuality and American Psychiatry*, 40.

[33] Ibid., 107.

[34] Ibid., 107-9.

[35] Ibid., 108-10.

[36] Seidenberg, "Accursed Race," 159.

[37] Bayer, *Homosexuality and American Psychiatry*, 111.

[38] Socarides, *Homosexuality A Freedom Too*, 162-3.

[39] Bayer, *Homosexuality and American Psychiatry*, 111.

[40] Ibid., 116.

[41] Silverstein, "Wearing Two Hats," 16.

[42] Ibid.

[43] Bayer, *Homosexuality and American Psychiatry*, 117.

[44] Ibid., 117-9.

[45] Ibid. 117.

[46] Ibid.

[47] Ibid., 117-8.

[48] Silverstein, "Wearing Two Hats," 16-7.

[49] Bayer, *Homosexuality and American Psychiatry*, 120.

[50] Solomon, "Proverb 18:17," 971.

[51] Bayer, *Homosexuality and American Psychiatry*, 120-1.

[52] Ibid., 121-2.

[53] Socarides, *Homosexuality A Freedom Too*, 105.

[54] Bayer, *Homosexuality and American Psychiatry*, 122-3.

[55] Ibid., 124.

[56] Ibid., 125.

[57] Ibid., 125-6.

[58] Robertiello, *More Positive View*, 176.

[59] Bayer, *Homosexuality and American Psychiatry*, 127-8.

[60] Ibid., 190.

[61] Socarides, *Homosexuality A Freedom Too*, 164.

[62] Ibid., 165.

[63] Bayer, *Homosexuality and American Psychiatry*, 129-31.

[64] Ibid., 131, 133.

[65] Ibid., 130-1.

[66] Ibid., 132-3.

[67] Ibid., 133-4.

[68] Socarides, *Homosexuality A Freedom Too*, 165.

[69] Ibid., 163.

[70] Ibid., 170.

[71] Ibid., 171.

[72] Ibid., 171-2.

[73] Bayer, *Homosexuality and American Psychiatry*, 137.

[74] Socarides, *Homosexuality A Freedom Too*, 172.

[75] Bayer, *Homosexuality and American Psychiatry*, 135.

[76] Socarides, *Homosexuality A Freedom Too*, 172-3.

[77] Ibid., 172-4.

[78] Bayer, *Homosexuality and American Psychiatry*, 139.

[79] Ibid., 141.

[80] Ibid., 140.

[81] Ibid., 141.

[82] Socarides, *Homosexuality A Freedom Too*, 173.

[83] Bayer, *Homosexuality and American Psychiatry*, 142.

[84] Ibid., 143-4.

[85] Ibid., 144-5.

[86] Ibid., 145-6.

[87] Socarides, *Homosexuality A Freedom Too*, 178.

[88] Bayer, *Homosexuality and American Psychiatry*, 145-6.

[89] Ibid., 146-7.

[90] Ibid., 147-8.

[91] Ibid., 149-50.

[92] Ibid., 149, 151.

[93] Socarides, *Homosexuality A Freedom Too*, 177.

[94] Ibid., 178-9.

[95] Bayer, *Homosexuality and American Psychiatry*, 152.

[96] Socarides, *Homosexuality A Freedom Too*, 175.

[97] Bayer, *Homosexuality and American Psychiatry*, 150.

[98] Socarides, *Homosexuality A Freedom Too*, 157.

[99] Ibid., 179.

[100] Ibid.

[101] Ibid., 76-7.

[102] Bayer, *Homosexuality and American Psychiatry*, 108.

PART III

THE EFFECTS, ADVANCEMENTS, AND DIVISION AFTER 1973

Chapter 7

Progressive Change – Gay Is Good

"The change in eroticism which we experience today

has been conditioned by the fall of Christian morality."[1]

J. J. Beljon (1967)

"I can see that we are moving toward a situation where no restrictions on sexuality

are imposed upon those who want to experience it to its fullest."[2]

Hendrick Ruitenbeek (1974)

Opening note

The 1973 declassification of homosexuality as a disorder by the American Psychiatric Association (APA) would be used extensively to further Alfred Kinsey's vision of an America whose Judeo/Christian norms of sexuality are replaced by sexual relativism. Robert Lindner and Thomas Szasz were the first to articulate that psychiatrists had in many ways assumed the influence that the clergy once had as authorities of what

was right and wrong, normal and abnormal. After 1973 normal variant psychiatrists in key positions of power altered psychiatry's influence upon society. The post-1973 paradigm was built on future promise. Its foundation was theoretical, not scientific. Many gay activists and normal variant psychoanalysts had sought the paradigm shift because they believed it was an injustice to condemn or discourage homosexual behavior. After 1973, American Psychiatric Association and the American Psychological Association literature began promoting the ideal that homosexuality was as normal as heterosexuality.

The reclassification of homosexuality was considered by normal variant psychoanalysts to be a needed progressive change. It led to many other forms of progressive change. Progressive relativist ideologies affirmed the various sexual behaviors of homosexuals as their right of sexual expression and, consequently, relativist ideologies grew more powerful in the universities. The growing influence of progressive ideologies changed the way governmental and institutional leaders related to the homosexual minority and their leaders, which led to changes in laws, changes within institutions, and the establishment of new institutions. This chapter will examine some of the ramifications that resulted from the 1973 reclassification of homosexuality by the American Psychiatric Association (APA).

The evolution of the progressive view of homosexuality

After homosexuality was no longer deemed a disorder by the American Psychiatric Association, psychologist and gay advocate Hendrick Ruitenbeek examined the new progressive sexuality he had helped shape and offered his progressive analysis

and vision of what society's role in sexuality should be. Ruitenbeek reminisced that Kinsey and "his associates were the prime movers in altering popular notions about sexual behavior in America. ... almost at one stroke, [they] changed many of the sexual inhibitions and prejudices that Americans still entertained."[3] One result of the publication of the Kinsey team's statistics and their relativist perspective of sex was the creation of the academic discipline of scientific sexology: the study of sexual behavior "not burdened by moral and cultural biases."[4] From this "scientific point of view whatever occurs in nature is natural, however unusual it may appear."[5] Ruitenbeek's logical conclusion was that sexologists then "have the task of helping to remove many prejudices about sexuality."[6]

"The more people come to feel that sexuality is both beautiful and their due, the more uneasy men and women become about their own sex lives, the more many couples realize what they are missing."[7] From his progressive point of view Ruitenbeek saw traditional marriage as "an obstacle to the full exploration of sexuality."[8] The villain from his point of view was the parent who projected their morality upon their children. Parents were told by Ruitenbeek to understand "that their children have their own *sexual* lifestyles," and their sexuality choices were analogous to vocational ambitions.[9] Ruitenbeek saw "no reason why parents should not discuss the various *taboos* of sexuality with their children,"[10] as options equal to heterosexual marriage.

According to Ruitenbeek, "Self-acceptance and a more secure possession of his identity as an individual are of greater significance to the homosexual patient than conversion to what is called *normal sexuality*."[11] Judd Marmor used his influence as a new leader in the APA to argue for the normalcy of homosexuality based on studies that

had shown homosexual work histories were as stable as their heterosexual counterparts.[12] As for those distressed over their homosexuality Robert Spitzer, with Judd Marmor's blessing, created a new classification called "ego-dystonic homosexuality" in 1977. The cause of this disorder was "those negative attitudes toward homosexuality which have been internalized."[13]

Judd Marmor claimed the views of reparative psychoanalysts were "derived from seriously neurotic, compulsively cruising homosexuals" who had sought them out for consultation. He claimed, "These views have no validity in relation to the many thousands of homosexuals in the world who have never found it necessary to seek psychotherapeutic help and who live quiet, dignified, and responsible lives."[14] By the mid 1970s the only official psychiatric disorder related directly to homosexuality was the homosexual who was troubled by his homosexuality due to society's disapproval, and some normal variant psychoanalysts, echoing gay activist arguments, "questioned whether the reversal of object choice can be an ethical aim of psychotherapy."[15]

Propelling this change in philosophy was a new disorder created by George Weinberg and called "homophobia." In 1972 Weinberg described homophobia as an "irrational social prejudice," caused by either "the prohibitions against homosexuality in the Bible," "the dread of being in close quarters with homosexuals," "the fear of being homosexual oneself," "repressed envy" toward the cavalier homosexual lifestyle, "resentment" because homosexuals "are as a threat to one's values," and "because the thought of persons without children reawakens their fear of death."[16]

Judd Marmor gave credibility to this new disorder in 1980 by claiming that "homophobia in its most intense forms represents a pathological fear of homosexuality, usually based on one or more of the following factors: (1) a deep-seated insecurity concerning one's own sexuality and gender identity, (2) a strong religious indoctrination, or (3) simple ignorance about homosexuals."[17] In 1984 gay mental health professionals David P. McWhirter, M.D. and Andrew M. Mattison, Ph.D. confirmed growing a political trend. Although homophobia was "intended as a psychological term to mean fear of being or being thought gay, and fear of gays, it was quickly incorporated into gay liberationist language as a political epithet to be hurled as an insult at any and all opposition to the progress of the gay rights movement."[18] Gay strategists Marshall Kirk and Hunter Madsen, Ph.D. found "homophobia a comforting word. ... it's comforting to imagine that we have, at the very least, the power to inspire fear. The very term 'phobia' ridicules our enemies (and intentionally so), evoking images many would find comical, such as the old lady standing on the dining-room table, hiking up her skirts, and shrieking-at a mere mouse."[19]

Homophobia became an effective weapon that was used on opponents to the gay equality movement. With the continued strategy of associating sexual orientation to race, homophobia was touted by normal variant progressives as analogous to racial prejudice. By George Weinberg's and Judd Marmor's definition a strong religious belief that homosexual behavior was immoral represented a "pathological fear." The political use of the term as a prejudice and the theoretical causation by a strong religious belief implied that homophobia was an unjustified religious prejudice. Homophobia was also used as a weapon against homosexuals that wanted to change their sexual orientation. The new

philosophy argued that the reason these homosexuals were unhappy as homosexuals was because of their unresolved internal homophobia. Homophobia became the professional and political theory that supported the claim that all the problems of homosexuality were the result of society's disapproval of homosexuality.

Gay and lesbian institutional influence

Many books could be written on the growth of influence the gay political movement has seen since the 1973 American Psychiatric Association's declassification of homosexuality as a disorder. Some of the bigger developments follow. After the National Gay Task Force helped convince the American Psychiatric Association to remove homosexuality from its list of disorders in 1973, the Task Force influenced APA president, John Spiegel, to issue an official statement stating that "there is no scientific basis for discrimination against gay teachers."[20] Judd Marmor followed Spiegel as president of the American Psychiatric Association and "extended the Association's critique of discriminatory practices against homosexuals to the armed services."[21]The National Gay Task Force then began putting pressure on industry and unions, and was able to get a resolution supporting gay civil rights approved by the National Council of Churches in 1975.[22] The National Gay Task Force has since changed its name to the National Gay and Lesbian Task Force and focuses its efforts at the community level.

The Caucus of Gay, Lesbian, and Bisexual Members of the American Psychiatric Association was formed at the Association's 1975 convention. Using Kinsey statistics the caucus estimated that "between 1,250 and 2,500" psychiatrists were homosexual, yet the

formal membership of the caucus barely rose above 100 through the 1970s. The gay and lesbian caucus was able to persuade the American Psychiatric Association to establish an official task force on gays and lesbians in 1978,[23] which was later incorporated into a standing committee within the American Psychiatric Association. This standing committee's main purpose was to encourage the association "to take positions against discrimination based on sexual orientation." In 1985 the gay and lesbian caucus changed its name to the Association of Gay and Lesbian Psychiatrists so that it could "take positions independent of official American Psychiatric Association policies." The Association of Gay and Lesbian Psychiatrists was instrumental in the removal of the disorder, "Ego-Dystonic Homosexuality," which it labeled a "prejudicial diagnosis," from the revised *DSM-III* in 1986.[24]

The Association of Gay Psychologists was formed in 1973 to eliminate "the conception of homosexuality as a clinical entity, and to encourage the reconceptualization of human sexuality in terms of its diversity and potentiality."[25] In 1975 the Association of Gay Psychologists persuaded the American Psychological Association to recommend "removing the stigma of mental illness that has long been associated with homosexual orientation."[26] In 1985 "it changed its name to the Association of Gay and Lesbian Psychologists."[27] The Committee on Lesbian and Gay Concerns was formed within the American Psychological Association in 1980 and soon took up the cause of removing "heterosexual bias" in the association. The caucus, with the help of the Association of Gay and Lesbian Psychologists, prepared nomenclature changes which were approved by the Board of Social and Ethical Responsibility in Psychology in 1987.[28] In 2011 the American Psychological Association had a Lesbian, Gay, Bisexual, and Transgender

Concerns Office and a Committee on Lesbian, Gay, Bisexual, and Transgender Concerns promoting gay views nationwide.[29] As of 2012 the American Psychological Association also has a division (44) called the Society for the Psychological Study of Lesbian, Gay, Bisexual and Transgender Issues[30] that caters specifically to gay viewpoints. Virtually all the information on the American Psychological Association's 2011 website regarding homosexuality was a product of these gay interest groups.

In 1991 the American Psychoanalytic Association, under threat of an ACLU lawsuit, removed its requirement that homosexual doctors undergo analysis for their homosexuality before entry into its training institutes. Yet heterosexual candidates were still subject to rigorous analysis for their heterosexuality.[31] In addition to these gay interest groups operating in the associations of psychiatrists and psychologists, by 1980 powerful gay and lesbian interest groups emerged in "the American Library Association, the Modern Language Association, and the American Sociological Association."[32]

The psychiatrist's bible, *The Comprehensive Textbook of Psychiatry*, removed Irving Bieber's essay on homosexuality and replaced it with an essay written by Judd Marmor in 1975. Marmor's essay "reflected his own well-known rejection of the pathological perspective as well as his belief that homosexuality represented a normal variant of human sexuality." There was nothing in the 1975 textbook to even suggest the pathological view of homosexuality existed.[33] That same year Charles Socarides entries into the *American Handbook of Psychiatry* were deleted because they did not conform to the new philosophy on homosexuality.[34] Socarides warned that the revolutionary changes in psychiatry regarding homosexuality "demonstrate a complete and disastrous disregard

of knowledge gained through painstaking psychodynamic and psychoanalytic investigations over the past 75 years."[35]

The gay influence swelled in other important institutions. The four member gay caucus of the Democratic Party at the 1976 Democratic Convention grew to seventy-six delegates and alternates at the 1980 convention. By the 1984 convention all the Democratic presidential contenders were on the record in favor of gay rights. At that convention gay activists were able to add to the platform of the Democratic Party a "pledge to end the exclusion of gays from the military and as immigrants." Openly gay men had also been elected to the city councils of Boston and Minneapolis by 1984.[36]

Before the removal of homosexuality as a psychiatric disorder in 1973, homosexual activists had "looked upon the law as an enemy." After 1973 they began to use the law as an ally, "as a means to bar discrimination in employment, housing, and public accommodations."[37] As the result of pressure from gay interest groups and their allies "by 1976 fifteen states had deleted sodomy statutes from their criminal laws" and "local governments across the nation began to enact civil rights codes designed to protect homosexuals; between 1972 and 1976 thirty-three cities had done so as a result of either legislation or executive order."[38]

The ACLU played a major role in the fight for gay rights with its biggest gay related victory being *Lawrence v. Texas* in 2003 in which the Supreme Court struck down the same-sex sodomy laws in Texas. The ACLU not only fought against the discrimination of homosexuals, but worked to promote homosexuality equality through the Lesbian Gay Bisexual and Transgender Project. The purpose of that department of the

ACLU was and is to move "public opinion through the courts, legislatures and public education across five issue areas: Relationships, Youth & Schools, Parenting, Gender Identity and Expression and Discrimination in Employment, Housing and other areas."[39]

The gay political movement has its own legal organizations as well a sub-organization within the ACLU, the oldest of which is called LAMBDA. With meager beginnings in 1973 LAMBDA now has regional offices across the United States and has had reported annual budgets of over $10 million.[40] LAMBDA seeks to influence both public education and public policy with their gay viewpoint. The largest lobbyist organization for gays and lesbians is the Human Rights Campaign. Formed in 1980 and based in Washington, D.C., the Human Rights Campaign advocates on behalf of GLBT Americans "to achieve equality for lesbian, gay, bisexual and transgender Americans."[41] The Human Rights Campaign was reported to have had income of over $16 million per year in the first years of the 2000 millennium[42] and its corporate sponsors include Microsoft, Chase, Google, IBM, Starbucks, and Shell.[43]

Another large gay and lesbian lobbyist organization is the Gay and Lesbian Alliance Against Defamation (GLAAD). GLAAD specializes in media lobbying. in 1992 "*Entertainment Weekly* named GLAAD one of Hollywood's most powerful entities and the *Los Angeles Times* described the group as possibly the most successful organization lobbying the media."[44] Two national organizations that concentrate on influencing K-12 schools with gay equality arguments are the Gay, Lesbian and Straight Education Alliance (GLSEN) and Parents, Families, and Friends of Lesbians and Gays (PFLAG). One result of gay organizational influence in K-12 schools has been nine-year-olds being taught "how to perform anal intercourse 'safely.'"[45]

Two newer gay and lesbian organizations that garner national attention with their gay equality efforts are ACT Up and Soulforce. Soulforce has taken a special interest in lobbying religious based universities and organizations with busloads of gay and lesbian indentified people to protest against any viewpoint that labels homosexual behavior as immoral, a concept they deem as "religious & political oppression."[46] ACT UP has grown to over 70 chapters since its conception in 1987. It uses tactics of "vocal demonstrations and dramatic acts of civil disobedience" in its self defined fight against AIDS.[47]

Gay student groups appeared on universities rapidly in the 1970s. Federal courts upheld the right of homosexual students in state run universities to be recognized as official student organizations when the purpose was to "provide a forum for a discussion of homosexuality."[48] What was somewhat surprising was the development of gay and lesbian offices within the universities. These gay and lesbian offices and departments soon dominated policy concerning homosexuality. The new offices and departments were in essence political interest groups operating within the university. In addition, many universities began supplying gay and lesbian centers for students.

As an example the University of Michigan's gay and lesbian influence began in 1971 when the University of Michigan chapter of the Gay Liberation Front was formally recognized as a student organization. As a student organization it was able to convince the university to hire "Human Sexuality Advocates." These advocate positions led to the Office of Human Sexuality and eventually to the Office of Lesbian Gay Bisexual and Transgender Affairs.[49] The University removed the words lesbian, gay, bisexual, and transgender from the office title in 2005, calling it simply the "Spectrum Center."[50] In

addition to the Spectrum Center actively promoting gay rights within the university administration system, the University of Michigan offers a "Lesbian, Gay, Bisexual, Transgender, Queer (LGBTQ) and Sexuality Studies Academic Minor" through the Liberal Arts Department.[51] San Francisco State University was the first university "to offer a formal academic program on gay, lesbian and bisexual culture" in 1993.[52]

When gay interest groups began to dominate mental health association and academic views on homosexuality the focus of research on homosexuality went from the cause and cure of homosexuality to a "descriptive and phenomenological approach to examine homosexual persons as they are and as they live." McWhirter and Mattison argued in defense of this approach that "the development of new theories about sexuality and relationships depends upon such work."[53] Although causation of homosexuality was no longer an academic concern, the possibility of a genetic component to homosexuality was entertained, because a genetic component could support the gay argument that homosexuality was analogous to left-handedness.[54]

In 1991 neuroanatomist Simon LeVay reported in *Science* magazine that he had found "a localized cluster (a 'nucleus') of cells in the brains of 'homosexual' men twice as large by volume on autopsy as in 'heterosexual' men." LeVay insinuated that this was evidence that homosexuality was an innate condition. Two years later on the 16th of July 1993 the *Wall Street Journal* ran the headline "Research Points Toward a Gay Gene." *The New York Times* headline of the same story read, "Report Suggests Homosexuality Is Linked to Genes." The headlines were about research data given to the media by Dean Hamer. Hamer had found that in a small number of families the maternal uncles of homosexual men – but no other relatives – were disproportionately homosexual. In a

family in which the homosexuality "seemed to follow a pattern of mother-son inheritance" a variation in the Xq28 chromosome was found. [55] Those headlines acted like cement binding the belief that homosexuality was a genetic condition to public opinion. In fact, Time magazine listed the new findings "suggesting gays are born that way as one of the ten great scientific happenings of 1993."[56]

Sexual Freedom 1971 - 1984

By 1981 the sexual freedom in the gay enclaves of San Francisco and New York would be called a sexual utopia by many gay men, and it had only take ten years to build.[57] In 1980 a gay doctor in New York City stated, "One effect of gay liberation is that sex has been institutionalized and franchised. Twenty years ago, there may have been a thousand men on any one night having sex in New York baths or parks. Now there are ten or twenty thousand – at the baths, the back-room bars, bookstores, porno theatres, the Rambles, and a wide range of other places as well."[58] Outside the gay subculture Americans in general had no idea that male homosexual promiscuity had exponentially multiplied by 1981. Two credible sources documenting the sexual abandonment in the gay enclaves were Randy Shilts and Larry Kramer. Both men were gay identified. Shilts wrote a comprehensive history of the AIDS epidemic entitled *And the Band Played On* (1987) as well as a biography of Harvey Milk. Kramer's contribution was a fictional novel called *Faggots* (1978). Based on Kramer's own experience and observations of his gay friends,[59] his novel provided a window into the New York bathhouse scene as well as the gay resort destination of Fire Island. A review of *Faggots* from the London *Gay*

Times is quoted on the back cover of the paperback edition. It reads "A novel of deep and abiding morality; bitter, harshly humorous, grotesque, frightening, comic, and as honest as one individual's perceptions can make it."[60]

The next three paragraphs contain rather graphic descriptions of gay sexual practices. Many will find the content objectionable, especially those with traditional moral values. Others with a relativist moral constitution might not even consider these sexual practices out of the ordinary. Only the more widely published forms of gay sexual practices are described to give the reader some knowledge of what Shilts and Kramer revealed of the gay sexual culture in the 1970s and early 1980s.

Besides sodomy, oral sex, and mutual masturbation Larry Kramer introduced those outside the gay enclaves to the male homosexual practices of rimming ("which medical journals politely called oral-anal intercourse"[61]), fisting (putting one's fist up a rectum), urinating activities, as well as sadomasochistic gay sex, gay orgy parties, gay bathhouses, and the park on Fire Island gays call the "Meat Rack." The novel found its humor in the personal lives of the characters and it was there that one could view characteristics of the so-called "normal" homosexual – homosexuals with no desire to be heterosexual. The characteristic that provided continuity in all Kramer's homosexual characters was their flippant attitude to have gay sex with a new acquaintance while supposedly being in love with another man they imagined being their ideal mate. That appeared to be a common trait of many "normal" male homosexuals that Kramer was criticizing. Kramer himself, through his main character, seemed to be put off by the more bizarre forms of gay sex.

Between Larry Kramer and Randy Shilts readers got a picture of what was in a typical gay bathhouse. The function of the bathhouse was to provide a place for gay men to have anonymous consensual sex. Within the bathhouse could be many vehicles for sex, such as mutual masturbation rooms, orgy rooms, private rooms, sado-masochistic rooms, and glory holes; glory holes being partitions with holes where men stick their penises through for another unseen male to fellatio. While masturbation, orgy, sadomasochistic, and glory hole rooms may be labeled, the private room activities were left up to the renters of the rooms.[62]

Larry Kramer gave this descriptive scene of a bathhouse in the later hours of the night. "Rancid and ratty would best describe the atmosphere of the Everhard Baths at this prime hour. ... the redolent smell combined the distinct odors of popper, dope, spit, shit, piss, and a bevy of lubricants. Hundreds of assorted bodies paraded through refuse and puddle-spotted floors, barefoot, bare-chested, protected only by sarongs of towel from complete usurpation by passing eyes. Earlier arrivals, the younger ones at any rate, in good physical shape and desirable, would by now have ejaculated in some manner or other, approximately three to six times, while older soldiers, passing thin-walled moans and groans, would by now have received approximately forty-nine rejections as they heaved pasty white frames from cubicle to cubicle ... eventually, exhaustion being the better part of their valor, settling for one of their own kind, taking ten minutes to get an erection and two seconds to come, then grabbing their clothes and heading for home."[63]

A 1978 survey by the Kinsey Institute gives a clue as to what the percentage was of "normal" male homosexuals who patronized bathhouses and gay bars. Judd Marmor noted that almost 40 percent of the 686 homosexuals in the survey "either did no cruising

[seeking an anonymous sexual contact] at all or did it no more than once a month. Most of the homosexual males sought their sexual partners in gay bars or baths with relatively few doing their cruising in public areas." From that statistic it is evident that around 60 percent of normal male homosexuals sought promiscuous and or impersonal sex more than once a month from bathhouses and gay bars. It is unclear what percentage of the other 40 percent still used the bathhouses and gay bars for sex once a month or less. The study confirmed "the general view that male homosexuals tend to be relatively promiscuous in their sexual behavior."[64]

Marmor had attempted to use the 1978 survey to argue "that not all homosexuals pursue patterns of promiscuity or impersonal sex. Most of them, indeed, are searching for a meaningful relationship." The survey had also found that a majority of the male homosexuals in the survey "sought and had more extended relationships. Although a majority of the extended relationships lasted only one to three years, many of them were long –time 'marriages.'"[65] The following story is an example of a gay man who sought an extended gay relationship.

One of the case histories revealed by Randy Shilts in *And the Band Played On* is that of Ken Horne. Born in a blue-collar family in Oregon his love of dancing, theatre, and men led him at age twenty-one to San Francisco to study at the San Francisco Ballet School. In 1965, "the sheer contrast between his childhood plainness and his adult beauty made Ken's introduction to San Francisco gay life rewarding". Ken dropped out of ballet school, took a clerical job and "soon fell in love with a German sign painter and lost touch with his early San Francisco friends. ... They were surprised five years later to happen into Ken at the Folsom Prison, a leather bar." ... "The sweet young kid who loved

romance" had become "the prototype of the black leather machismo then sweeping San Francisco ... Ken complained about how tough it was in this 'city of bottoms' to find a man who would screw him."[66]

Ken's "friends decided that Ken had fallen into the trap that had snared so many beautiful gay men. ... When he did not find a husband, he took the next best thing – sex – and soon sex became something of a career. It wasn't love but at least it felt good; ... As the focus of sex shifted from passion to technique, Ken learned all the things one could do to wring pleasure from one's body. The sexual practices would become more esoteric; that was the only way to keep it from getting boring. The warehouse district alleys of both Manhattan and San Francisco had throughout the 1970s grown increasingly crowded with bars for the burgeoning numbers of leathermen like Ken Horne."[67]

A study of gay male couples was published in 1984 by a male psychiatrist, David McWhirter, and a male psychologist, Andrew Mattison, who were themselves a gay male couple. The study interviewed and questioned 156 male couples who had been together from one to thirty-seven years.[68] "Nearly three-quarters of the couples report[ed] that sexual exclusivity was either explicitly agreed upon or that they each had an implied assumption about it when they started living together," but sexual exclusivity was abandoned by all the couples, usually sooner than later. All the male couples who had been together five or more years had made provisions for sex with other men. The typical male couple surveyed would bring in other males for a three-way or go out individually on clandestine sexual excursions.[69]

McWhirter and Mattison concluded that male homosexual "fidelity is not defined in terms of sexual behavior but rather by their emotional commitment to each other."[70] "Many couples learn very early in their relationship that ownership of each other sexually can become the greatest internal threat to their staying together."[71] The gay authors saw a link in their profession's abandonment of the cause and cure of homosexuality to the abandonment of cultural norms based on prejudice. Gay couples who have abandoned society's norm of heterosexuality can just as reasonably abandon the norm of monogamy, thereby having "the freedom to explore new and alternative pathways," just as psychiatry now had the freedom to explore new theories about sexuality.[72]

One of the consequences of the growing sexual freedom gay men experienced after the 1973 deletion of homosexuality as a psychiatric disorder was a dramatic increase in disease related to gay sex. In 1980 a Chicago clinic catering to gay identified individuals found that over "one-half of the gay men tested at the clinic showed evidence of a past episode of hepatitis B. In San Francisco, two-thirds of gay men had suffered the debilitating disease." Other surveys from 1980 showed that 30 percent of the patients at the New York Gay Men's Health Project "suffered from gastrointestinal parasites. In San Francisco, incidence of the 'Gay Bowel Syndrome,' as it was called in medical journals, had increased by 8,000 percent after 1973. Infection with these parasites was a likely effect of anal intercourse, which was apt to put a man in contact with his partner's fecal matter, and was virtually a certainty through the then-popular practice of rimming, which medical journals politely called oral-anal intercourse. What was so troubling was that nobody in the gay community seemed to care about these waves of infection."[73]

Gay promiscuity was viewed by many gay men as sexual liberation. Sexually transmitted diseases were an unfortunate byproduct. "A Denver study found that an average bathhouse patron having his typical 2.7 sexual contacts a night risked a 33 percent chance of walking out of the tubs with syphilis or gonorrhea."[74] In San Francisco gay men had developed "such a cavalier attitude toward venereal diseases that many gay men saved their waiting-line numbers [from clinics treating venereal diseases], like little tokens of desirability, and the clinic was considered an easy place to pick up both a shot and a date."[75]

The popularity of oral-anal intercourse among gay men was spurred by a 1977 book coauthored by gay psychologist Charles Silverstein entitled *The Joy of Gay Sex*. In the book Silverstein referred to rimming as the "prime taste treat in sex." In practice "there wasn't a much more efficient way to get a dose of parasite spoor than by such direct ingestion."[76] The coauthor, Charles Silverstein, was the same gay counselor that the New York Gay Activist Alliance handpicked to prepare the gay critique before the American Psychiatric Association's Committee on Nomenclature in 1973.

AIDS – 1980 to 1986

At the end of 1980 fifty-five young men in the United States "had been diagnosed with an infection linked" to a new virus. Purple spots often appeared on the skin. Soon the rare cancer Kaposi's sarcoma (KS) was being diagnosed in gay men. Other gay men were being diagnosed with the rare Pneumocystis carinii pneumonia (PCP). Typical symptoms included swollen lymph nodes, fevers, diarrhea, weight loss, yeast infections,

and thrush. The first published report on the epidemic appeared in June of 1981. Center for Disease Control staffers were worried about offending gay indentified individuals with the report so it appeared in an inconspicuous slot on page two of the *Morbidity and Mortality Weekly Report*. "Any reference to homosexuality was dropped from the title, and the headline simply read: *Pneumocystis* pneumonia – Los Angeles. Don't offend the gays and don't inflame the homophobes. These were the twin horns on which the handling of this epidemic would be torn from the first day of the epidemic."[77]

By February of 1982 the syndrome causing KS and PCP was given the name of Gay-Related Immune Deficiency or GRID. Across the United States 251 Americans had been diagnosed with GRID and 99 had already died from it, including Ken Horne. "The typical KS or PCP patient had had hundreds of partners, most drawing their contacts from gay bathhouses and sex clubs." The epidemic in the United States was traced down to a handful of gay men, one of which garnered the dubious title of Patient Zero, a gay airline steward named Gaetan Dugas.[78]

"Gaetan was the man everyone wanted, the ideal" for the gay communities of San Francisco, New York, Los Angeles, Toronto, and Fire Island. Like Ken Horne, Gaetan's childhood was plain; "he was the major sissy of his working class neighborhood in Quebec City," but he had blossomed into a beautiful physical specimen of a man. "Gaetan was the ugly duckling who had become the swan." His sexual appetite was enormous and was often fueled by drugs. Sex defined his identity. Even when Gaetan knew he was spreading the new epidemic through sex he continued to frequent the gay bathhouses.[79] Many other infected gay men showed Gaetan's lack of concern for other

gay men and continued their sexual lifestyle without telling their sexual partners, even educated gay men with PhDs and influential libertarian philosopher Michel Foucault.[80]

Soon after the Center for Disease Control confirmed hemophiliac cases of the new epidemic the acronym GRID was replaced with Acquired Immune Deficiency Syndrome (AIDS).[81] It will probably never be known exactly how the AIDS epidemic came to the United States, but the virus was first traced to Africa. Once in the circuit of male homosexual promiscuity the virus had an efficient medium to spread. In Europe an AIDS researcher called AIDS "'the charter disease,' because so many of the early European gay cases were among the men who had boarded the inexpensive charter flights to New York and San Francisco."[82]

Historian Randy Shilts claimed that "The gay liberation movement of the 1970s had spawned a business of bathhouses and sex clubs."[83] These businesses for consensual sex became a $100 million dollar industry across the United States and Canada. Once the AIDS virus arrived, the promiscuous gay lifestyle these institutions supported spread the virus rapidly. When this fact became more and more obvious the reaction from the gay community was denial. A county health director in Oakland who suggested that male homosexuals needed to curb their promiscuous lifestyle was called an "anti-gay bigot" by the gay press. A small group of gay men who supported an effort to close bathhouses in San Francisco were labeled "traitors." Two gay men who wrote articles "urging gay men to modify their sexual life-styles" were called a "sexual fascist" and a "sexual Nazi." Another gay leader in San Francisco who made the same suggestion received "the ultimate psychological insult," he was accused of suffering from "internalized homophobia." The author of *Faggots*, Larry Kramer, complained in a 1983 article that

"the New York gay doctors, as a group, have 'done nothing,'" to make gay men aware that their promiscuous lifestyle was spreading AIDS, and the Advocate, the national gay news magazine was "yet to quite acknowledge that there's anything going on." In response to Kramer's article gay men wrote letters to the editor condemning Kramer as "alarmist" and "sex-negative."[84]

When it became more and more obvious that gay men had contaminated the nation's blood supply with the AIDS virus by donating their blood another political battle took place. The initial response from the gay activists on the screening of blood donors was that male homosexuals were being used as scapegoats "reminiscent of miscegenation blood laws that divided black blood from white." In January of 1983 prodding from gay activists in the National Gay Task Force produced a joint statement from all the major blood banks opposing donor screening. The statement called questions "about a donor's sexual preference ... inappropriate." The National Hemophilia Foundation, however, believed donor screening was needed to protect their constituents who were the "innocent victims." Enraged, gay groups across the country organized "to oppose what they called the "quarantine of gay blood."[85]

In Washington, D.C. during February of 1983 "gay leaders were successful in persuading Red Cross officials to back off from their plans for sexual-orientation questions." Veteran gay activist "Frank Kameny, said he would 'advise fellow gays to lie' if the local blood bank officials proceed with screening. In New York, the National Gay Task Force rounded up virtually every gay leader in Manhattan to stand on the steps of the New York Blood Center for a press conference denouncing efforts to screen donors." The irony of the press conference was pointed out by a leader of a New York

AIDS group. "He knew that virtually every gay man there had had hepatitis B and that most had engaged in the kind of sexual activities that put them at high risk for AIDS. Not one of them could in good conscience donate blood."[86]

In 1984 uproar occurred in the gay community when the Center for Disease Control (CDC) suggested a registry of people be kept of those whose donated blood contained the AIDS virus once a test was available. The CDC kept a similar registry of those infected with hepatitis B and syphilis. Another conflict ensued when an antibody test for the AIDS virus in blood was developed in 1985. Some gay activists were worried more about their civil rights than saving lives. "The Lambda Legal Defense Fund, a New York-based gay legal group, threatened to block release of the test in court." They filed a petition in federal court along with the National Gay Task Force and were able to persuade the Federal Drug Administration to have this warning written on each test label, "It is inappropriate to use this test as a screen for AIDS or as a screen for members of groups at increased risk for AIDS in the general population." Gay activists were worried that the test might be required as a condition of employment, for insurance coverage, and even for a roundup of AIDS carriers into "medical concentration camps."[87]

In New York City gay activists were able to influence the Health Commissioner to prohibit laboratories from conducting the antibody tests except for scientific research and for the blood banks. The antibody test was valuable to find out if a patient had AIDS or not. It was valuable to test pregnant women with histories of drug abuse, "but doctors were denied its use for their patients because a handful of gay AIDS activists and political leaders had persuaded the health commissioner to ban the test for political reasons." America was led to believe by the media that San Francisco was AIDS City,

but "New York City had three times the AIDS cases and nearly one-half of the nation's AIDS caseload." In addition "it was common knowledge that Manhattan gay doctors weren't reporting many of their cases because of the confidentiality dispute with the CDC."[88]

With the politically charged epidemic came "a new language forged by public health officials, anxious gay politicians, and the burgeoning ranks of 'AIDS activists.' The linguistic roots of AIDSpeak sprouted not so much from the truth as from what was politically facile and psychologically reassuring ... the language went to great lengths never to offend. ... 'Promiscuous' became 'sexually active,' because gay politicians declared 'promiscuous' to be 'judgmental.'" Similarly, the word "semen" was replaced by "bodily fluids." Although AIDSpeak was created out of good intentions, AIDS historian Randy Shilts argued that it was actually "a language of death," because it would not confront the real problem of sexual promiscuity or sexual practices, and therefore the AIDS virus continued to spread at an alarming rate.[89]

At the second annual AIDS Forum in 1983 the public policy committee opposed "'any attempt to legislate morality.' They officially opposed 'any legislative attempts to restrict sexual activities or to close private clubs or bathhouses.'" This group of AIDS activists claimed that "homophobia" was the major threat to the health of gay men. A gay columnist from the San Francisco area summed up the mindset of the gay community at that time by maintaining that "it was society's responsibility to find the medical technology to prevent all sexually transmitted diseases, rather than the gay community's responsibility to keep sexuality in line with what medical technology could cure." At the end of 1983 it became known that the incubation period from the time the AIDS virus is

received to the onset of AIDS ranged from six months to eleven years, with the mean incubation period at 5.5 years.[90]

In October of 1984 the first gay bathhouses in America were closed by a local health department. Nine months later the Center for Disease Control released a report that stated over 12,000 Americans had been diagnosed with AIDS and 6,000 of those diagnosed had died. Less than two years later the death toll climbed to over 20,000.[91]

Opposition – 1976 into the 1990s

"In 1976, the psychiatric profession called a symposium on the psychogenesis of homosexuality." Charles Socarides, Irving Bieber and other distinguished mental health professionals who treated people with unwanted same-sex attractions were participants in the symposium. "Hours before the meeting, gay activists surrounded the hall, men with torches and police whistles and amplifiers blaring forth the sounds of barking dogs. They lay down in the atrium to prevent people from entering the hall." Gays inside the "auditorium turned to people around them and excoriated them for their very presence in the hall. Everyone was very intimidated. Many rose and left the hall." Socarides called the event "the profession's last attempt to have a public dialogue on homosexuality."[92]

In the late 1980s a psychologist by the name of Joseph Nicolosi had been asked by several homosexual men to help them change their sexual orientation. Nicolosi had not been given any information in graduate school that a homosexual might even want to change their sexual orientation. As he researched the subject he was surprised at the evidence of sexual orientation change and the large volume of research and case histories.

He contacted Charles Socarides and learned about the battle he had waged within the American Psychiatric Association. In 1992 Nicolosi joined with Socarides and psychiatrist Benjamin Kaufman as founding members of an organization called the National Association for Research and Therapy of Homosexuality or NARTH. NARTH was a professional response to the American Psychiatric Association and the American Psychological Association's acquiescence to gay activists. Its mission was and is to offer "hope to those who struggle with unwanted homosexuality" through educational information, scientific research, the promotion of effective therapeutic treatment, and referrals for those seeking help.[93] Nicolosi emerged in the 1990s as a new mental health leader defending the rights of individuals with unwanted same-sex attractions to have trained professional therapists help them change their sexual orientation.

In 1995 and 1996 psychiatrists Jeffrey Satinover and Charles Socarides published books that critiqued Simon LeVay and Dean Hamer's research, exposing the flaws that never received the press coverage that the 'gay gene' had received. Socarides revealed that Dean Hamer had asked the editors of *Science* to not mention the fact that he was gay because he claimed it was not relevant to his findings.[94] In critiquing Hamer's research Satinover quoted "Genetics researchers from Yale, Columbia, and Louisiana State Universities." N. Risch, E. Squires-Wheeler, and J. B. K. Bronya's analysis concluded that the results of Hamer's research were "not consistent with any genetic model," the differences weren't "statistically significant," and because of the small sample sizes many other possibilities, including environmental conditions, could account for the variation in the Xq28 gene.[95] Hamer would later admit to *The Times* that "Sexual orientation is too complex to be determined by a single gene,"[96] but then go on to testify as an expert

witness in a Colorado court reviewing "Proposition 2" that he was "99.5 percent certain that homosexuality is genetic."[97] Despite continued efforts a gay gene has not been found as of 2011.

In critiquing Simon LeVay's research Jeffrey Satinover pointed out that LeVay's subjects were all dead and there was not any way for an outside observer to verify which subjects were heterosexual and which were homosexual. In addition, individual studies of differences in the size of different parts of the brain meant almost nothing as far as being the cause of a particular trait. Satinover argued that the significance of LeVay's brain examinations was "on a par with the discovery that athletes have bigger muscles than nonathletes." The example he gave was of a study by the National Institute of Health that found "in people reading Braille after becoming blind, the area of the brain controlling the reading finger grew larger."[98] The point being that repeated behaviors can make certain parts of the brain bigger. LaVay who was also gay identified left his position as a neuroanatomist to "found the Institute of Gay and Lesbian Education."[99]

Socarides and Satinover also critiqued a study of twins conducted by two gay researchers attempting to find a genetic cause of homosexuality. J. Bailey and Richard Pillard, both professors of psychiatry,[100] recruited homosexuals who were a twin through an advertisement in a homosexual magazine.[101] They found that in approximately 53 percent of their sample of identical twins, both brothers were gay identified. Socarides pointed out the Bailey-Pillard study proved "nothing." "If genes made 53 percent of the identical twins gay, why didn't genes make the other 47 percent gay as well?"[102] Socarides and Satinover both pointed out that the study did not look at any environmental factors of the twin's lives, and that Pillard had openly admitted that "his research was

designed 'to counter the prevalent belief that sexual orientation is largely the product of family interactions and the social environment.'"[103]

In a scathing critique, Socarides argued in his 1995 book that the 1973 decision by the American Psychiatric Association was used by those wishing to legitimatize homosexuality to influence adolescents struggling with homosexual urges. That influence was used to urge males with gender identity confusion "to take the leap into same-sex sex, and, as a result, become infected with AIDS." Socarides contended that the APA decision played a substantial role in "the rise of the gay bath house culture" which fueled "the plague of AIDS." Socarides criticized the government for bowing to gay activists and not tracking AIDS patients in a similar way as gonorrhea and syphilis patients were tracked. He accused the media, academia, and the medical professions of suppressing the truth about AIDS. Doctors, he claimed, who dared to speak out were "threatened with lawsuits, firing, loss of license, expulsion from their professional societies, severely bodily harm, even death." For his stance Socarides received hate mail and threats, and was on "a national enemies list by a group that the New York City police commissioner called "a legitimate terrorist organization." As for the lesbian, gay, bisexual, transgender (LGBT) organizations that were appearing on most university campuses, Socarides called them "centers for the seduction of the innocent." He lamented that "those of us who believe homosexuality is a disorder, have been all but silenced."[104]

Jeffrey Satinover took another offensive approach. As a medical doctor and psychiatrist he argued that "anal intercourse is not safe for anyone, under any circumstances." Because of the widespread practice of sodomy by male homosexuals, they are "disproportionately vulnerable to a host of serious and sometimes fatal infections

caused by the entry of feces into the bloodstream. These include hepatitis B and the cluster of otherwise rare conditions, such as shigellosis and Giardia lamblia infection, which together have been known as the 'Gay Bowel Syndrome.'" "Even if condoms are used, anal intercourse is harmful primarily to the 'receptive partner.' Because the rectal sphincter is designed to stretch only minimally, penile-anal thrusting can damage it severely." The result of this unsafe practice is a major reason why "the gay male life span, even apart from AIDS and with a long-term partner, is significantly shorter than that of married men in general by more than three decades."[105]

From a philosophical perspective Satinover argued that "individual professionals and the organized professional guilds are no more capable of deciding whether any trait – including homosexuality – is consensually desirable or undesirable to society than are any other citizens or groups." Because science needs "to restrict itself to data, logic, mathematical precision, and probabilistic conclusions," morality is not science's domain. Satinover asserted that "religion is the originator of all morality," not science, and that it is a pagan error to argue "that morality is determined by nature." After criticizing the homosexuality in nature argument Satinover observed, "The fierce campaign to normalize homosexuality represents therefore not merely the weakened moral authority of church and synagogue, but more importantly a widespread loss of faith in a just but gracious and truly transcendent God. ... Without God and his grace ... the judgment of homosexuality as immoral will indeed appear as but a hypocritical cruelty to individual homosexuals."[106]

As the professions of psychiatry and psychology abandoned the homosexual with unwanted homosexuality, former homosexuals themselves formed organizations to help

others with unwanted same-sex attractions. Homosexuals Anonymous was formed by a former homosexual and modeled Alcoholics Anonymous, except the organization used fourteen steps and recognizable Judeo-Christian language.[107] The largest organization begun and managed by former homosexuals is Exodus International. Exodus started with a small conference in 1976 and has grown into a national ministry network with "over 245 Member Ministries, Churches and Professional Counselors in North America."[108] All of the affiliate ministries under the Exodus umbrella have an evangelical Christian dimension, using a personal relationship with Jesus Christ as a source of healing and power. Many of the former homosexuals who have developed ministries to help others with unwanted same-sex attractions or who have been national leaders in Exodus have written books on their lives and healing experiences. The term "ex-gay" is now used to describe former homosexuals and the movement of former homosexuals that helps others with unwanted homosexuality.

A Christian based family organization called Focus on the Family is one of the few organizations that has dared to inform the public that unwanted same-sex attractions can and have been changed. Focus was founded and led for many years by psychologist James Dobson. Besides occasionally featuring psychologist Joseph Nicolosi and ex-gays on its national radio program, Focus initiated one day conferences on homosexuality across the nation called "Love Won Out." Love Won Out conferences featured Nicolosi, ex-gay testimonies, and information on the growing influence of gay organizations. Attendees learned about the causes of homosexuality and how reparative psychotherapy could help those with unwanted homosexuality change their sexual orientation. From the testimonies of ex-gays, attendees learned about the darker side of the gay lifestyle and the

hard work it took to change one's sexual orientation from homosexual to heterosexual. The story of the capitulation of the American Psychiatric Association to gay political activists in 1973 was also explained at the conferences as well as examples of gay activist agendas in schools.

There was a bit of irony in a religious based organization disseminating truths about homosexuality that were being suppressed by institutions who considered themselves to be champions of objective truth, specifically the professional associations of psychiatry and psychology, the universities, and the media. Virtually every Love Won Out conference has been picketed by gay activists and their supporters. Gay activists have called the conferences homophobic and hateful, but in reality most attendees at Love Won Out conferences developed compassion for individuals who struggle with homosexuality.

Closing remarks

After homosexuality was deleted from the list of psychiatric disorders one of Charles Socarides' former clients called the gay psychiatrist who had disguised himself on the 1972 panel at the American Psychiatric Association convention in Dallas. The gay psychiatrist, John Fryer, later revealed his identity. Socarides' former client told Fryer that "he was hurting a lot of homosexuals" and that he "was a successfully treated homosexual." Fryer responded that "there is no such thing." As the two talked Fryer "was getting more and more upset" and the former homosexual became calmer. The former homosexual believed that this gay psychiatrist had done a terrible thing by helping to

remove homosexuality from the list of psychiatric disorders, because one of his motivating factors was the idea that he thought he was ill. As they talked the former homosexual began to feel "sorry in some way" for the gay psychiatrist because he realized that he "was talking to somebody that was sick."[109]

McWhirter and Mattison, who studied the 156 male couples, approved of their professions abandonment of the cause and cure of homosexuality. But after interviewing several hundred male homosexuals they strongly suspected that "absence of male bonding is connected with the development of a homosexual orientation among men."[110] At the end of Larry Kramer's novel *Faggots* the main character realized that he had "been looking, seeking, demanding, the love of Lester [his father]" all his life. Kramer's gay reality novel centered around a homosexual man whose gay affairs were symbolic attempts to make his father love him so that he "could be loveable."[111] Even when gay activists intuitively know the cause of homosexuality to be an identity malfunction related to the lack of childhood bonding with the same sex parent, they still deny that homosexuality is a disorder.

It is an interesting phenomenon how many gay identified individuals refuse to acknowledge that some homosexuals have been distraught in the gay lifestyle and have successfully changed their sexual orientation to heterosexual. The reason seems obvious, although it may often be unconscious. The concept that many homosexuals want to change their sexual orientation significantly undermines the movement for homosexual equality. Former homosexuals not only deny the hypothesis that homosexuality is equal to heterosexuality; they seem to threaten the identity of gays as psychologically healthy individuals. The gay rights movement has out of survival made the ex-gay an enemy.

Charles Socarides has argued that "there is a normal fear of homosexuality in most people who cherish their male or female identity. ... To be male or female in a functioning society produces great pride and self esteem, the kind that keeps us healthy and functioning." Socarides observed that homophobia was "an epithet, a scare word that activists use to silence anyone who does not automatically accept the 'normalcy' of same-sex sex."[112] In the same way "internalized homophobia" is used as an epithet to silence and discredit ex-gays and individuals with unwanted homosexuality. The success of this tactic parallels the success of the homosexual equality movement. Homophobia is listed in many institutional policies as an infraction worthy of discipline or dismissal.

The homosexual equality movement has been a delusion with devastating consequences. While the hard data on the causation and cure of homosexuality has been suppressed, normal variant philosophies and gay initiated causes have dominated the American Psychiatric Association and the American Psychological Association. Gay affirmative psychotherapists and gay activists have not owned up to the fact that they were directly responsible for the exploding gay bathhouse culture and subsequent AIDS deaths of thousands. The American Psychiatric Association silence on how its 1973 decision contributed to the bathhouse culture and the spread of AIDS is in effect denial.

The first candlelight march for AIDS took place on May 2, 1983 in San Francisco. It was the idea of gay psychologist Gary Walsh and patterned after the 1978 candlelight march that followed the murder of Harvey Milk. Gary Walsh had been a pioneer of gay affirmative psychotherapy in San Francisco and helped invent gay couples' therapy. As for his own lifestyle Walsh frequently cruised the bathhouses of San Francisco and "kept up his active sexual pursuits even after he was settled down with a wonderful

boyfriend."[113] When Walsh was diagnosed with AIDS he became concerned that "there was no outrage" over the media's lack of attention to AIDS and the government's feeble effort to cure AIDS. On that evening in May thousands of gay and lesbian identified individuals followed Gary Walsh and other men with AIDS down Market Street. They wanted the world to know that many people were dying from this new epidemic and more needed to be done to help those infected.[114]

A gay affirmative psychotherapist leading the 1983 AIDS candlelight march in San Francisco can be seen from another perspective. Therapists and counselors that practiced gay affirmative therapies affirmed that homosexuality was a normal variant of human sexuality that can lead to an equally fulfilled life. Homosexuality was not a disorder; it was society that had the disorder of homophobia. Most gay affirmative psychotherapists informed their clients that sexual orientation was not changeable. In a corresponding relativist philosophy promiscuity was affirmed as just as moral as monogamy, because morality was relative and determined by each individual.

Internalized homophobia was the diagnosis gay affirmative psychotherapists gave to those who were troubled by their homosexuality. In particular, it was society's archaic Judeo/Christian condemnation of homosexuality that was the cause of their internalized distress. Instead of showing options of therapy that included changing same-sex attractions, gay affirmative psychotherapists limited their client's choice of treatment to gay affirming. Thus, they led many into a lifestyle with behaviors that virtually ensured their exposure to a life-threatening virus. In a way the May 1983 candlelight march symbolized the thousands of homosexuals led by gay affirmative psychotherapists to

accept the gay lifestyle that gave them AIDS. That should be a cause of outrage and yet only a few have even dared to raise the issue.

Many prominent people died of AIDS without the public knowledge that AIDS was the cause of their death. AIDS historian Randy Shilts stated that "only the most knowledgeable of obituary readers could detect the presence of this epidemic in the death notices."[115] Signs of an unpublished AIDS death were a male leaving no wife or children, middle-aged, death being listed as cancer and pneumonia, and the occupation of the man.

One such obituary listing was for a national leader in the fight to normalize homosexuality. On the local level he was the Chairman of the Board of Trustees of the Homosexual Community Counseling Center in New York City. His gay affirming organization vowed to help "homosexuals live a more self-actualizing homosexual life" and instill gay pride, thereby removing the "high motivation to change" in individuals who struggled with their homosexuality.[116] That national leader was Hendrik Ruitenbeek. His vision after the 1973 removal of homosexuality as a psychiatric disorder was a society "where no restrictions on sexuality are imposed upon those who want to experience it to its fullest."[117] He died in 1983 at the age of 55. Although he wrote and edited twenty-five books there is no record of his private life, a wife, children, or how he died.

Notes

[1] Ruitenbeek, *new sexuality*, 2. Ruitenbeek took the quote from "Waar je Kijkt ... Erotiek," by J. J. Beljion, Amsterdam: Wetenschappelijke Uitgeverij, 1967. Beljon was described by Ruitenbeek as a Dutch writer.

[2] Ibid., 3.

[3] Ibid., 59.

[4] Ibid., 58.

[5] Ibid., 70.

[6] Ibid., 62.

[7] Ibid., 144.

[8] Ibid., 142.

[9] Ibid., 122.

[10] Ibid.

[11] Ibid., 85.

[12] Marmor, "Clinical Aspects," 272.

[13] Bayer, *Homosexuality and American Psychiatry*, 176-7.

[14] Marmor, "Epilogue: Homosexuality," 395.

[15] Kirkpatrick and Morgan, "Psychodynamic Psychotherapy," 369. Two sources were cited by the authors of this article: F. Acosta, 1975, "Etiology and treatment of homosexuality," *Archives of Sexual Behavior*, 4(1):9-29; and R. J. Stoller et al., 1975, "A symposium: Should homosexuality be in the APA nomenclature?" *American Journal of Psychiatry*, 130(11):1207-16.

[16] Weinberg, *Society and the Healthy*, 4, 9, 11,12,16,17, 21.

[17] Marmor, "Overview: The Multiple Roots," 19.

[18] McWhirter and Mattison, *Male Couple*, 138.

[19] Kirk and Madsen, *After the Ball*, xxii.

[20] Voeller, "Society and the Gay," 248.

[21] Bayer, *Homosexuality and American Psychiatry*, 160.

[22] Voeller, "Society and the Gay," 248-9.

[23] Bayer, *Homosexuality and American Psychiatry*, 162-3.

[24] Association of Gay and Lesbian Psychiatrists, "AGLP History."

[25] Division of Rare and Manuscript Collections, Cornell University Library, "Guide to the Association."

[26] Kirk and Madsen, *After the Ball*, 32-3.

[27] Division of Rare and Manuscript Collections, Cornell University Library, "Guide to the Association."

[28] American Psychological Association, "Removing Bias in Language," 1.

[29] American Psychological Association, "Public Interest."

[30] American Psychological Association, "Society for the Psychological."

[31] Socarides, *Homosexuality* A *Freedom Too*, 153.

[32] Humphreys and Miller, "Identities in the Emerging," 148.

[33] Bayer, *Homosexuality and American Psychiatry*, 164.

[34] Socarides, *Homosexuality* A *Freedom Too*, 173-4.

[35] Satinover, *Homosexuality and the Politics*, 169. The quote was from an article Socarides entitled "Beyond Sexual Freedom: Clinical Fallout" in the *American Journal of Psychotherapy* 30, no.3 (1976), 41-7.

[36] Shilts, *Band Played On*, 31, 390, 468.

[37] Slovenko, "Homosexuality and the Law," 199.

[38] Bayer, *Homosexuality and American Psychiatry*, 156.

[39] American Civil Liberties Union, "LGBT Rights."

[40] Haley, *101 Frequently Asked Questions*, 176.

[41] Human Rights Campaign, "What We Do."

[42] Haley, *101 Frequently Asked Questions*, 174.

[43] Human Rights Campaign, "Partners."

[44] Haley, *101 Frequently Asked Questions*, 174.

[45] Satinover, *Homosexuality and the Politics*, 22.

[46] Soulforce, "About."

[47] Act Up, "Capsule History."

[48] Slovenko, "Homosexuality and the Law," 199.

[49] University of Michigan Office of Lesbian Gay Bisexual Transgender Affairs, "Office of LGBT Affairs."

[50] University of Michigan Provost Office, "Spectrum Center."

[51] University of Michigan College of Literature, Science, and the Arts, "LGBTQ and Sexuality Studies."

[52] Socarides, *Homosexuality* A *Freedom Too*, 242.

[53] McWhirter and Mattison, *Male Couple*, 2-3.

[54] Marmor, "Epilogue: Homosexuality," 398.

[55] Satinover, *Homosexuality and the Politics*, 78-9, 109-111, 260.

[56] Socarides, *Homosexuality* A *Freedom Too*, 97.

[57] Shilts, *Band Played On*, 59.

[58] Ibid., 20.

[59] Ibid., 210.

[60] Kramer, *Faggots*, back cover.

[61] Shilts, *Band Played On*, 19.

[62] Ibid., 197.

[63] Kramer, *Faggots*, 173-4.

[64] Marmor, "Clinical Aspects," 269.

[65] Ibid.

[66] Shilts, *Band Played On*, 45-6.

[67] Ibid., 46.

[68] McWhirter and Mattison, *Male Couple*, ix.

[69] Ibid., 252-4.

[70] Ibid., 252.

[71] Ibid., 256.

[72] Ibid., 3-4.

[73] Shilts, *Band Played On*, 18-19.

[74] Ibid., 19.

[75] Ibid., 39.

[76] Ibid., 19, 39.

[77] Ibid., 49, 61, 68-9.

[78] Ibid., 23, 86, 100, 121, 126.

[79] Ibid., 21-2, 251-2.

[80] Ibid., 413, 472.

[81] Ibid., 171.

[82] Ibid., 248.

[83] Ibid., 19

[84] Ibid., 19, 245, 312, 357, 445, 559.

[85] Ibid., 220, 224, 226, 238.

[86] Ibid., 238-9.

[87] Ibid., 471, 521, 540-1.

[88] Ibid., 542-3, 268, 400.

[89] Ibid., 315.

[90] Ibid., 325, 327, 378, 402.

[91] Ibid., 489, 580, 596.

[92] Socarides, *Homosexuality* A *Freedom Too*, 228-9.

[93] National Association for Research and Treatment of Homosexuality, "NARTH Mission Statement."

[94] Ibid., 96.

[95] Satinover, *Homosexuality and the Politics*, 111-2. The quote reference is from *Science* 262 (1993), pp. 2063-65, in the article "Male Sexual Orientation and Genetic Evidence" by N. Risch, E. Squires-Wheeler, and J. B. K. Bronya.

[96] Socarides, *Homosexuality* A *Freedom Too*, 97.

[97] Satinover, *Homosexuality and the Politics*, 113.

[98] Ibid., 79. The quote is by K. Lansing from his presentation "Homosexuality: theories of Causation, Reorientation and the Politics and Ethics Involved." Lansing was citing K. Klivingstion of the Salk Institute. The quote was published in the "Proceedings of the 1993 Annual Scientific Meeting of the National Association for Research and Treatment of Homosexuality," p. 50.

[99] Ibid., 39.

[100] Socarides, *Homosexuality* A *Freedom Too*, 98-9.

[101] Satinover, *Homosexuality and the Politics*, 86.

[102] Socarides, *Homosexuality A Freedom Too*, 99.

[103] Satinover, *Homosexuality and the Politics*, 39. Satinover was quoting the article "Heritable Factors Influence Sexual Orientation in Women" by J.M. Bailey et al. in the *Archives of General Psychiatry* 50, no. 3, pp. 217-23.

[104] Socarides, *Homosexuality A Freedom Too*, 79, 158, 224, 228, 250.

[105] Satinover, *Homosexuality and the Politics*, 23, 67-9. The life span data that Satinover used came from "P. Cameron, W.L. Playfair, and S. Wellum, "The Homosexual Lifespan," Presentation to the Eastern Psychological Association, April 1993."

[106] Ibid., 43, 121, 160, 166.

[107] Homosexuals Anonymous, "The 14 Steps."

[108] Exodus, "Regions."

[109] Socarides, *Homosexality – Psychanalytic Therapy*, 524-5.

[110] McWhirter and Mattison, *Male Couple*, 135.

[111] Kramer, *Faggots*, 378.

[112] Socarides, *Homosexuality A Freedom Too*, 37.

[113] Shilts, *Band Played On*, 88-9,250, 284.

[114] Ibid., 250, 285.

[115] Ibid., 472.

[116] Blair, *Etiological and Treatment Literature*, 40.

[117] Ruitenbeek, *new sexuality*, 3.

Chapter 8

The Continuing Professional Division over Homosexuality

"I believe that reparative therapy practices distort mainstream psychoanalytic theories and practices.[1]

Jack Drescher, gay affirmative therapist (1998)

"Gay-affirmative therapists are working very hard as boosters of their own philosophy."[2]

Joseph Nicolosi, reparative therapist (2009)

Opening note

The mental health profession's division over whether homosexuality is a disorder or a symptom of a psychological disorder continues to this day. As of the writing of this thesis the post-1973 paradigm still reigns in the American Psychiatric Association and the

American Psychological Association. Although normal variant advocates control issues of homosexuality in both associations, a minority of psychotherapists continue to help those with unwanted homosexuality attempt to change their sexual orientation. Within this minority major advances in the psychoanalytic treatment of homosexuality have been made, while the latest gay affirmative psychoanalytic advance has a definite political bent.

This chapter will examine the progression of normal variant/gay affirmative psychotherapies and reparative psychotherapies from 1974 to the present. At the beginning of the twenty-first century gay-identified psychiatrist Jack Drescher had emerged as the most prominent advocate of gay affirmative therapy, as well as the most prominent critic of reparative therapy to change sexual orientation. On the reparative therapy side of the division psychologist Joseph Nicolosi was an outspoken advocate of reparative psychotherapy in the first decade of the twenty-first century. He also played a prominent part in developing major advances for treating unwanted homosexuality and the prevention of homosexuality.

Judd Marmor vs. Charles Socarides 1974-1980

Psychiatrists Judd Marmor and Charles Socarides went head to head over the removal of homosexuality as a psychiatric disorder in 1973. Soon after the 1973 paradigm shift in the American Psychiatric Association (APA) Marmor was elected president of the APA and he used his influence to undermine Socarides' influence. Although Marmor did not view homosexuality as a disordered state he was conflicted by

what he believed therapists should do to benefit their patients and what he wished the culture was. He was verbally committed, on an ethical level, to helping patients with unwanted homosexuality, but his actions gave power to those within the organization who sought to discredit clients with unwanted homosexuality and deny them therapeutic help in changing their homosexuality.

Marmor claimed that by the time his 1980 anthology on homosexuality was published "considerable advances" had been made in the "understanding of the phenomenon of homosexual experience."[3] Marmor argued that clinical observations, dating from Freud to the present, which showed male homosexuals were apt to come from homes "with weak or absent fathers and frustrating mothers" was not sufficient to be a causative theory because many heterosexuals had similar backgrounds. Lawrence Hatterer, Marmor explained, had listed "over fifty variables in maternal, paternal, sibling, and familial patterns ... relevant in the homosexual development of his male patients." Marmor argued that "Homosexual behavior may also be the expression of transitory and exploratory sexual interest among adolescents and preadolescents. ... It may even have ideological roots, as in the deliberate lesbian activity of some radical women's liberationists."[4]

What Marmor presented in 1980 regarding etiology was not new. His point, that because there are so many variables in the causation of homosexuality a single theory cannot explain it, was not new. It was a fact accepted by both sides of the homosexual issue in 1973. The theory that homosexual behavior can be transitory or exploratory came from Sandor Rado's theory that homosexuality sometimes was a reparative adaptation. Rado's theory was the foundation that other etiological theories were built upon.

Marmor's comparison of the cultural stigma of the homosexual to that of the Black or the Jew was not new either[5]. It was used by gay activists in the 1960s. Moreover, Marmor's contempt of "the Judeo-Christian tradition" that designated homosexuality as an "unnatural sin"[6] was shared publicly by many before 1973 also.

What was new in the argument for homosexual normalcy was validity and importance given to the concept of "homophobia" as a pathological disorder. In eight years homophobia had been transformed from an idea to discredit the clinical theories of homosexual causation into the philosophical foundation of gay affirmative therapy. Homophobia was being more and more recognized as a psychological disorder caused by "a strong religious indoctrination, or ... simple ignorance about homosexuals."[7] In statements that supported the concept of homophobia, Marmor gave credibility to those who wanted to discriminate against people with the religious conviction that homosexuality was a perverse behavior. In the 1973 battle of paradigms on homosexuality Marmor had accused his professional adversaries of being ignorant of normal homosexuals. In 1980 Marmor had the pseudo-pathological label of "homophobia" to put on both mental health professionals and citizens who opposed the normalcy of homosexuality.

Marmor did not deny that the evidence showed homosexuality was changeable and the fact that many homosexuals sought out therapists to help them change their sexual orientation. Marmor acquiesced that homosexuals whose "motivation to change is sincere and strong ... deserve an opportunity to try to accomplish their goal, with all the help that psychotherapy can give them." The quandary was that the very professionals who could best help those with unwanted homosexuality were the Socarides group and

their clinical knowledge that Marmor had worked to suppress. Marmor was skeptical of sexual reorientation therapy success because the evidence suggested that "once a major pathway to sexual gratification has been established and reinforced by repeated experiences, the track of that pathway can never be totally obliterated."[8]

In 1980 Marmor still saw the prevention of homosexuality in childhood and adolescence a legitimate goal for society "until, therefore, our societal mores develop to a point at which homosexual behavior is no longer regarded with prejudice."[9] Richard Green, the creator of the heterosexual bias argument, summed up the view of moderate normal variant advocates like Marmor, "I believe our responsibility at the micro level is to the individual patient, while on the macro level it is to attempt to induce changes in the larger culture."[10] These influential professionals condemned psychiatry's past for acting as "agents of social control" for putting the label of "psychopathology" on homosexuality[11], and when they ascended to power they advocated using psychiatry to change the culture to their liking.

Despite going from a recognized expert on homosexuality to being vilified for his views, Charles Socarides continued to refine his psychotherapeutic approach to help those with unwanted homosexuality. He resolved to collect and compile "all available scientific findings on the subject of male and female homosexuality"[12] and that resolve remained undeterred.

Socarides, who was both a psychiatrist and psychoanalyst, described an etiological theory of homosexuality that he developed in 1978 as "the obligatory, preoedipal type." He acknowledged there were many other causes and types of

homosexuality, but this was a particular pattern he saw in many of the men who came to him with unwanted homosexuality. Socarides' preodipal homosexual type will be the focus of the rest of this section on Socarides. Drawing on earlier theory, Socarides believed that normal childhood development required certain psychological developments at critical "age adequate" periods. Consequently, Socarides' hypothesized "preoedipal homosexuals have been unable to make the progression from the mother-child unity of earliest infancy to individuation." During the first three years of life they "failed to make the separation from the mother at the proper stage of development." The child had instinctively wanted to become his own individual personality, but was inhibited by the mother because her "conscious and unconscious tendencies were felt as working against separation."[13]

Socarides explained that homosexuality developing from this early psychological development failure "is a living relic of the past testifying to the fact that there was once a conflict ... in which complete victory was impossible for the ego and repression was only partially successful." This type of homosexuality "can be seen as a resolution of the separation from the mother by running away from all women." Socarides contended that this type of homosexual "has not given up his maleness at all; he urgently and desperately wants to be a man but is able to do this only by identifying with the masculinity, penis, and body of his partner in the sexual act."[14]

Along with this etiological theory Socarides offered a psychological explanation for the prevalent indiscriminate sexual practices of this type of male homosexual. Preoedipal "homosexuals desperately need and seek a sexual contact whenever they feel weakened, frightened, depleted, guilty, ashamed or in any way helpless or powerless. In

the patients' words, they want their 'shot' of masculinity. ... They instantaneously feel reintegrated upon achieving orgasm with a male partner. Their pain, fear, and weakness disappear for the time being and they feel well and whole again." In the treatment of preoedipal homosexuals Socarides found that the clinical evidence showed "the greater the capacity of the orgasm to restore a sense of a bounded and cohesive self, the more difficult it becomes to remove the homosexual symptom."[15]

Socarides direction to psychotherapists was to neither "encourage nor prohibit" the homosexual activity of the client. "The patient ... at a suitable point in therapy, will be able to decide on a course of action. ... Our aim is that the patient not flee therapy as a result of unwise prohibitions against homosexual activity." Socarides plan of therapy was to help "mobilize the patient's feelings and fantasies which accompany his sexual contacts and masturbation" and "direct the patient's interest to a minute investigation of his aims in his perversion and in his acting out. ... He must reexperience and understand the early frustrations, intimidations, and fixations; give up his attachment to his mother; and transfer his libidinal interest to other women. Before this aim can be achieved all developmental phases have to be investigated, including his identification with the father (analyst) in the transference."[16]

The role of the therapist was of utmost importance in Socarides' psychotherapeutic model, because it was through the therapeutic alliance that the patient gained the capacity for being a part of a healthy relationship. In addition, the revival of primitive emotions with the therapist precipitates an affective discharge and "leads to a gradual diminishing of their force, especially if combined with a new understanding of chronically persisting and highly disturbing childhood memories and fantasies."[17]

Successful therapy with the preoedipal homosexual, from Socarides' perspective, meant the patient was able to reintegrate the psyche "to the extent of living an organized life, often being able to marry, having sex with women, and ridding themselves of their perversion and symptomatology."[18] Socarides did not just advocate for the right of those with unwanted same-sex attractions to have professional help to change their sexual orientation, he provided it. He was able to provide that help by treating homosexuality as a developmental disorder.

The advancement of normal variant / gay affirmative psychotherapy

Internalized homophobia - mid 1970s into the 1980s

As a gay graduate student in 1973 Charles Silverstein was not only handpicked by the New York Gay Activist Alliance to prepare and deliver the gay argument before the American Psychiatric Association's Committee on Nomenclature, he cofounded the Institute for Human Sexuality. The purpose of the Institute for Human Sexuality was to create a professional environment for gay and lesbian therapists "to serve the psychotherapeutic needs of the gay community." All the literature at the Institute for Human Sexuality emphasized their goal of "of creating a positive gay identity." The therapists at the Institute refused to entertain any goal of sexual orientation change, "even if requested." Some came to Silverstein so distraught about their homosexuality that they were contemplating suicide if they could not be rid of it. Silverstein not only refused any client's goal of sexual orientation change, he would not even refer a client to a therapist who would try to help them change it. Silverstein reasoned such reorientation therapy

"would only subject them to more years of self-hatred and failure." Instead, those seeking sexual orientation change were told by Silverstein that they should participate in local gay groups.[19]

According to Silverstein the first step in developing "a non-prejudiced theoretical model of homosexuality to replace the illness theory of homosexuality was the invention and propagation of the term 'homophobia' ... This term was quickly adopted and was a brilliant strategy of name-calling by the gay community. If we suffered from 'homosexuality,' they suffered from 'homophobia.' The political use of the term quickly spread to academia." While psychotherapist George Weinberg first published the concept of homophobia in 1972, psychologist Alan Malyon, Ph.D. gave it substantial credibility in 1981/1982.[20]

From research and clinical data derived from gay men Malyon observed that "the internalization of homophobic partiality renders homosexual desire unacceptable even before the process of attribution begins." The "process of attribution" Malyon referred to was the individual's realization that they have homoerotic attractions. Using Weinberg as his reference, Malyon, argued that "homophobic beliefs are a ubiquitous aspect of contemporary social mores and cultural attitudes." The tacit conclusion reached by Malyon was that every adolescent brought up in contemporary society harbors homophobic sentiments. When a child reaches adolescence and realizes he has homoerotic attractions, his homophobic sentiments clash with his homoerotic feelings. In adolescence the primary personality task "is that of identity formation" with peer groups providing "the primary context for this process." Because stigmatized differences like homosexual attractions result in alienation from peer groups, "the adolescing homosexual

is encouraged to obtain peer-group validation through the development of a false identity; that is, by the suppression of homoerotic promptings and the elaboration of a heterosexual persona."[21]

Malyon hypothesized that in developing this false identity formation the "psychological defenses" of the adolescent homosexual "become highly elaborated." His efforts to conform to "the prevailing heterosexual standard precludes psychological integrity." Other aspects of the personality may continue to develop, but Malyon argued "the rejection of homosexual proclivities truncates the process of total identity formation." Besides inhibiting identity formation, Malyon argued that internalized homophobic content in the conscious and unconscious mind negatively influenced "self-esteem, the elaboration of defenses, patterns of cognition, psychological integrity, and object relations," as well as contributing to a propensity for guilt among homosexual males.[22]

According to Malyon's model when the male homosexual begins the process of "coming out," he starts a "second epoch of identity formation." The tension from previous conflicts is lessened in the coming out process, opening up the possibility of mature personality development. Because the gay affirmative point of view "regards homosexuality as a non-pathological human potential," the coming out process is encouraged and a major task of the gay affirmative therapist becomes to help the client develop a positive gay identity. From Maylon's gay affirmative point of view the same-sex attracted client who had not embraced a gay identity was stuck in an adolescent fantasy. His personality development had been "interrupted" and inhibited. Therefore, Maylon reasoned that when the client began the coming out process to himself, he would

be restarting the maturation process that stalled when the false identity was formed in adolescence. [23]

Malyon developed a four stage model of gay-affirmative psychotherapy. Its primary objective was "to provide corrective experiences to ameliorate the consequences of biased socialization." [24] The Malyon model followed a traditional approach to psychological treatment in the sense that it included "both conflict resolution and self-actualization." The first stage of Malyon's therapeutic process was devoted to building the therapeutic alliance. This alliance was vital because "reparative success often can be accomplished only through the emotional relationship with the therapist." The first step was also a time of "information gathering and assessment." Maylon advised that "it is especially important to identify the presence and nature of internalized homophobia" in the client – "both conscious and unconscious."[25]

Phase two of Maylon's gay affirmative psychotherapy was the analytic phase "devoted to conflict resolution and cognitive restructuring." Malyon stated that phase two "is an insight-oriented phase of therapy; its purpose is to assist the client in relating to the unconscious in a conscious way," with "a particular focus on homophobia." Using the assessment of the client's problems the therapist inferred that "unconscious homophobic content" along with "conscious homophobic ideation" were at the root of all his problems that could be associated with the "consequences of biased socialization." These included problems of low self-esteem, lack of psychological integrity, problems with intimacy, psychological defensive mechanisms, and a particular vulnerability to depression. The object for the gay affirmative therapist was to shift the individual's negative feelings about their homosexuality into negative feelings toward homophobia.[26]

Phase three of Maylon's gay affirmative psychotherapy was concerned with helping the client consolidate a positive gay identity "and with facilitating the capacity for intimacy." The therapist helped the client go through their "second-epoch adolescence," shedding the false identity built in the teen years. Once the client had established a positive gay identity the psychotherapy moved to issues of intimacy, which were much "more complicated for the homosexual male than for the heterosexual." The complications were generally attributed to internalized homophobia and societal homophobia. Malyon advised that a gay male therapist had an advantage over a heterosexual male therapist in this phase because "client-therapist similarities invite the very distortions and conflicts which are likely to operate in an empathic and erotized relationship with a male lover."[27]

The final phase of Maylon's gay affirmative psychotherapy helped the client "establish a sense of personal meaning and purpose." Malyon stated that "these issues are post-narcissistic concerns" and "usually become most critical when the client is in his 40s and 50s, for only after pre-genital and adolescent fixations have been attenuated do existential questions tend to arise." Middle-aged gay men do not have the existential reference points most heterosexual males have – "the nuclear family, orthodox religious beliefs, rigid sex-role models, and conservative morality." Malyon qualified gay affirmative therapy by stating that in all psychotherapy "conflict resolution is never complete, nor is psychological growth a process with finite limits."[28]

Historically, Malyon stated that although "psychotherapy was regarded as value-free" in the past, "it no longer is presumed so. Values and attitudes influence virtually every aspect of the treatment process, from *what* is interpreted to *how* it is interpreted." In

gay affirmative psychotherapy homosexuality is not seen as a pathological variable. It is homophobia that is seen as the pathological variable, and as such the problems associated with homosexuality "are considered to be the result of social values and attitudes, not as inherent to the issue of object-choice."[29]

Meanings of feelings - 1998

Psychiatrist and psychoanalyst Jack Drescher has become one of the most vocal and published advocates for gay affirmative therapy. Drescher uses the ideas of homophobia and heterosexism to analyze his patients and teach other analysts. According to Drescher the psychological struggle for gay men "is often between their homoerotic and homophobic feelings and the role of the therapist is to help the patient contain, tolerate, and hopefully integrate them." Because many patients cannot articulate their conscious and unconscious moral condemnations of their homosexuality, Drescher contended in 1998 that the therapist needed a thorough understanding of "overt antihomosexual attitudes" as well as the trials of "growing up gay in heterosexual world." For example Drescher argued that just "contending with cultural constructions of masculinity and femininity is a major stressor for men who grow up to be gay." According to Drescher, "clinicians need to acknowledge the present uncertainty in our understanding of the origins of human sexuality. To avoid retraumatizing gay patients in treatment, the principle therapeutic goal should be to help them understand how to make sense of their homoerotic affects, rather than assuming one can determine why they are gay." [30]

Drescher believed psychoanalytic treatment was better suited to decipher the meanings of feelings rather than discover their origins. He described "some broad concepts" to help "provide clinicians with an initial basis for entering into the subjectivity of a man with same-sex feelings." One subjectivity he described is the "closeted man" who "is unable to acknowledge to himself that he has homoerotic feelings and fantasies." Another subjectivity is the "homosexually self-aware man" who "acknowledges to himself the existence of his homoerotic feelings and attractions." If the homosexually self-aware man defines himself as gay, he has "some level of self-acceptance." A third subjective homosexuality "is that of the non-gay-identified man. This man is aware of his same-sex feelings and may have even acted on them, but he cannot or will not accept any meanings that might naturalize them." Drescher wrote that these three subjective homosexualities should not be thought of "as being with more or less psychopathology" or of being on a continuum.[31]

In assessing a patient Drescher suggested "a clinician should take into account four domains used in meaning-making. The first is the quality of the desire. The second is the awareness of the desire. The third is the acceptance of the desire. The fourth is the conclusions drawn about one's identity on the basis of the first three domains." Drescher saw the therapist's job "to remain open to hearing the patient's complaints, sexual or otherwise," and to help the patient be comfortable with their feelings.[32]

Drescher informed clinicians to be aware of sexual hierarchies that "refer to the ordering of sexual practices as better or worse in terms of some implicit or explicit value system." There are three value systems Drescher advised the therapist to recognize: his own, the patients, and the value system embedded in the theory the therapist learned.

Even valuing monogamy over promiscuity was a value system that Drescher believed should not be in the analytic setting. The "official belief in neutrality asserts that the well-trained analyst does not bring personal issues into the treatment setting, except as undesirable countertransferences."[33] Therefore, Drescher maintained that sexual hierarchies had nothing to do with a successful gay affirmative therapy. Comfort with sexual feelings and practices determined the degree of success. Some gay men defined their "promiscuous homosexual behavior as a revolutionary response to the oppressive heterosexual mores."[34] Drescher's type of psychotherapeutic success enabled these men to be comfortable with their promiscuous sexual life.

Drescher's gay affirming "meanings of feelings" theory started with H.S. Sullivan's insight that dissociation may help functioning but it inhibits personal growth, because the person with dissociative defenses does not know what the meanings are for their dissociative actions.[35] The dissociative defense Drescher focused on was the closeted homosexual's hiding of his homosexuality. Drescher's model of therapy saw the hiding of one's homosexuality as inhibiting their growth as a person. The logic of his model of therapy concluded that the therapist who helped a client find meaning in their homosexuality, in turn, helped the client remove the dissociative function of hiding in multiple areas of the personality. The goal for Drescher was integration; a process where the mind makes sense of feelings and psyche accepts the feelings. Thus, a closeted homosexual who accepted his homosexuality and came out was considered to have achieved a successful therapeutic outcome. Coming out, according to Drescher, "marks the beginning of openly transgressing heterosexually constructed categories of gender and sexuality,"[36]

Drescher has qualified that "declaring one's sexual identity as gay, in and of itself, does not necessarily have to lead to integration. It can, instead, express compliance, anger, or resentment." In general Drescher argued that "to be gay, in contrast to being homosexually self-aware, is to claim a normative identity. From this perspective, coming out to oneself is an integrative process that serves to affirm one's sense of worth." There are many phases and environments where a homosexually self-aware person could come out. Some change as life moves along. So coming out, as viewed by Drescher and analysts with similar philosophies is "an ongoing process that never ends."

For example, many gay men recalled feeling "set apart from others" as a child. Another subset of his clients felt feelings of "failure for being unable to conform to the gender roles expected of them." Yet, as Drescher has pointed out, despite the fact that many gay men report childhood memories of displeasure associated with rough-and-tumble play as children, there are many heterosexual men who did not participate in rough-and-tumble play as well as some gay men who enjoyed it as a child.[37] What seems almost universal is that after puberty "the rituals of conventional adolescence ... generate confusion, shame, and anxiety in adolescents who grow up to be gay."[38] In one of Drescher's case reports he told a patient who was harassed in high school for being feminine that "If people treat you as defective, you may come to believe that you are." The patient responded, "That's what happened. How does one undo that? I don't want to feel defective anymore."[39]

Drescher stated that etiological theories of homosexuality are only helpful in psychotherapy as a "valuable way to make sense of the cultural forces that can shape and define a gay patient's identity." Drescher categorized homosexual etiology into "theories

of immaturity, pathology, and normal variation." When the therapist understands each of these theories and identifies which theory the client ascribes to, then "some of the moral judgments and beliefs embedded in each of them can become clearer to both the patient and the therapist."[40] Only the normal variant etiological theory of homosexuality is viewed by Drescher as healthy for the homosexual, because it is the only etiological theory that can sustain a positive gay identity.

Although Drescher claimed that "little is known about the feeling states of children that later develop into adult sexual attractions" he conceded that "there are developmental themes that do recur in the narratives of gay men." For example, many gay men recalled feeling "set apart from others" as a child. Another subset of his clients felt feelings of "failure for being unable to conform to the gender roles expected of them."[41] What seemed almost universal was that after puberty "the rituals of conventional adolescence … generate confusion, shame, and anxiety in adolescents who grow up to be gay."[42]

Liberation Psychology - 2007

Liberation psychology is a recent advancement in gay affirmative therapy. The term, liberation psychology, originated with Ignacio Martin-Baro in 1994. Psychologist Lillian Comas-Diaz described 'psychology of liberation' as a process where the therapist works with the client to enhance their awareness of the oppression "that has kept them subjugated and oppressed, thereby collaborating with them in developing critical analyses and engaging in a transforming praxis." Rutgers University professor of psychology, Judith Glassgold, Psy.D., stated the objective somewhat clearer, "Thus, liberation is not

only an individual's achievement of undoing internalized oppression, but also the individual's capacity to engage in collective action to change society."[43]

Glassgold traced the roots of liberation psychology to Karl Marx and Frantz Fanon. Fanon and other "researchers studying the legacy of colonialism and the psychology of ethnic minority populations" have shown that the effects of "powerlessness and oppression" produce "profound emotional consequences that are usually manifested in shame about one's individual self and the stigmatized group identity." From Marx came the solution in the form of resistance and efforts to change society. Glassgold believed her identity as a lesbian was linked to resistance. "If resistance did not exist, we, as LGBTQ [lesbian, gay, bisexual, transgender, queer] individuals would not exist. This is an ontological statement of LGBTQ liberation psychology."[44]

Glassgold described "agency" as "an attempt to live as authentically in the world as we can, given its restraints and limits." She explained that "when feelings that are the result of oppression remain unresolved, mental health and behavioral problems emerge that impair the ability of individuals and groups to develop agentic solutions to their lives. ... Showing how these feelings come from living in a society which uses ideological violence and force to harm and control is therapeutic. ... This reframes the problem from an individual disease with immense self-blame to a broader dilemma of finding agency in an oppressive world."[45]

According to Glassgold, "therapy becomes an arena for healing oppression, if the goal includes the recognition and assertion of the self in the mutuality of the therapeutic

relationship." The liberation psychology therapist helps develop assertion in the client by urging them to seek recognition from the outside world for being gay or lesbian, transgender or queer. As the therapist and client accompany each other through the awakening process of liberation psychology, ideally, suffering is transformed into compassion for oneself and others. Glassgold argued that when liberation therapists "help hold another's anger so that it can be borne, then that anger can be used as energy to commit to a cause, without consuming the bearer."[46] For Glassgold a successful liberation psychotherapy was recognized when the client became an activist for LGBTQ causes, because that was where the identity was found and strengthened.

"From the perspective of liberation psychology," Glenda Russell, Ph.D. and Janis Bohan, Ph.D. reasoned that "an individual's homonegative feelings and acts do not reflect intrapsychic pathological self-hatred; rather, they are manifestations of immersion in a homonegative and alienating environment that is fundamentally political rather than individual." The negative attitudes a person may have for their homosexual behaviors and identities "are products of the pervasively homonegative political circumstance in which we live." Russell and Bohan contended that the social context of liberation psychology "suggests that traditional psychotherapy would often not be the sole healing medium of choice" for homosexual related problems. They suggested that "active involvement in the broader sociopolitical realm might prove very healing for the individual struggling with issues regarding her/his relationship to LGBT identity."[47]

Russell was part of a research group that studied the "homonegativity" resulting from the Amendment 2 campaign in Colorado to limit marriage between one man and one woman. The research "found that when [LGBT] individuals are actively involved as

change agents they are better insulated against the damage wrought by anti-gay politics." By reframing "homophobia and heterosexism … as elements of a widespread campaign of oppressive politics" anti-gay political actions "can be seen not as personal attacks but as expressions of broad cultural attitudes in need of change. … becoming active in the wake of such attacks enhances coping and provides a degree of resilience for the future."[48]

The advancement of reparative psychotherapy

Defensive detachment – 1983/1991

This section on reparative therapy will primarily focus on male homosexuality. After Socarides' 1978 treatise on the causation and treatment of homosexuality the next major advancement in reparative therapy came from psychologist Elizabeth Moberly's 1983 reassessment of homosexual causation. Moberly identified the psychological phenomenon of "defensive detachment as the primary block to healing" homosexuality. By isolating "a basic resistance in treatment" she laid the groundwork for developing a treatment that addressed that resistance. Defensive detachment had "long been recognized in the literature as an infantile, self-protective maneuver against emotional hurt." Moberly's contribution was to recognize "that the [male] homosexual's hurtful relationship with father" resulted in defensive detachment, which was "carried over to relationships with other men." She began to suspect this dynamic from conversations with a gay activist friend. [49] Her insights came from eight years of work seeking to understand "what healing can mean for the homosexual and how it may be achieved."[50]

The defensive detachment model of causation looks like this: a young boy's relationship with his father produces "hurt and disappointment," which leads to frustration and protest by the boy. The protests of the boy in the unhealthy family system "are ignored and in some cases punished." Eventually he "lapses into helplessness and surrenders the struggle. The lesson learned from this failed protest is that he has no alternative but to retreat to mother carrying a sense of weakness, failure, depression, and victimization. As protection against future hurt, he defensively detaches from father." This "final self-protective stance" says to his father, "I reject you and what you represent – namely your masculinity."[51]

At age 5 to 12 years of age the boy with this defensive detachment "is typically fearful and cautious toward other boys his age, staying close to his mother and perhaps grandmother, aunts, or older sisters. He becomes 'the kitchen window boy,' who looks out at his peers playing aggressively ... He is attracted to the other boys at the same time he is frightened by what they are doing. Defensive detachment emotionally isolates him from other males and his own masculinity. Females are familiar, while males are mysterious." When puberty begins he will be attracted to other boys, because "we do not sexualize what we are familiar with. We are drawn to the 'other-than-me.'"[52]

From this theoretical model of homosexuality the defensive detachment that caused the alienation between the boy and his masculinity was brought on by the boy's legitimate need to feel affirmed and loved by his father, which was denied. It follows that when the "healthy need for intimacy with other males ... is frustrated, homosexual attraction emerges as a 'reparative striving.'"[53] Conflicting feelings develop toward other males; "Although he desires men, the homosexual is afraid of them." The "binding

ambivalence" of this type of homosexual is a main reason why psychologist Joseph Nicolosi believed many "same-sex relationships lack authentic intimacy." Intimacy and trust were also inhibited, according to Nicolosi, when male couples agree to outside sexual relationships. Defensive detachment theory also "explains the quality of loneliness and alienation so often associated with the homosexual experience."[54]

Nicolosi developed a psychotherapeutic model based on Moberly's defensive detachment theory of homosexuality. Successful treatment in this form of reparative therapy "is based on the [male] client's choice to grow in male identity." In the therapeutic alliance "with the same-sex therapist, a client can find some of what he missed in the failed father-son bond. That is the way a man absorbs the masculine – through answering the challenge of nonsexual male friendships characterized by mutuality, intimacy, affirmation, and fellowship." Therefore, "the therapist who possesses the qualities of the salient father – a balance of nurturance and dominance" will provide the most benefit to this client. Establishing and maintaining a "man-to-man dialogue on an equal basis" becomes the task of both the client and therapist. The reparative therapist follows an initiatory therapeutic model where he is both supportive and confrontive, "facilitating growth as a mentor, leader, model, and coach." Nicolosi maintained that "only through nonerotic intimacy will male bonding occur and the masculine identity form." The key sign that the essential healing experience has occurred in the male homosexual is when his sexual feelings for men become fraternal feelings.[55]

Therapy begins with the male client articulating his perception of masculinity and then evaluating what he sees as deficits in his masculine identity. The client is often "surprised to realize that what he seeks in other men, he himself feels deficient in." This

begins the process of de-mystifying the men he is attracted to. "Growth involves not just a behavioral change of giving up homoerotic behavior, but a deeper transformation of personal identification." The goal is to enable the client "to feel different about himself, relate differently, to see the world from the perspective of a fully male-identified man." When the client realizes that he holds the power to transform his life, his task becomes to learn how "to give up this defensive attitude toward all men, beginning with his father." This involves being able to forgive. Being able to forgive their father is not an easy task for these men. "It often feels like a death experience for a young man when he realizes that he must bury once and for all the fantasy of receiving his father's love." The final step of forgiveness for the man with defensive detachment is compassion for his father.[56]

Most of Nicolosi's male clients have been quick to understand how defensive detachment from males works and "personally identify with this tendency." In a corresponding way the therapist also needs to help the client "identify exactly when and how they detach from men." The client whose defensive detachment has created a false self that has been carried since childhood faces another daunting challenge, because he has to discover "what will replace the old, familiar false self." He has to "fully believe that he *can* grow into a new sense of self with peace, a mature perspective on life, self-possession, and the capacity for intimacy and trust." Central to this process of repairing the homosexuality and becoming a new person "is the establishment of nonsexual intimate relationships with men." Group therapy is used to help develop those relationships with "mutuality in relationships" as the goal.[57]

While this treatment model fit most of Nicolosi's homosexual clients in 1991, it did not fit some clients. Those homosexuals the model did not fit showed "no signs of

gender-identity deficit" and their childhood did not follow the development model. Others the model did not fit were satisfied with their homosexual orientation and did not desire to change. These clients were brought in by parents or a spouse. Some client's did not have "the ego strength to see it through." Nicolosi stated that "it is usually possible to predict in the first session or two if reparative therapy will be of help to the client. ... If the first session lapses into a debate about the merits of reparative therapy or the ethical implications of the gay life-style alternative, this is an indication that the client is not ready for this therapy."[58]

The reparative therapy goal of sexual orientation change is referred to as "change" rather than "cure." Nicolosi advised his clients that "usually some homosexual desires will persist or recur during certain times in the life cycle." Psychotherapeutic change is an "ongoing process," because "no psychological treatment can be conceptualized in terms of absolute cure."[59] In a similar way depression, alcoholism, drug addiction, and self esteem disorders are ongoing processes.

Affect focused therapy/body work - 2009

A new intervention in reparative therapy was adopted from the therapeutic school known as Affect-Focused Therapy (AFT). AFT is based on the hypothesis that much of the pathology of psychotherapeutic clients is the result of attachment loss. The research that developed this conclusion was based on the study of mother-child bonding in primates and humans. Reparative therapy's AFT approach combines the attachment loss knowledge with neurophysiologic research that found the unconscious can mind hold a

"buried 'body memory' that operates without cognitive awareness." In 2009 Joseph Nicolosi detailed reparative therapy's adaptation of AFT for interested therapists. He claimed AFT produced "the quickest results toward the resolution of same-sex attraction." This reparative therapy adaptation "has moved away from traditional attempts at resolving intrapsychic conflict and turned greater focus on affect regulation, with the therapist as affect-regulation facilitator."[60]

A key premise for Nicolosi's AFT adaptation is that hurtful relationships have impeded the homosexual client's ability to attach, detach, and reattach in a healthy way. The AFT adaptation "emphasizes not so much confrontation but a collaborative and supportive working alliance," because men with same-sex attractions usually have "a history of feeling victimized by manipulation and control." Reparative therapists refer to their adaptation of AFT as "body work," although no touching is involved.[61]

In the eighteen years between Nicolosi's 1991 and 2009 books on reparative therapy his understanding of the causation of homosexuality had changed. Whereas in 1991 he understood the homosexuality he treated most often to be "a symbolic attempt to repair gender identity deficit," in 2009 he saw it more "as a striving to repair deep *self*-deficits," and at its deepest level to be "*a defense against the profound pain of attachment loss.*" His clinical observations suggested one particular trend in his homosexual clients, "*specifically, an accumulation of early, core emotional hurts that have led to an attachment injury.*" Homosexuality in these clients was more than "a defense against gender inferiority," it was also "*a defense against a trauma to the core self.*"[62]

The new understanding of homosexuality causation followed the historical progression of causation, but added more insight into the core emotions. In the typical male homosexual's family, observed by clinicians over fifty years ago, there was a pattern of a mother overly involved in unhealthy ways with her son and a father who was hostile or ignoring of his son. From Charles Socarides' observations it was learned that this unhealthy bonding with the mother and the disconnection between the father and son often began when the boy was a toddler. Elizabeth Moberly was the first to suggest the father-son disconnection was a form of a psychological disorder called "defensive detachment." In 1991 Joseph Nicolosi suggested that what the psychological profession now calls "defense of dissociation," Moberly originally identified as "defensive detachment." Nicolosi went one more step in 2009 and proposed that the typical homosexual condition is "an attempt to heal an abandonment-annihilation trauma ... an attempt to 'repair' a shame-afflicted longing for gender-based individuation."[63]

Abandonment-annihilation trauma to the child is the perception by the child that the parent has abandoned them. Not necessarily in the physical sense, but in the emotional sense. The child feels he is not seen as an individual person even when he is in the same room with the parent. It is "felt like a hollow emptiness," like an expulsion: "a shunning that is experienced as nothing less than hopeless abandonment." The child feels so shamed by the parents for his feelings that those feelings become "unbearable." The "shame posture," a new name for "defensive detachment," becomes the child's defense to prevent the recurring trauma of the shame experience.[64]

Advances in neuroscience enabled therapists to better understand how psychotherapy works to help people. Researchers found that all "interpersonal

communication has a neurobiological impact, either corrective or harmful." Powerful memories, traumatic memories are stored not only cognitively but also in the body. The shame moment is a "freeze response" where the person loses his physical vitality "with the body becoming rigid and stiff." It follows that the shame posture, the defensive detachment, the "shutdown is actually a *physiological, bodily* reaction." The mind can deceive the person about the state he is in, but the body memory does not deceive. Psychotherapy then offers an opportunity to make "actual neurological changes in the brain." The therapeutic experience holds the possibility of laying down new positive neurological pathways "on top of the old, traumatic neurological memories."[65]

Reparative therapy's adaptation of AFT "is intended to evoke both emotional and cognitive reexperiencing of past trauma, that is, the shame moment. To accomplish this, interventions are necessarily uncomfortable and challenging. The client must be enabled to move past his anxiety and abandon his defenses in order to fully feel and express the emotions and impulses that will lead to an innate affect. The result is a psychic restructuring, often accompanied by an observable phenomenon called the 'felt shift' of affective expansion."[66] This 'felt shift' is likely linked to a profoundly positive new neurological pathway.

Nicolosi has developed a sequence for AFT adaptation. The sequence's objective is to move the client from anxiety to deep feelings and then offer a "healing moment," or a "corrective emotional experience" in psychotherapeutic terminology. Having already agreed upon "goals and objectives as defined by the client," within each individual session the client chooses "the identified conflict." Nicolosi advised that "once the conflict is identified, it is unproductive to further discuss the event itself; rather, the

therapist remains focused on the feelings/impulses that exist about it in the present moment," often countering the defenses the client throws at him. The focus on the client's feelings "must be slow and deliberate, conveying respect and value for the client's gradual attempts to identify his feelings." The therapist asks the client questions like, "What does it feel like in the body?" "Where in the body do you feel it?"[67]

When the therapist determines "that the client has experienced and expressed feelings/impulses to the level of a core feeling," he asks the client to remember past relationships where he felt the same deep core feelings that he is now feeling. The "recall of this memory is not just an intellectual insight, but a *felt* insight, akin to the Aha experience of Karl Bühler (1990)." After the affect of the insight is released the therapist and client discuss the historical context of the deep core feelings and what caused them. "The therapist models vulnerability and offers an opportunity for the client to experience moments of intimacy." After the therapist has compassionately supported the client's journey into his core feelings, the end of the session is used to "encourage the client to explore and own his own feelings" and "create a meaningful narrative of his experience."[68]

When the core feeling is shame "the therapeutic goal is for the client to remain in the shame (with all the feelings that surround and underlie it) while he simultaneously experiences emotional contact with an understanding and accepting therapist. Thus he allows himself to be 'seen' while he 'sits in the shame.'" Therapists have found that what alleviates shame "is a surrendering or releasing of it." The release permits "the client to go deeper into core feelings." When the client feels that his therapist has understood, supported and affirmed him, "the affirmative message is internalized into [his] self-

identity." A process of intrapsychic integration takes place when there is a healthy reattachment of the core feeling to the client personally.

Because clients often confuse guilt and shame Nicolosi recommended that the therapist "convey the distinction between the guilt messages ("You did something bad") and the shame messages ("You are bad"). Nicolosi explained that guilt is the justifiable result of bad behavior; shame has no real justification."[69]

As the client goes through this AFT adaptation with the reparative therapist many times he will begin to identify certain disturbing feelings in his body. They will become cues that tell him what is happening to him before he cognitively realizes it. One of the therapist's goals is to teach the client to "listen sensitively to his body responses" and recognize that certain body cues point to past trauma and unhealthy responses. For example, parental criticism of the child's authentic needs led a child to devalue himself, which in adult life led to a similar pattern where the adult devalued himself when he perceived any type of criticism or rejection. This embodied experience "is felt primarily in the chest area, first as a quick jolt, followed by a gripping tightness (fear), followed by a lower-chest sinking or dropping sensation (sadness)." Nicolosi refers to this phenomenon as the "paralyzing effect of anticipatory shame." Once the client recognizes it as it happens, he can change the course of direction by taking an assertive stance rather than entering into a self-critical depressed state for which homosexual behavior serves a reparative function.[70]

Grief work - 2009

When reparative therapy's AFT adaptation takes the client to his deepest levels of core feelings, it "opens the way for the next step of the process," which Nicolosi called "grief work." "Therapeutic grief work is approached through two pathways: anger and sadness. Here, the client confronts the profoundly disturbing feelings associated with the attachment loss." Research has shown that "the pathological legacy of unfinished grieving" is "an ongoing fear of emotional closeness and a limited capacity for genuine intimacy."[71]

"Any time there is a failure to develop the parental attachment bond, the person must address the shame of not having felt genuinely known and fully loved by one or both parents. When he becomes a man, the child who experienced that loss must acknowledge and grieve it. Grief resolution requires releasing these body-held memories and then mourning the loss." According to Nicolosi the best time for a reparative therapist "to move into grief work is when material is offered by the client that directly or indirectly suggests shame. ... Most often when shame is discussed, sad and angry feelings will also surface. These are the two innate affects that form the parallel paths to grief."

The shamed self feels sadness for the one who shamed them and anger at themselves because they believe it was their fault the other is disappointed. This is usually based on the distortion that they are bad and unlovable. To move from shame to grief the therapist helps the client turn the anger away from himself toward the other and the sadness from the other to himself.[72] Before a therapist moves to grief work there needs to be "a sufficient positive transference established to allow the client to release his

lifelong defenses against feeling the deepest level of pain." The client also needs to be willing to move into that level of pain.[73]

Nicolosi has conceptualized grief work into four tasks: (1) "recalling any traumatic childhood events;" (2) "going beyond recall to feel and express the associated affects (sadness and anger);" (3) "facing the painful consequences of those past traumatic events as they affect his life today;" and (4) "resolution of past losses and developing realistic expectations for the future." Grief work is another path the AFT progression can take. It would go something like this. Once a conflict in the present was identified, the therapist would move the client to locate the feelings associated with the conflict and then ask the client to associate those feelings with a past experience. Recognizing the past experience as a traumatic event that may not have been grieved sufficiently, the therapist asks the client if he wants to explore the feelings related to the past event more deeply. If the client does, the therapist helps the client go deeper into the feelings and express their associated affects. From the deepest levels of hurt the therapist helps the client face the consequences that the past traumatic event has had on his life.[74]

"As the client approaches these deeply painful levels of grief," Nicolosi advised the therapist, to "move ever more slowly and gently. His task is to remain present with him in his sadness, containing and supporting him while he 'sits in the ashes' of the loss." As the client "enters the despairing depths, the therapist replaces his focused pressure with a more passive 'attendance.'" Long, silent moments pass as the client "becomes acquainted with, explores and then simply dwells in the abyss. This experience of grief is often so deep that it is a death-like experience," but it "is all part of the psychic reorganizing process."[75]

"Successful grief work means not only facing the reality of past losses but also the painful truth that no one in his present life will ever be able to make up for those losses." The client will never have the love and acceptance that he needed from his father. He will never have the respect and admiration of those who belittled him in school. He will mourn lost years and opportunities. "Many clients must continue for some time to face the reality of the unfairness of their life, their deep attachment deprivation and the difficulty of their struggle against homosexuality." In the real sense, none of those painful realities can be undone. "Rather, the client must make a practical adaptation through incremental phases of acceptance, followed by gradual adjustment." At this point in 'grief work' the therapist helps the client resolve the past loss by "developing realistic expectations for the future."[76]

"Grief work addresses this 'defective self,' the inauthenticity that is the root cause of their same-sex desire." Yet, reparative therapists found that some clients who respond to grief work "will also grieve the impending loss of his old, familiar identity, 'The false self I've fabricated, in place of who I was meant to be,' as one man put it." After the client has assimilated the loss of the false self, he "must thoughtfully consider who he hopes to become. ... *Who is this person I am becoming*, he wonders, *as I discard the false self?* As the illusions and distortions are unmasked, he begins to recognize this new man - a new man who needs neither to idealize and aggrandize other men, nor to deprecate them."[77]

One illusion that Nicolosi emphasized be abandoned with the false self is "the narcissistic illusion that there's one man 'somewhere out there, if only I can find him' who will meet all his emotional needs; a special man who holds the key to finally making

him feel connected to himself. ... Gradually, he comes to realize that he must abandon this illusion in order to experience the affirmation of true male friendships characterized by mutuality, dignity and equality." Ideally, "as the narcissistic defenses are relinquished, they are replaced not only by greater humility but also gratitude." Successful guilt work through reparative therapy is evidenced when the client shifts "from entitlement to gratitude, from self-abnegation to assertion, from narcissism to humility, and from emotional isolation to authentic attachment." Nicolosi contended that "along with this new, heightened capacity for genuine intimacy comes a diminishment of homosexuality's illusionary power."[78]

Eye movement desensitization and reprocessing (EMDR) - 2009

EMDR is a treatment approved by the American Psychiatric Association that is most effective "in the treatment of trauma-induced symptomatology." "Studies on sleep physiology in the 1950s found that rapid eye movement (REM) is the brain's natural way of diminishing disturbing memory traces accumulated during the course of the preceding day." The rapid back-and-forth movement of the eyes actually causes body-held stresses "to be released from the nervous system." In Francine Shapiro's earliest work with posttraumatic stress disorder "she found that when the REM state was interrupted due to trauma, the processing of major trauma was prevented." Instead of being released from the nervous system through REM, the trauma remained stored. Because reparative therapists see homosexuality causation related to abandonment-annihilation trauma to the child, EMDR has been used with unwanted homosexuality and "observed to diminish unwanted homosexuality and enhance heterosexual potential."[79]

EMDR represents a modality option for reparative therapists to use along with their AFT adaptation or other psychoanalytic therapies. Briefly summarized the EMDR process follows a protocol where the client chooses the target memory. Next, the therapist directs the client to find a picture in his mind that "represents the worst part of the incident" and then articulate the negative belief about himself. The client is asked to rate the target memory on a cognitive and somatic scale that can be used for further reference. After this preparation and assessment the client is asked to concentrate on three aspects of the target memory that were developed in the preparation – the image representing the worst part of the incident, the negative belief about himself, and "the emotion now felt in the body." As the client is urged to concentrate on the three aspects he is instructed to do the eye movement. The most often used bilateral stimulation is moving the eyes back and forth rapidly approximately thirty times, which is called "one set."[80]

"After a set, the therapist should instruct, 'Let it go, take a deep breath, and tell me what comes up for you' or 'What do you get now?' or 'Where does it take you?'" After exploring the client's answers to those questions another cognitive and somatic assessment is done rating the target memory. The process is then repeated a number of times until the "subjective units of disturbance" are at the least distressing end of the scale, there is no emotion felt in the body, and the client believes a positive picture of himself. In effect, this part of the EMDR process attempts to remove the stored trauma from the nervous system. Only the trauma related to the memory in the nervous system is removed, not the memory itself. The "final phase of EMDR attempts to reinforce into

consciousness the insights gained and to counter any denial or minimization of progress."[81]

"EMDR is not only a process of desensitization, but more importantly one of reprocessing. The goal is for the client to have no feelings about a particular shame target; he will continue to have the memory, but see that memory in the new way." Reparative therapists use EMDR "to target past shame moments associated with gender self-assertion." Traumas that contained the message, "You cannot succeed as a male." EMDR is not effective "for present or future incidents (anticipated trauma). Nevertheless, the frequency of anticipatory shame is lessened by working through past shame moments." Although EMDR offers a more direct process of laying down new neurological pathways, reparative therapy's AFT adaptation offers other benefits EMDR does not. The AFT adaptation "offers the client a broad experience of interpersonal exchange and enhances his future capacity to trust, thus preparing him for future intimacy."[82]

Reparative psychotherapy with teenagers - 2009

The particular challenges of working with teenagers that have same-sex attractions requires its own intervention strategies, according to Nicolosi. The challenges often include the adolescent's "ambivalent commitment to therapy; intense sexual feelings; unstable personal identity; high susceptibility to the influence of media, peers and pop culture; suspicion of adult authority; teenage narcissism; rebellion; poor impulse control; the need to learn through experience; ... and high vulnerability to the influence of gay websites, especially gay porn." In addition to these challenges the adolescent of

today is educated with misinformation propagated by the gay influence in the educational institutions. He is often taught that homosexuality is biologically determined and therefore sexual orientation change is impossible and dangerous. Likewise, the relationships of gay men are described to adolescents as similar to monogamous heterosexual relationships and the gay life is touted as a healthy alternative. At the same time the traditional moral values of American culture are condemned for being homophobic and heterosexist.

With hurt feelings of not belonging the young man with same-sex attractions finds a gay culture eager to embrace him and offer an "extraordinarily easy availability of gay sex." These influences "can quickly lead any confused young person into a deepening gay self-identity." On top of all these challenges many teenagers are brought to a reparative therapist by their parents and against their own will.[83]

A typical teenage scenario that reparative therapists work with begins when the parents discover that their teenage son has been visiting gay pornographic websites. In Nicolosi's reparative therapy model the parents are told about the therapeutic process and encouraged "to back off from pressuring their son to change." Reparative therapists associated with Nicolosi "believe that parents are owed some assurance of the direction the therapeutic agenda will take;" in particular, the assurance they will "not simply support the child's notion about claiming any lifestyle option he chooses." That said, the parents are informed "that if their son doesn't want therapy, all that can be done is to provide information. The therapist can only offer him the opportunity to make an educated choice – that is, to make a life decision based on accurate information." A

substantial number of teenagers after hearing their option of reparative therapy decline the invitation.[84]

"In the first session the client should be informed that although he has been asked by his parents to consider the possibility of a change in his sexuality, we [therapist and client alliance] agree from the start that he will not be manipulated in that direction. Ultimately, his life choices must be his own." Nicolosi stated he tells his young clients, "Rule number one – never agree with anything I say unless it rings true for you." ... "If the teen disagrees with the therapist's views on homosexuality, then the foundation of the working alliance can simply be to 'agree to disagree.' In other words, the therapist *exposes* his *views* on homosexuality, but he doesn't *impose* the direction of treatment on the client."[85]

Nicolosi's reparative therapy approach with a teenager is not "primarily on the question of whether to be gay or not;" gay being "a social-political identity." Instead, the focus of therapy is on "the development of the confident, assertive, manly and strong person he himself wants to be – overcoming the false self that harbors feelings of intimidation, inhibition, unmanliness and hidden shame." Regardless of whether the teenager changes his sexual orientation to heterosexual, "an authentic therapeutic relationship with the therapist – a salient man who respects, values and understands him – will ultimately be of benefit" to him. Those benefits include a demystifying of men in general and "learning how to better connect with them as people."[86]

A key factor in helping the teenager with same-sex attractions and struggling with his sexual identity is the "unconditional acceptance" of the teenager as a person by both

the therapist and the parents.[87] Nicolosi counseled the parents of his teenage clients that they can affirm their adolescent child as a person without affirming the child's same-sex attractions "as normal and desirable."[88] Parents were not given "specific details of the [teenager's] session," but instead "a general report of his overall progress."[89]

Reparative psychotherapeutic approach with preteens and prevention - 2002

"Before the APA's paradigm shift in 1973, it was accepted practice to try to prevent homosexuality." Homosexuality was considered a "disordered sexual-identity development [that] should be avoided whenever possible."[90] Even Judd Marmor, the leading psychiatrist in the successful effort to remove homosexuality as a psychiatric disorder, supported efforts to prevent homosexuality, at least until the culture accepted it as an equal alternative to heterosexuality. While the mental health associations and academic research have ignored the subject, major advancements in the prevention of homosexuality were published in 2002 by Joseph Nicolosi and his wife Linda.

The advancements in prevention emanate from reparative therapy's new approach. Reparative psychotherapy now views the over-bearing mother and the distant/hostile father causation factors of homosexuality from a more relational and emotional perspective. The father-son disconnect is viewed as "defensive detachment," "defense of dissociation," or a "shame posture." Based on that relational breakdown the Nicolosis' prevention model seeks to undo the defense of dissociation and "prevent the boy from detaching from his normal maleness." The Nicolosi prevention model encourages a boy dissociated from his gender "to claim the masculine identity for which he was designed."

The Nicolosis' did not suggest the child be molded "into the caricature of a macho man (this may not be who he is, and that is okay), but to help him develop his own maleness within the context of the personality characteristics with which he was born." They were adamant that a gender-nonconforming boy who is sensitive, gentle, and artistic can in later life be an artist, actor, dancer, and heterosexual. "With appropriate masculine affirmation and support" these finer traits in a boy "can all be developed within the contest of normal heterosexual manhood."[91]

The advancements in the relational and emotional aspects of homosexual causation have led to a complete reworking of the practical application to prevent homosexuality. Whereas, the "traditional psychoanalytic treatment for prehomosexuality focused on the child being seen alone with the psychotherapist ... from two to five times a week for many years," the Nicolosi group advocated that the therapist "work on a regular basis with the parents and not the child." Relationally, the prehomosexual boy is reluctant to identify with his dad and his own masculinity, while the prehomosexual girl is reluctant to identify with her mother and her own femininity. The Nicolosi perspective believed that the best way for the child to identify with the same-sex parent a was for the parent to change the dynamic of the parent-child relationship so that it was attractive. The task involves "*emotional* bonding with the same-sex parent," for which it is the parent's responsibility to reach out to the child. "After a few weekly sessions, the therapist should usually see the parents only on an as-needed (perhaps monthly) basis to coach them and monitor the boy's progress." Usually, the psychotherapist need only "see the child for an initial assessment and then from time to time afterward."[92]

A general description of the prehomosexual boy is the three to five year old boy who is more interested in girl attire and activities than in boys. Nicolosi and Nicolosi's general advice to the parents of a young son who fits the prehomosexual pattern was for the dad to get involved with the son, while the mother should intentionally become less involved with the son. The goals included helping the son disidentify with the mother and identify with the father, and for the boy to "perceive the father worthy of emulation." It is important that the parents do not shame the boy "into covering up his effeminate mannerisms. The process of change must proceed gradually, through a series of steps that are accompanied by loving encouragement." Parents were told by the Nicolosi team that it was important for their son "to feel and express his sadness and loss" at the disposing of feminine items, and for the parents to sympathetically hear their son's pain of the loss. If the child "becomes withdrawn, depressed, angry, frustrated, or nervous" the parents are moving too quickly and need to back off. "Once the child realizes that both parents, as a team, will no longer ignore his inappropriate cross-gender behavior, he will begin to adjust."[93]

The Nicolosi team told fathers of prehomosexual boys to be there emotionally for their boy, because most of these fathers "are simply uninvolved, emotionally distant and disconnected, especially from their sons."[94] Although some fathers are emotionally unavailable due to a psychological disorder such as narcissism, other reasons are more situational. Absence due to work, "financial and emotional burdens of a new family, or a difficult relationship with the boy's mother" can cause a father to be emotionally unavailable. The father may not have learned how to work through conflict with a loved one and feeling rejected by his son's defensive detachment, he simply has withdraw from

him.[95] The Nicolosis' counseled fathers to not let their son reject them. They told fathers directly that their task was to pursue their son; to "push through his defensive detachment, and with steady and consistent efforts, to become an important person in his life."[96]

Joseph and Linda Nicolosi adhered to the principle that "men and boys connect best through doing any sort of physical competition or shared activity, and if it is experienced as fun, it will facilitate father-son bonding." Therefore their counsel to the father was to "play rough-and-tumble games with his son – games that are decidedly different from those he would play with a little girl." The rationale behind rough and tumble games "is to encourage a little of the 'wild boy' to break through. By 'playing weak' the dad allows the son to feel tough, strong, and aggressive."

The Nicolosis' urged these fathers to take father and son trips out of the house, doing little things like letting the young boy pump the gas with his father standing beside him. Showering with dad was also recommended for the small boy with cross-gender behavior. It helps to foster "a common, relaxed anatomically based identity and breaks down the fascination and sense of mystery around male anatomy which will fuel male eroticism when puberty arrives." The wrong approach for the father of prehomosexual boy is "militant monitoring" of the boy's effeminate behaviors. "It is through bonding with the father and finding emotional security in the father-son relationship that the boy will feel capable of giving up his cross-gender fantasy."[97]

The Nicolosis' counseled single mothers to "be mindful not to develop an excessively close relationship with their sons." She "has to go the extra mile in affirming

her son's masculinity. From day one, she has to make him feel that his maleness is different from her femaleness and that that differentness is good, healthy, and a part of who he is." If the father is not a part of the son's life, the Nicolosis' suggested that single mothers seek a trusted close male family member to be the father figure. If that was not possible, they suggested finding a church youth leader, a coach, Boy Scout leader, or Big Brother to be a positive role model for the boy.[98]

Positive male role models other than the father were recommended for the parental team also. Other male relatives, friends, coaches, and teachers can help build up the weak gender esteem of the boy along with the parent's efforts. A trusted male who can help the boy become better in a sport that he is interested in "can make a big difference." The Nicolosis' counseled parents not to use the word "homosexual" or "feminine" in conversations with other men they wished to be role models for their son. They suggested they tell these men that their son has "low gender esteem" or "gender issues" or that he is "having trouble feeling like one of the guys."[99]

Girls in contemporary culture are allowed a wider range of gender nonconformity than boys. "Tomboyish behavior in girls is, in reality, often a passing phase, while sissyish or effeminate behavior in boys usually is not." Sometimes fathers are "disappointed at having a daughter and treated her as if she were a son, resulting in the 'forced choice' to abandon her feminine aspirations to gain her father's love." In other family situations a father may have taken over the child rearing due to severe depression in the mother. The father may then see "his daughter as a 'buddy,' encouraging her to behave like he does and to share in his masculine interests. With little influence by the mother, such girls often become masculinized by the age of three or four." The Nicolosis'

adhered to researcher Robert Stoller's observation that "if one wishes to promote gender identity of a girl, there should be a warm mother-daughter intimacy, along with a father who does not promote identification of the daughter with himself." The best role a father can play "in developing his daughter's feminine identity is to reflect his daughter's gender-differentness from himself with respect and appreciation."[100]

Reparative psychotherapists "have found that once parents are given accurate advice, they quickly make changes and proceed enthusiastically toward helping their child develop a healthy gender identity."[101] The steps to helping the child with gender issues are simple in many respects and easy to understand. In actuality, they are a lot harder to implement and require patience, determination, and compassion from the parents. One would suspect that the parent's personalities are also altered by changing their relationship with their child. Many parents will learn to resolve intrapersonal conflict better and to understand their feelings and their child's feelings better. The prevention technique promoted by the Nicolosis is a win-win for both the parent and the child. It is possible that despite the parents' efforts the child will still develop a homosexual orientation. If that does occur and the child identifies as gay or lesbian later in life, the Nicolosis' encouraged parents to "always cherish and keep a relationship with your child. Also, you should never give up hope for healing change at some time in the future."[102]

Criticisms by psychoanalysts

Criticism of gay affirmative therapy

Psychologist Joseph Nicolosi's criticism of gay affirmative psychotherapy began with its dismissal of the clinical evidence. Specifically, the clinical evidence that has shown homosexuality to often be a symptom of psychopathology and the evidence that homosexual orientation can be changed. Nicolosi argued that "in fact there is no scientific data to controvert 75 years of clinical and empirical research on homosexuality. In what other forum has it ever been generally concluded that 75 years of professional observations have been simply 'disproved'? The debate must in fact go on."[103]

To counter the clinical research on homosexuality social activists have blamed "every painful developmental stage of the homosexual ... on either social or internalized homophobia. ... The homosexual adult's alienation from family and society is attributed to homophobia." The same-sex attracted adolescent's "depression, loneliness, low self-esteem, and any drug and alcohol abuse are often blamed on social or internalized homophobia. Even narcissism has been attributed to introjected homophobia." A homosexual's "interpersonal problems" and promiscuity have also been "attributed to self-punishment induced by internalized homophobia." This "catchall term" has been used "to explain any and every negative response to homosexuality."[104]

By 1977 the term homophobia had grown to include "any belief system that values heterosexuality as superior to and/or 'more natural' than homosexuality."[105] Applying this definition to the culture, Nicolosi surmised that "probably every religious tradition and every culture in world history could be considered homophobic." Nicolosi concluded this argument by stating that "without being 'phobic' about it, it is quite possible to reject the gay life-style within the framework of one's own values."[106]

Nicolosi had heard complaints from clients. Some of his clients left gay affirmative psychotherapy after a few sessions and sought out reparative therapists. They "reported the explicit impression that their therapist was trying to indoctrinate them against their true feelings, and they often felt this was because the therapist himself was gay-identified."[107]

Much of gay affirmative therapy is desensitizing the client to his feelings of guilt about his homosexuality. Consequently, when gay affirmative therapy is promoted as the only acceptable treatment of homosexuality it actually provokes guilt onto the homosexual who would like to change his sexual orientation. [108] Gay affirmative therapy in one breath condemns the guilt societal homophobia places on the homosexual and in the next breath it creates guilt for those who have unwanted same-sex attractions.

"Gay apologists who do acknowledge the research evidence of [male homosexual] promiscuity tend to rationalize it as part of the gay condition."[109] Nicolosi pointed out that "in the clinical literature, some gay clinicians actually advocate public sex, open relationships, and group sex as good strategies to resolve sexual boredom."[110] One of those gay clinicians is Charles Silverstein who has recommended homosexual one-night stands and brief flings as a source of "variety and excitement."[111] Silverstein, in particular, sees no contradiction in psychotherapists frequenting gay bathhouses, sex clubs, or public sex hangouts as long as the therapist does not have sex with a client. [112] Nicolosi's criticism implied that many gay affirmative therapists are out of touch with the cultures norms and that in many respects they are blind guides.

Similar to the way promiscuity is rationalized by some gay therapists, others rationalize gender ambiguity. Gay psychiatrist Justin Richardson "goes so far as to say that an indifference to gender distinctions is a mark of intellectual superiority!" Nicolosi, claimed Richardson was out of touch with the reality. Nicolosi countered Richardson by arguing that a "healthy development requires that a person's interior sense of gender identity and his biology must correspond."[113]

Nicolosi presented the case that gay affirmative therapists work "very hard as boosters of their own philosophy. They tell clients that their same-sex feelings are 'sacred.' They push them to revolutionize society's and church's attitudes."[114] Many individuals with same-sex attractions have been led "into a gay lifestyle after they were told by their therapist that there was no hope of change."[115] Nicolosi inferred that ethical lines had been crossed by these actions.

This concern over the political nature of gay affirmative psychotherapy is heightened by the number of teenagers who are confused over their sexual identity. A national survey on sexual behavior published in 1994 found that "while only 2 to 3 percent of adult males are homosexual, 10 to 16 percent of all men go through a homosexual phase earlier in their lives."[116] In 1992 another major study "found that more than one-quarter of twelve-year-olds are *unsure whether they are heterosexual or homosexual.*"[117] Nicolosi was especially concerned that gay school counseling programs would lead these sexually confused children and adolescents to identify as gay.[118]

Nicolosi has sounded the alarm that in general therapists and counselors are not telling parents "the truth about their children's gender confusion. Parent's have no idea

what, if anything, to do about it." The politically correct alternative parents are given ignores "the child's symptoms, it seems, and focus on the parents' problem with 'unenlightened homophobia' or 'heterosexism.'" Nicolosi accused these clinicians of "replacing genuine helpfulness with a social agenda that conflicts with the values and concerns of most families. This is because one undeniable fact remains: most parents do not want their children to grow up homosexual."[119]

Nicolosi's strongest criticism of gay affirmative therapy and counseling compared its bias to criminal neglect. "Someday, perhaps, parents who have watched a son die of AIDS will decide to sue their pediatrician because when they brought the child for treatment for Gender Identity Disorder, they were told not to worry, or that nothing could be done. Perhaps the parents of another boy will bring suit against a school system which labeled the child as unchangeably homosexual and turned him over to a gay support group, where he contracted AIDS. In both cases, proper diagnosis and treatment might have prevented a negative outcome."[120]

Criticism of reparative therapy

As a gay activist psychiatrist Jack Drescher has been outspoken in his opposition to psychotherapy that considers homosexuality a disorder, especially if it has a goal to help a homosexual change his sexual orientation. Drescher has been particularly critical of Charles Socarides, Joseph Nicolosi, and reparative therapy. He has argued that reparative therapy should not exist in the profession "on the same practical basis as conventional psychoanalysis or psychoanalytic psychotherapy." Drescher's charge of heresy was based on his "belief that psychoanalytic treatment is voluntary, respects the

individuality of the patient, and seeks to provide relief through means other than suggestion, coercion, or indoctrination." According to Drescher "reparative therapy practices distort mainstream psychoanalytic theories and practices."[121]

Drescher claimed that there is a "lack of respect" for same-sex relationships in reparative therapy, which actually disguises contempt for those relationships. Drescher argued reparative therapists "necessarily reinforce social expectations for heterosexual normativity." Articulating his argument further Drescher stated that "when therapists take sides in a patient's internal struggle to establish a sexual identity, they run the risk of reinforcing dissociative, rather than integrative tendencies. The risk is compounded in a treatment predicated upon an unproven theory that a gay man's major difficulty is a failure to establish a relationship with a benign, paternal figure." Drescher continued his criticism by objecting to any effort that encourages the client to identify with the therapists "attitudes or values." He also criticized the view that transference enactments between the homosexual client and the reparative therapist could be related to "some original traumatic disidentification."[122]

Drescher had a number of other criticisms against reparative therapy, such as the concept in reparative therapy where the male therapist serves as a male guide. According to Drescher, this concept not only shows "their theoretical biases, but their ignorance of human sexual diversity and about normal gay male development as well." Referring to psychoanalyst Lionel Ovesey (1969), Drescher complained that "gay men in analytic treatments were often encouraged to date women or told that treatment would be terminated if they engaged in homosexual activity." In another criticism Drescher claimed reparative therapy's philosophical position of equating "psychological gender

with biological anatomy" was outdated. "For contemporary theorists, social forces, rather than biology, dictate whether feelings and behaviors are designated as either male or female." Even reparative therapists draw upon cultural definitions of masculinity and femininity, Drescher argued, yet they equate psychological gender with biology.[123]

Drescher's critique claimed that "the disjunction between a partial and total success" in reparative therapy lends credibility to his charge that reparative therapy should not "be considered a psychoanalytic form of treatment." From Drescher's understanding of reparative therapy a successful therapy is a change in sexual orientation even though all the homosexual feelings are not erased, while "a partial reparative therapy success is the man who still has same-sex feelings but remains celibate, rather than 'acting out' on them." The disjunction, Drescher argued, "creates a serious difficulty in assessing what is truly transpiring in reparative therapy."[124]

One of Drescher's clients who went through reparative therapy and was unable to change his sexual orientation reported the experience as "painful and humiliating." From reparative therapy literature the most important factor to changing sexual orientation is the client's motivation, so when sexual orientation is not changed, the failure, according to Drescher, "only reinforces feelings of failure and incompetence" in the client. In addition, "gay men who anecdotally report 'successful' reparative therapies, often return to homosexual activity," according to two prominent gay activists cited by Drescher. The reason these reparative therapies fail, Drescher surmised, is that "the compliant patient uses the therapist's moral stance to suppress same-sex feelings."[125]

Criticism of the gay political influence in psychotherapy

Nicolosi alleged that the American Psychiatric Association and the American Psychological Association are "cheerleaders for the gay-activist cause" and as such "hold to a one-sided worldview that tolerates no dissent. The American Psychological Association, for example, admits that homosexuals are not 'born that way,' but then its leaders refuse to investigate the family and social factors that shape sexuality." Nicolosi called the American Psychological Association's "political control over the free flow of ideas ... oppressive," claiming the organization is "less of a scientific group than a professional trade guild whose goal is to advance a liberal political agenda within our society." Leaders like Judd Marmor have marginalized and disrespected the religious values of clients who viewed their homosexuality as immoral behavior. Nicolosi claimed these leaders "overstep their bounds." Furthermore, liberal leaders have incorrectly assumed that their professional organizations knew "something definitive about the purpose of human sexuality of which a religious belief system is ignorant."[126]

The liberal one-sided worldview of the mental health associations has been adopted by most public and private universities. Nicolosi contended that "in the vast majority of graduate programs in clinical psychology, students are taught that homosexuality is part of a person's core nature."[127] The gay political influence has resulted in it becoming academically "fashionable" to neither discuss possible causation factors of homosexuality other than genetic or endocrine, nor to discuss the unhealthiness of the homosexual lifestyle.[128] Reparative therapists who study homosexuality have been frustrated because there is "a weaker review process screening gay and lesbian studies before publication, while research that contradicts the aims of gay activism (that is, studies showing that homosexuals can change) is discouraged or actively excluded from

professional journals." At the turn of the century Nicolosi was convinced that the American Psychological Association "is not interested in studying the family and social influences that lead to a homosexual identity" because "gay activists in the association do not want them to."[129]

At the time Nicolosi was writing his 2009 volume on homosexuality the only debate within the mental health associations on homosexuality was: "Should treatment for unwanted homosexuality be considered *permissible?*" Nicolosi has responded harshly to that debate. He asserted that the push within the mental health associations "to outlaw treatment for unwanted same-sex attractions is in striking violation of contemporary liberalism's own professed commitment to diversity." Nicolosi also lamented that only a few members of his profession "have had the courage to speak up for a true diversity of worldviews."[130]

Closing Evaluations

Similarities between gay affirmative psychotherapy and reparative psychotherapy

Despite the chasm of division between reparative psychotherapy and gay affirmative psychotherapy, there are some similarities. The foremost similarity is the importance of the therapeutic alliance with the client. Besides the fact that the therapeutic alliance is important in psychotherapy, it appears that for many clients with same-sex attractions the relationship with the therapist is often the first deep mutual relationship

with another person of the same sex. Reparative therapists attribute this most often to the defense of dissociation personality trait linked to the child's rejection of the same-sex parent, while gay affirmative therapists would likely attribute this to the false-self personality developed as a defense against homophobic pressures. For many homosexual clients it is the first time a significant other sincerely cared what they thought and how they feel. Once trust is established the client learns through interaction with the both the gay affirmative and the reparative therapist how to function in a healthy mutual relationship. Both psychotherapy types promote this relational skill as well as give the client confidence that they are valued as a person. From a negative perspective, in both types of therapy the client may be prone to say things and behave in ways he thinks will please the therapist, rather than from a true change in the self.

Both reparative therapists and gay affirmative therapists state "that their clients report significant growth in self-esteem," and both "agree on what the homosexual man needs and desires: to give himself permission to love other men. However, gay affirmative therapy works within the gay ideology of eroticization of these relationships," while reparative therapy sees the needed love as brotherly bonding and man-to-man affirmation. Reparative therapists and gay affirmative therapists also agree that a homosexual's "coming out means not just admitting one's homosexuality to oneself and others, but taking leave of the dominant heterosexual culture." But where the gay affirmative therapist sees this as a healthy adjustment, the reparative therapist sees the coming out "reacculturation" as expanding his defense of dissociation "on a social scale."[131]

Another similarity between reparative therapy and gay affirmative therapy is that potentially there is no end to the transformation process of the client. "In his final work, 'Analysis: Terminable and Interminable,' Freud concluded that analysis is essentially a lifetime process."[132] Reparative psychotherapy associates homosexuality with its pleasure reward as similar to alcoholism or a sexual addiction. It also considers homosexuality similar to self-esteem problems and as such overcoming homosexuality "requires an ongoing growth process."[133] Rather than "cure," reparative therapist Joseph Nicolosi referred to successful therapy as "'change,' a meaning shift beginning with a change in identification of self."[134] The successful reparative psychotherapy client will usually have some homosexual desires that "will persist or recur during certain times in the life cycle."[135] The conditioned unconscious reflex of switching to a defense of dissociation will be triggered at certain times, but cognitively the client will have learned to identify the triggers. Reparative therapists explain the recurring unconscious reflex and homosexual desires with science. Behavior patterns and working through traumatic memories can lay down new neurological pathways on top of the old, but underneath the old neurological pathways still remain.

Gay affirmative therapist Alan Malyon qualified cure by stating that "conflict resolution is never complete, nor is psychological growth a process with finite limits."[136] Another gay affirmative therapist, Jack Drescher, stated that "when one is gay in a heterosexual world ... coming out is an ongoing process that potentially never ends."[137] All the triggers that are attributed to internalized homophobia remain in the client. Similar to reparative therapy, new neurological pathways can be laid down, but the old still remain. A gay affirmative psychotherapy often lasts five years or more, with some

lasting over ten years. In addition Malyon's gay affirmative model suggests that a second round of psychotherapy is often needed when the gay identified male becomes more concerned with existential issues in his 40s and 50s. Liberation psychology brings the existential element to the younger homosexual by giving them purpose and meaning through gay liberation politics, but even the gay liberation existential purpose is viewed as a life-long process.

Perhaps the one philosophical tenet that both reparative therapists and gay affirmative therapists agree upon completely ensures that their division will never end. Gay affirmative therapist Jack Drescher has stated that as far as the culture views homosexuality, "neither science nor psychoanalysis are capable of deciding this question as a moral issue."[138] Liberation psychology advocates Glenda Russell and Janis Bohan "concur that scientific evidence cannot 'prove' values or provide criteria for judging the superiority of one value over another." In addition they argue that "it is impossible not to bring values to matters of public policy; there is no value-neutral position in such debates – and those debates do occur in and affect the lives of psychotherapy clients."[139]

Reparative therapist Joseph Nicolosi made a similar statement in arguing that science cannot prove that homosexuality is normal. "The concept of 'who we are' – what is normal, healthy, adaptive, self-actualizing or high-functioning in a fully human sense – is not ultimately a scientific concept but a philosophical concept. ... Science is blind to the human spirit. It cannot tell us about our core identity – who we are."[140] Psychiatrist Jeffrey Satinover and friend of Nicolosi articulated the normal and moral question. "Individual professionals and the organized professional guilds are no more capable of deciding whether *any* trait – including homosexuality – is *consensually desirable or*

undesirable to society than any other citizens or groups. If people agree to consider homosexuality to be undesirable, then it is consensually undesirable. This does not necessarily make it an illness, for to be an illness it would also need to be associated with identifiable abnormalities. But neither does it not being an illness inevitably make it desirable."[141]

Differences between gay affirmative psychotherapy and reparative psychotherapy

The differences between gay affirmative psychotherapy and reparative therapy remain significant and at times polar opposites. At the core of the division are the differing causation models which reflect the differing opinions on whether homosexuality is inherently a healthy sexual orientation. Gay affirmative psychotherapy "regards homosexuality as a non-pathological human potential"[142] or "normal variant"[143] to be defended. They account for the many pathological aspects of homosexuality by attributing their causation to society's longstanding prejudice against homosexuality as a perverse behavior. In contrast reparative psychotherapy views homosexuality as often being a symptom of a variety of psychopathological problems related to same-sex acceptance and identity. Reparative therapists acknowledge that society's bias against homosexuality can create anxiety in a homosexual, but they believe that clinical science has shown that most of the psychopathological problems associated with homosexuality have their origins in childhood trauma. As such reparative psychotherapy views homosexuality as inhibiting an individual's human potential. In a similar way a reparative psychotherapy definition of maturity includes a "secure gender identity" based on the

person's biological gender, in contrast to the gay movements "drive to destabilize the categories of sex and gender."[144]

The core theoretical differences determine each side's view of the person with unwanted same-sex attractions. Gay affirmative therapists rationalize that the reason the same-sex attractions are unwanted is because the individual "found the heterosexual marginalization of gay life to be unbearable."[145] The gay affirmative philosophy's only acceptable cause of an individual's unwanted same-sex attractions is society's disapproval of homosexuality. Reparative therapists view clients that come to them with unwanted same-sex attractions as individuals "whose deeply held values and sense of self prevent them from embracing a gay identity." In their own way homosexuals seeking reparative psychotherapy "express the conviction that gay sex doesn't 'work' – it never satisfies their inner longings, and it doesn't reflect who they are as gendered beings."[146] These differing views are polar opposites and irreconcilable.

The differing psychotherapies both work through shame, guilt, and dissociation, but with different philosophical approaches. For the gay affirmative therapist the shame and guilt the homosexual feels are reflections of his internalized homophobia brought upon him or her by a prejudiced society. The therapist empathizes with the client and soothes the client with the interpretation that homophobia is the cause of the pain associated with their shame and guilt. Dissociative personality characteristics are interpreted to the client as resulting from not fully embracing their homosexual human potential. The gay affirmative therapist explains to the client that his individual efforts to conform to the dominant heterosexual society created a false self that needs to be abandoned in order to build a positive gay identity. Therefore, a positive gay identity is a

major indicator of the successful resolution of shame and guilt in gay affirmative psychotherapy.

Reparative psychotherapists see the shame and guilt felt by the majority of their homosexual clients as related to their unsuccessful bonding with the same-sex parent and peers, which resulted in a deficit in the man's masculinity or the woman's femininity. The client's homosexuality is usually viewed as a reparative effort to fill the deficit, sometimes interpreted as "a narcissistic solution to the shame problem."[147] Both shame and guilt are worked through by the therapist empathizing with the client, interpreting the cause of the shame or guilt, and at the deepest psychological level sitting with them as they grieve. Through a good therapeutic alliance and the resolution of the defense of dissociation disorder, shame and guilt diminish. A major sign that shame and guilt have been resolved through reparative psychotherapy is when the man begins a new identity that no longer needs to idealize or deprecate men.

A major divide lies between the way gay affirmative's liberation psychology uses the client's anger and how reparative psychotherapy's Affect Focus Therapy tries to resolve it. With the ultimate purpose being to change the oppressive heterosexual culture, liberation psychology advises the therapist to hold the client's "anger so that it can be borne, then that anger can be used as energy to commit to a cause, without consuming the bearer."[148] When this tactic is associated with helping the homosexual through his "second epoch adolescence" it is eerily similar to the brainwashing of adolescents being groomed for war by a political regime. In contrast Affect Focused Therapy views anger as a feeling growing out of fear and directly associated with the feeling of sadness. While the client's anger at himself is considered "self-defeating and shame-evoking," the client

is encouraged by the therapist to express his anger at other objects. In one aspect transference anger toward the therapist can be used to develop relational attachment-detachment-reattachment skills and self-confidence. On a deeper level Affect Focused Therapy directs anger and sadness into grief work leading in turn to psychological healing.[149]

Gay affirmative psychotherapist Alan Malyon regarded "oppression and anti-homosexual attitudes to be just two of the many factors that influence the process of personality and psychological adaptation."[150] Malyon stated that gay affirmative psychotherapy "also appreciates the equally salient contributions of other pathogenic variables."[151] The impression promoted by Malyon was that gay affirmative psychotherapy objectively considers all the environmental factors of psychopathological maladaptation. But the bias of gay affirmative psychotherapy does not allow the possibility that homosexuality can be a psychopathological maladaptation.

An objective view of personality and behavior maladaptations must consider the possibility that the homosexual condition can be a maladaptative condition caused by psychopathological factors. In contrast to the gay affirmative therapists, reparative therapists search for possible pathogenic origins of a client's same-sex attractions. A client's false-self personality can often be traced back long before they turned into same-sex attractions, giving the client a more comprehensive interpretation to contemplate. The discovery of pathogenic origins to homosexuality gives the reparative therapist psychotherapeutic options the gay affirmative therapist does not use or even acknowledge as psychotherapeutic. If a male client lacks masculine identity, the reparative therapist can help him develop a masculine identity, rather than a gay identity. If the client has

never received the love he needed from his father, the reparative therapist can support him through the process of recognition, in grieving the loss, and model the good father.

Gay affirmative psychotherapy does not disguise its bias that homosexuality is as healthy as heterosexuality or that the traditional norms of sexuality are relics to be discarded. The post-1973 paradigm acknowledges that it has cultural and political bias. Malyon stated in 1983. "In the past, psychotherapy was regarded as value-free; it is no longer presumed to be so. Values and attitudes influence virtually every aspect of the treatment process."[152] Glassgold wrote in 1995 and in 2007 that "human sexuality, personal identity, and psychotherapy are not independent from society and are neither universal nor politically neutral."[153] Drescher acknowledged that "any discussion of the definition of gay is inseparable from social and political attitudes about same-sex relationships."[154] The relativist morality of gay affirmative therapists like Drescher claims that all forms of consensual aberrant sexual behavior should be valued equally by society.

Reparative therapists' value systems differ from gay affirmative therapists. Reparative therapists affirm a client's value system that sees homosexuality as a sexual behavior to be avoided, whereas gay affirmative therapists see that belief system as homophobic and in need of destruction. Reparative therapy also sees modifying sexual behavior to traditional norms a valid psychotherapeutic goal, compared to gay affirmative therapy's relativist view of sexuality and distain for traditional sexual norms. Clearly, reparative therapy offers therapeutic alternatives that gay affirmative therapy does not. On the other hand, if the client wants to identify as gay, reparative psychotherapy views that choice as less than optimal and does not support the illusion of clients who believe

they were "born that way." Reparative therapists will, however, work on "problems of living" with gay-identified individuals when the precondition is agreed upon that the issue of sexual identity change will not be addressed.[155] Reparative therapists have strived to remain objective as psychotherapists, but Nicolosi has argued that reparative therapists need to counter the gay affirmative therapists by speaking up to defend their own worldview "that humanity was designed for heterosexuality."[156]

Although reparative therapists do not agree with much of gay affirmative psychotherapy, they support the principle of diversity of views and psychotherapies. Reparative therapists have not called for the banning of gay affirmative psychotherapy. In contrast, many gay affirmative therapists have expressed the opinion that reparative psychotherapy should be prohibited.

Notes

[1] Drescher, *Psychoanalytic Therapy*, 153.

[2] Nicolosi, *Shame and Attachment Loss*, 26.

[3] Marmor, Preface to *Homosexual Behavior*, xi.

[4] Marmor, *"Overview:The Multiple Roots," 5,10.*

[5] Marmor, "Epilogue: Homosexuality," 395.

[6] Marmor, *"Overview:The Multiple Roots,"18-9.*

[7] Ibid.

[8] Marmor, "Clinical Aspects," 276.

[9] Ibid., 274.

[10] Green, "Patterns of Sexual Identity," 265.

[11] Marmor, "Epilogue: Homosexuality," 1980, 396.

[12] Socarides, *Homosexuality – Psychoanalytic Therapy*, 2.

[13] Ibid., 63, 66, 75-6.

[14] Ibid., 67, 70, 72.

[15] Ibid., 71, 486.

[16] Ibid., 412, 416.

[17] Ibid., 465.

[18] Ibid.

[19] Silverstein, "Wearing Two Hats," 18-9, 24-5.

[20] Ibid., 23.

[21] Malyon, "Psychotherapeutic Implications," 59-61.

[22] Ibid., 60-1.

[23] Ibid., 61-2, 66.

[24] Silverstein, "Wearing Two Hats," 23.

[25] Malyon, "Psychotherapeutic Implications," 62, 64, 66.

[26] Ibid., 64-5.

[27] Ibid., 66-7.

[28] Ibid., 63, 67-8.

[29] Ibid., 63, 69.

[30] Drescher, *Psychoanalytic Therapy*, 3, 105, 107, 148, 256.

[31] Ibid., 154, 172-4.

[32] Ibid., 174, 328.

[33] Ibid., 217, 222-3.

[34] Ibid., 40-1.

[35] Ibid., 261. Drescher identified H. S. Sullivan's sexual orientation as a "closeted gay man" on page 260.

[36] Ibid., 293, 315-8.

[37] Ibid., 214, 231-2, 237, 242.

[38] Ibid., 250. Drescher credits this observation to an article by J. Hunter and R. Schaecher entitled "Gay and Lesbian Adolescents," published in *Encyclopedia of Social Work*, ed. R. Edwards and J. Hopps. Washington, D.C.: NASW Press, 1995, pp. 1055-1061.

[39] Ibid., 245-6.

[40] Ibid., 47.

[41] Ibid., 214, 231-2, 237, 242.

[42] Ibid., 250. Drescher credits this observation to an article by J. Hunter and R. Schaecher entitled "Gay and Lesbian Adolescents," published in *Encyclopedia of Social Work*, ed. R. Edwards and J. Hopps. Washington, D.C.: NASW Press, 1995, pp. 1055-1061.

[43] Glassgold, "In Dreams Begin Responsibilities," 45.

[44] Ibid., 45-6, 48.

[45] Ibid., 47-9.

[46] Ibid., 51.

[47] Russell and Bohan, "Liberating Psychotherapy," 67-9.

[48] Ibid., 70-1.

[49] Nicolosi, *Reparative Therapy*, 19-20, 104-5.

[50] Moberly, Preface to *Homosexuality: A New Christian.*

[51] Nicolosi, *Reparative Therapy*, 57-8.

[52] Ibid., 58-9.

[53] Ibid., 34.

[54] Ibid., 106, 110, 113.

[55] Ibid., 20-1, 99, 150, 176, 183, 185, 200.

[56] Ibid., 158-61.

[57] Ibid., 191-2, 194, 209, 269-70.

[58] Ibid., 219-21.

[59] Ibid., 165, 167.

[60] Nicolosi, *Shame and Attachment Loss*, 128-9, 138.

[61] Ibid., 34-5.

[62] Ibid., 31, 350-1.

[63] Ibid., 31, 78.

[64] Ibid., 98-9, 133, 353.

[65] Ibid., 129, 134, 136-8.

[66] Ibid., 150.

[67] Ibid., 150, 153-5, 159, 167.

[68] Ibid., 167-9. Nicolosi's reference to K. Bühler was his book *Theory of language: The representational function of language.* Philadelphia: John Benjamins, 1990.

[69] Ibid., 146, 209, 212, 267.

[70] Ibid., 141, 207, 241.

[71] Ibid., 132, 353.

[72] Ibid., 353, 358-9.

[73] Ibid., 353, 358-9, 366.

[74] Ibid., 367.

[75] Ibid., 114, 418, 432.

[76] Ibid., 367, 373-4, 376.

[77] Ibid., 375, 432.

[78] Ibid., 404, 433, 438.

[79] Ibid., 442-3.

[80] Ibid., 445-7.

[81] Ibid.

[82] Ibid., 444, 447-9.

[83] Ibid., 287-8, 294, 298-9.

[84] Ibid., 287, 300-1.

[85] Ibid., 288-9.

[86] Ibid., 290-1, 299, 301.

[87] Ibid., 297.

[88] Nicolosi and Nicolosi, *Parent's Guide*, 122.

[89] Nicolosi, *Shame and Attachment Loss*, 288.

[90] Nicolosi and Nicolosi, *Parent's Guide*, 14.

[91] Ibid., 25, 48.

[92] Ibid., 82, 194.

[93] Ibid., 29-30, 79, 186, 190.

[94] Ibid., 29, 78.

[95] Nicolosi, *Reparative Therapy*, 50-1.

[96] Nicolosi and Nicolosi, *Parent's Guide*, 80.

[97] Ibid., 24, 82, 89.

[98] Ibid., 75-7.

[99] Ibid., 92.

[100] Ibid., 155-7.

[101] Ibid., 15.

[102] Ibid., 111.

[103] Nicolosi, *Reparative Therapy*, 135.

[104] Ibid., 137-8.

[105] Ibid., 138. The 1977 quote that Nicolosi referenced was from an article by S. Morin in the *American Psychologist* 32:629-637 entitled "Heterosexual bias in psychological research on lesbianism and male homosexuality."

[106] Ibid., 138.

[107] Ibid., 221-2.

[108] Ibid., 15, 142.

[109] Ibid., 133.

[110] Nicolosi and Nicolosi, *Parent's Guide*, 181.

[111] Nicolosi, *Reparative Therapy*, 123. Nicolosi attributed this observation to the book *The Joy of Gay Sex* authored by Charles Silverstein and E. White, New York: Crown, 1977.

[112] Silverstein, "Wearing Two Hats," 19-20.

[113] Nicolosi and Nicolosi, *Parent's Guide*, 52-3. Nicolosis' comment about Justin Richardson is based on his article in the *Harvard Review of Psychiatry* 4 (1996): 49-53, entitled "Setting Limits on Gender Health."

[114] Nicolosi, *Shame and Attachment Loss*, 26.

[115] Nicolosi and Nicolosi, *Parent's Guide*, 132.

[116] Nicolosi, *Shame and Attachment Loss*, 294-5. The survey was called *Sex in America* and the results were published as *The social organization of sexuality: Sexual practices in the U.S.*, Chicago: University of Chicago Press, 1994. The authors were E. O. Laumann, J. H. Gagnon, R. T. Michael, and S. Michaels.

[117] Ibid., 295. The statistic quoted came from G. Remafedi, M. Resnick, R. Blum, and L. Harris, "Demography of sexual orientation in adolescents," *Pediatrics (1992)*, 89, 714-21.

[118] Ibid., 295. Nicolosi also shared this concern in an earlier book *A Parent's Guide to Preventing Homosexuality, 123-4.*

[119] Nicolosi and Nicolosi, *Parent's Guide*, 12, 34.

[120] Ibid., 121.

[121] Drescher, *Psychoanalytic Therapy*, 152-3.

[122] Ibid., 170, 181-2.

[123] Ibid., 113, 145, 161.

[124] Ibid., 180.

[125] Ibid., 179, 185, 189.

[126] Nicolosi and Nicolosi, *Parent's Guide*, 17, 166, 170.

[127] Ibid., 167.

[128] Nicolosi, *Reparative Therapy*, 10.

[129] Nicolosi and Nicolosi, *Parent's Guide*, 58, 60.

[130] Nicolosi, *Shame and Attachment Loss*, 20.

[131] Nicolosi, *Reparative Therapy*, 143-5.

[132] Ibid., 22.

[133] Ibid.

[134] Ibid., 165.

[135] Ibid.

[136] Malyon, "Psychotherapeutic Implications," 63.

[137] Drescher, *Psychoanalytic Therapy*, 294-5.

[138] Ibid., 162.

[139] Russell and Bohan, "Liberating Psychotherapy," 61.

[140] Nicolosi and Nicolosi, *Parent's Guide*, 168.

[141] Satinover, *Homosexuality and the Politics*, 43.

[142] Malyon, "Psychotherapeutic Implications," 62.

[143] Drescher, *Psychoanalytic Therapy*, 26.

[144] Nicolosi and Nicolosi, *Parent's Guide*, 67.

[145] Drescher, *Psychoanalytic Therapy*, 174.

[146] Nicolosi, *Shame and Attachment Loss*, 17, 20.

[147] Ibid., 33-4.

[148] Glassgold, "In Dreams Begin Responsibilities," 51.

[149] Nicolosi, *Shame and Attachment Loss*, 163-5.

[150] Malyon, "Psychotherapeutic Implications," 62.

[151] Ibid., 69.

[152] Ibid., 63.

[153] Glassgold, "In Dreams Begin Responsibilities," 46. The reference was from an essay entitled "Psychoanalysis with lesbians: Self-reflection and agency" from the book *Lesbians and Psychoanalysis: Revolutions in Theory and Practice*, 203-227, edited by J.M. Glassgold and S. Iasenza, New York: Free Press, 1995.

[154] Drescher, *Psychoanalytic Therapy*, 39.

[155] Nicolosi, *Shame and Attachment*, 25.

[156]Ibid., 26.

Chapter 9

Related Developments in the Treatment of Homosexuality

1983-2012

"From the 1990s to the present, there has been common ground between traditional psychiatry, psychological practice and gay people. This is mainly due to the work of gay psychiatrists within the American Psychiatric Association and local associations of gay psychiatrists."[1]

Charles Silverstein (2007) – gay psychologist

"Psychology, psychiatry, and social work have been captured by an ultraliberal agenda, much of which we agree with as citizens. However, we are alarmed with the damaging effect it is having on our science, our practice, and our credibility."[2]

Nicololas Cummings (2005) – psychologist - appointed the first Task Force on Lesbian and Gay Issues while he was president of the American Psychological Association in 1979[3]

Opening note

This chapter will look at selected developments in the treatment of homosexuality and the conflict over the treatment of homosexuality. The insights selected come from a variety of sources including the ex-gay movement, a new framework for treating homosexuality called "sexual identity therapy," and current AIDS statistics and policies. Also included is a review of two controversial studies by mental health professionals that were key players in the effort to remove homosexuality from psychiatry's list of disorders. The chapter will end by describing some of the goings on in the American Psychiatric Association and the American Psychological Association concerning the conflict over the treatment of homosexuality. Although this chapter is not an exhaustive review of all that has transpired in the conflict over the treatment of homosexuality, the selected developments are comprehensive enough to give the reader a good view of the big picture.

Progression of the ex-gay movement's therapies

Elizabeth Moberly's impact

When psychologist Elizabeth Moberly presented her homosexual etiological theory of "defensive detachment" in 1983, the audience she intended to reach appeared to be Christian counselors and church leaders, more so than secular psychotherapists. Moberly's defensive detachment theory of homosexuality holds that "any incident that happens to place a particular strain on the relationship between the child and the parent of the same sex is potentially causative." In that respect the book provided both a major psychoanalytic advancement in the reparative psychotherapy for homosexuality and a

new direction in religious based treatments for homosexuality. The title of her book outlining the defensive detachment theory is *Homosexuality: A New Christian Ethic.* Moberly's message to Christian churches and their counselors was that they wrongly focused on the homosexual behavior. With defensive detachment from the same-sex parent ascertained as a causative factor in many cases of homosexuality, Moberly argued that homosexual behavior should be seen as the person trying to satisfy legitimate same sex needs in an inappropriate way. The real problem was the defensive detachment disorder of the personality and the unfulfilled need for same-sex attachment. Moberly declared that the appropriate response from church leaders "is not hostility, fear, or bewilderment, but compassion."[4]

Religious leaders had been and still are divided on the issue of homosexuality. The religious division over homosexuality differs substantially from the professional division. The differences between the religious views of homosexuality tend to revolve around whether homosexual acts are legitimate (not sinful) or illegitimate (sinful). The conservative approach in the church had been focused on stopping the homosexual behavior without fulfilling the unmet needs of same-sex attachment. The liberal approach in the church was to affirm the eroticization of same-sex desires without recognizing the fact that the unmet attachment needs of the homosexual are not sexual. Moberly's argument was that both sides of the religious division over homosexuality were wrong. She conceded that any objective biblical study on homosexual behavior must conclude "that homosexual acts are always condemned and never approved," but the internal force driving same-sex attraction is a legitimate need to fulfill unmet same-sex attachment bonds.[5]

A major contradiction confronted Moberly's criticism of the liberal approach to affirm the same-sex eroticization. If the homosexual has a deficit related to same-sex attachment, why doesn't a homosexual relationship fulfill that deficit? Moberly gave three reasons why a 'stable' homosexual relationship will not resolve the same-sex deficit of the homosexual. The first is that the deficits carried by each partner in a homosexual relationship are similar and therefore render each "less able to meet the other person's needs." Second, the deficits of each adult partner often include deep dependency needs related to childhood. "Thirdly, and most significantly, the defensive detachment that was originally responsible for checking the normal process of growth may re-emerge and disrupt the renewed attachment." Moberly argued that a long-term homosexual relationship "indicates only the continuing lack of resolution of same-sex deficits."[6]

Based on her causative theory of arrested psychological development, Moberly articulated that the church should be treating the troubled homosexual like they are supposed to treat the orphan. She pointed out that people are not born homosexual or heterosexual. People are not born as adults either. The goal of human development to adulthood and same-sex identity is "not something given 'ready-made' right from the start." Therefore, Moberly contended, the goals of Christian ministries to homosexuals should be to help them develop into healthy heterosexuals similar to how they are to help orphans develop into healthy adults. A healthy heterosexual was defined by Moberly as having the ability to relate to both sexes, not just to the opposite sex, "as a psychologically complete member of one's own sex." Moberly suggested that Christian ministries pursue the same twofold goals of conventional therapy: to undo the defensive detachment toward the same sex and to make up for the unmet needs that were bypassed

consequent to the defensive detachment. In addition, Christian ministries should offer the healing power of forgiveness and prayer. [7]

Moberly affirmed that the relational deficit of the homosexual implies "the need for corrective interpersonal experience" solved through relationships. She contended that "relationships are the normal medium for psychological growth within the purposes of God." She challenged the church to be willing to provide the "good non-sexual relationships" that homosexuals need to fulfill their unmet same-sex attachment needs. Her recommendation was that the person willing to be in a close same-sex friendship with the troubled homosexual be secure in their heterosexuality. In addition to meeting the same-sex attachment need of the homosexual, Moberly advised that there is "a particular need for the healing of memories" and a mourning process related to the past. While the lay person can help heal unmet attachment needs, a Christian counselor or psychologist may be needed to help the homosexual undo their defensive detachment and mourn the losses of the past.[8]

Moberly also argued that the "suppression of homosexual acts cannot be equated with healing." Healing for the homosexual happens when the defensive detachment is undone and "unmet same-sex needs have been fulfilled," through good non-sexual relationships. The goal for Christian ministries to troubled homosexuals "is not change as such, but fulfillment – a fulfillment that would in turn imply change."[9]

Moberly's new Christian ethic used her defensive detachment theory, along with psychotherapeutic principles, to offer practical application principles for counselors and ministers to use. Her theory of defensive detachment was constructed on solid

psychoanalytic and attachment theory concepts. How many religious leaders were influenced by her theory and new Christian ethic is not known.

Leanne Payne's impact

An organization called Pastoral Care Ministries founded by Leanne Payne has had a substantial influence on many of the Exodus affiliate ministries where former homosexuals help others with unwanted same-sex attractions. Her books have resonated with those seeking to follow the God of the Bible and who are troubled by their homosexuality. *The Broken Image* was published in 1981 and *Healing the Homosexual* was published in 1984. Pastoral Care Ministries is a self-described "healing ministry," not physical healing but healing of memories.[10]

Payne's healing ministry is based on the recognition that deep psychological wounds may "lie unrecognized and out of sight." In that respect it shares similarities with depth-psychology, according to psychiatrist Jeffrey Satinover. "From the perspective of depth-psychology, parts of the self are routinely split off from our conscious awareness primarily in response to early emotional wounds." These splits are "one of the most common ways" in which people protect themselves "from the painful memory of the wounding itself." Secular therapists "believe that through sufficient inner examination all these wounds and all their consequences can be undone – by human effort alone." Satinover believes that secular therapists are "too optimistic" in that belief and sees advantages to religious based ministries like Payne's, which associate healing with "the forgiveness of sin." Accordingly, Payne's approach to healing "pays careful attention to the specific origins of psychological brokenness but also to the necessity of genuine,

healing prayer. ... A feature of *healing* prayer as applied to psychological difficulties is that it requires a deep and careful articulation of the problem to be laid before God. Healing prayer thus incorporates the kind of psychological insight that is at the heart of the best secular psychotherapy."[11]

For those who believe in the God of the Bible another factor in the treatment of homosexuality comes into play - God Himself. "Healing of memories therefore departs from secular psychological theory in two critical ways: healing is, first, made far more likely because of openness to God; and, second, healing itself is effected by God. Both of these processes depend on something even more fundamental, which is necessarily lacking in a secular treatment setting – the conviction that conscience is genuine and absolute and not merely the internalization of parental and societal norms."[12] The pragmatic point of Payne's ministry is that many individuals have overcome homosexuality, psychic wounds, and unwanted behaviors through these healing of memories ministries.

Andrew Comisky's impact

Many ex-homosexuals have written books on their process of overcoming homosexuality. One of the most influential was *Pursuing Sexual Wholeness* by Andrew Comiskey. Comiskey states that his "life as a homosexual was neither miserable nor guilt-ridden. It simply wasn't whole." Comiskey claimed that God healed him through a "painful and exhilarating" four year step-by-step process." What makes Comiskey so influential is that he developed the "Living Waters – Sexual Redemption in Christ"

treatment program based upon his book about his coming out of homosexuality. It is used by many of the two hundred plus Exodus affiliates.[13]

Comisky's model of ministry was influenced by Leanne Payne, Elizabeth Moberly, and former homosexuals who were leaders of Exodus. The first priority of *Living Waters* is to help the person build a relationship with Jesus. By building "a mature and stable friendship with Jesus," the homosexual in the *Living Waters* program "can form mature and stable friendships with others." Viewing this process as an outsider it looks like the *Living Waters* participant learns relationship skills through their relationship with Jesus, but it is more than that. The ultimate purpose of all Christian relationships is to be centered on Jesus.[14]

Comisky leaned heavily on Moberly's work regarding the importance of establishing healthy same-sex friendships to meet the homosexuals unmet needs of same-sex attachment. The insight Comisky has to offer comes from his own experience in trying to establish those healthy relationships. Comisky warns the person trying to overcome homosexuality not to set up another same-sex friend as an "emotional messiah."

Comisky had his own struggles of trying to make a same-sex friend "the sum total" of his need for his father's love. He overcame that obstacle by prayerful confession and repentance of the illusion, and succumbing to the reality that his friend could not complete him. Almost immediately after Comisky prayed he began to realize that his friend was not exclusively his. Comisky began encouraging his friend "to grow into the fullness of his true heterosexual identity" and began to see the friend as a man "who

could go far in his own relational and spiritual development," with or without him. Comisky realized that he did not need to share his neediness struggle with the friend and did not. He shared the neediness struggle in prayer and slowly Comisky became "less of a needy child" to his friend and more of an adult friend. Comisky learned to love his same-sex friend in such a way that brought his friend closer to God, which in turn kept Comisky's childish tendencies in check and gave him "a healing source of acceptance."[15]

Alan Chambers' impact

Alan Chambers has been the president of Exodus International for approximately ten years as of the first quarter of 2012. Beginning in 2006 Chamber's began to qualify what kind of "change" can be expected when homosexuals seek change through Exodus ministries. The definition and semantics of what "change" is has continually been a point of contention in the division over the treatment of homosexuality. Being the president of the largest ex-gay organization in the world has put Chambers in the middle of that contentious debate.

Those who practice reorientation therapy repeatedly qualify that a successful reorientation change does not mean that the person will never have any same-sex attractions or thoughts in the future, but many troubled by their homosexuality want that kind of complete and total success. Gay activists, in turn, call anything less than the complete removal of same-sex attractions a fraudulent reorientation change. To his credit Chambers took the bold move of apologizing for any Exodus ministry in the past that may have led a participant to believe that change would include the removal of all same-sex attractions. He stated, "I believe that complete orientation change occurs very rarely.

For us to have integrity, I think it is important to acknowledge this." [16] Chambers honesty has led to criticism from Christian leaders, reparative therapists, as well as gay activists and gay affirmative therapists.

Chambers' marriage in 1998 followed the pattern described by reparative therapist Joseph Nicolosi. It was not lustful attraction that drew Chambers to his wife Leslie. It was her self-confidence, her smile and "intoxicating" laugh, and her initial resistance to acknowledging him. Chambers fell head over heels for the person in the woman, not the figure of the woman as most heterosexual men do. Chambers states that his same-sex temptations "aren't the same today as they were 20 years ago," but he still says he has temptations and struggles. Because he still has some level of same sex attractions he monitors what stimuli he receives. He explained that his monitoring of homosexual stimuli is similar to the monitoring he does related to food and materialism, which are other areas he has struggled with in the past.[17]

This next insightful paragraph by Chambers personalizes much of what he has experienced as change. "When it comes to orientation, attractions, desires, feelings or whatever word you choose to use, I think very little about them. They are what they are. I know them. I understand them. I know how to live with them. I also know a lot of the things that cause them to manifest. SSA [same-sex attraction] isn't a greater struggle or more concerning to me than other things in my life. Again, they just *are*. I guess that is why I have no problem talking about them, admitting them and feeling really great about myself even though I have them. They do not define me. Leslie isn't threatened by my SSA, either. She knows how I feel about my relationship with Christ first and how I feel

about her followed by our kids and so on. She isn't a surrogate for sexual acting out. She is my treasure and the object of my deepest human longings. Have I experienced change in my life? To be sure. And to be clear, the change is primarily a matter of seeking to live out what I value most. It is centered on who I am in Christ and flows outward in a way that is specific to me and doesn't contradict what the Bible teaches. The same was true for me as a single, celibate Christian man."

Chambers claims to be more of an expert "at needing a Savior" that an expert on homosexuality. His greatest desire is to point people to Jesus Christ. Although he leads a national organization with 266 independent affiliate organizations, he has pointed out that not everything he says or believes is necessarily what all the independent leaders say and believe. [18] Chambers compassionate and honest responses to the criticism and insults thrown at him are a testament to his faith.

Sexual Identity Therapy

The birth of sexual identity therapy

In 2006 two psychologists, Warren Throckmorton and Mark Yarhouse, published guidelines to a new therapeutic approach for those people distressed or confused over their homosexual attractions. Both men had counseled people with same-sex attractions and studied the research on homosexuality. Some of the clients Yarhouse had worked with had been in sexual reorientation therapies or Christian ministries to change their sexual orientation and had not experienced "as much success in their change effort as

they were led to believe was possible." Many of these clients felt that they either were going to change their sexual orientation or they were destined to be gay. "They did not feel another option was available to them." Yarhouse's motivation was to explore a way of psychotherapy that respected the clients values and beliefs and yet allowed for a direction "that was meaningful even if their sexual orientation did not change."[19]

Throckmorton desired to establish a set of guidelines in the treatment of homosexuality that would not "stigmatize same-sex eroticism or traditional values and attitudes." The two available alternatives in professional psychotherapy for people with same-sex attractions in 2005 were gay affirmative psychotherapy or reparative psychotherapy – polar opposites. Throckmorton argued that when people seek out a professionally trained counselor, they are often seeking "an unbiased relationship to discuss their conflicting values and feelings." The typical conflict is between the client's same-sex attractions and their religious beliefs or desire to be in a traditional marriage. Throckmorton's and Yarhouse's sexual identity therapy was designed to help the person troubled with this type of conflict make an informed decision on what sexual orientation they want to identify with, pursue that decision, and be respected whatever that outcome is.[20]

The neutral stance

The philosophy of sexual identity therapy is based on the health care ethic of the client's right to self-determination. Specifically, Throckmorton and Yarhouse sought to set guidelines that helped the client choose a direction of sexual identity without coercion from a therapist's biases. The sexual identity therapist is required to remain neutral

regarding the information he gives the client and to remain neutral when the patient makes a choice of sexual orientation that the therapist believes is not in his or hers best interest.

Client autonomy is something that all professional therapists should support, but most therapists will not help the client reach a goal they believe will harm the client. For example, the gay therapist believes it is harmful and disintegrative for a person with same-sex attractions to change their sexual orientation. Therefore, as gay affirmative therapists, they will not help a client try to change their homosexual orientation. Neither will gay affirmative therapists help a client integrate a value system that believes homosexual behavior is sin. Likewise, a reparative therapist will not help a client integrate a gay identity if that is what they seek to do. The reparative therapist will help the client with other psychological issues, but believes it is tragic to build a gay identity "around one's gender-identity incompleteness."[21]

Once sexual identity therapy has progressed to where the client has decided the sexual identity he or she will pursue, sexual identity guidelines give the therapist an out if their values strongly conflict with the client's values. That "out" is to refer the client to another therapist whose values or expertise mirror those the client seeks to identify with. Referral is recommended in these instances with the caveat that "referral may generate charges of discrimination and trigger legal or clinical exposure in certain cases."[22]

Sexual identity therapy framework

The first phase of sexual identity therapy is "assessment." Here the therapist helps the client understand himself and gives the client accurate information. The therapist

helps the client uncover his motivations, his moral convictions, his sexual attractions, and the conflicts between them. It is suggested that the therapist discuss the different versions of sexual attraction etiology and consider how an identification with one version or another would alter the direction of sexual orientation they would pursue or be comfortable with.[23] Obviously, whether a client believes they are born as a homosexual versus whether they attribute their homosexuality to their rejection of masculinity has a direct bearing on whether they will perceive a homosexual orientation as a healthy alternative.

Yarhouse offered a more detailed description of the sexual identity therapy assessment procedure he uses. First he clarifies the distinctions between "same-sex attraction, a homosexual orientation, and a gay identity" with the client. "Being gay," Yarhouse explains, is a "sociocultural label," a "self-defining identity label." Second, Yarhouse works with the client to analyze the factors that go into sexual identity and find what aspects of sexual identity the client feels are most important to him. Third, is "an 'attribution search' for identity." This is a process similar to gay affirmative therapist Jack Drescher's search for meanings. Yarhouse sidesteps any etiological factors that might be related to the homosexual desires and discusses with the client "how they make meaning out of their attractions." Some clients may cite etiological factors in their meaning, but the purpose of this focus is to continue the process of determining what is important to the client. "The fourth and final key" for Yarhouse is using all the knowledge gained to help the client "line up their behavior/identity and beliefs/values," which is called "congruence."[24]

Along with the concepts Yarhouse has outlined, the sexual identity therapist is supposed to provide detailed information about the client's sexual orientation options. For those conflicted between their homosexual attractions and their moral values, options include trying to change their attractions, living with sexual feelings they do not prefer, or modifying their moral values to accommodate their same-sex attractions. Sometimes clients do not choose a sexual identity direction right away. In that case the therapist remains supportive while the client contemplates their options and concerns.[25]

When the client is ready to pursue a particular sexual identity Throckmorton and Yarhouse recommended that an informed consent document be drawn up and signed by the client. In addition to the sexual identity direction that the client had chosen to pursue, they recommended that the consent form include the fact that "same-sex eroticism per se is not considered a mental illness by any of the major mental health organizations." Other recommended topics of the consent form included how the etiological questions were discussed and what the client thinks of his homosexual etiology. Another part of the form should state that there "are no well-designed, controlled outcome studies of reorientation therapies, gay affirmative therapies or sexual identity therapy." Religious based interventions may be an option for the client. In those cases the informed consent document should state that the research on that type of therapy is also obscure; some research shows it helpful and other research shows it harmful.

The therapeutic goal of the informed consent form was "to help the client make a truly informed decision." The legal objective was to protect the therapist in a

psychoanalytic area full of conflict. Throckmorton and Yarhouse called the informed consent phase "an ongoing process."[26]

Once the client has chosen a sexual identity direction, the therapist and client determine the type of psychotherapy to be used, or the therapist refers the client to another therapist more equipped to move the client to the sexual identity he has chosen. Particular schools of therapy like cognitive-behavioral or interpersonal can, dependant on the therapist, help the individual accept and acclimate to whatever sexual identity they choose,[27] although Throckmorton has stated that "reparative therapy per se is incompatible with sexual identity therapy."[28]

A successful sexual identity therapy involves a client finding comfort in the direction he has chosen as his sexual identity. Throckmorton and Yarhouse referred to this comfort as a 'synthesis of a sexual identity that promotes well-being and integration with other aspects of personal identity (cultural, ethnic, relational, spiritual, worldview, etc.)."[29]

Sexual identity, reparative, and gay affirmative therapies compared

The sexual identity therapy utilizes the constructs of cognitive behavioral therapy instead of attempting to resolve past traumas related to parent/child relationships (reparative psychotherapy). Sexual identity therapy clients are advised that "psychotherapy may not quickly or permanently eliminate all aspects of sexual identity conflict."[30] So this third option for those with distress associated with same-sex attractions shares the same questionable resolution as the other two. Reparative therapy does not usually remove all same-sex attractions. Gay affirmative therapy does not

usually remove all internalized homophobia. Likewise, sexual identity therapy does not usually remove all sexual identity conflict.

Although the sexual identity therapist does not necessarily look for homophobic causations to a client's reluctance to embrace his homosexual attractions, there are similarities to gay affirmative therapy in the assessment phase. The most obvious is the dismissal of the seventy years of clinical research on the etiology of homosexuality. Throckmorton and Yarhouse claimed to take "no position on the primary causes or factors associated with how or why sexual attractions take the direction they do for all people." They argued the research is still developing and provides only "a basis for tentative hypotheses."[31] While it is true that research is still developing and most likely always will be, primary causes have been sufficiently proven for many cases of homosexuality. Psychologist Elisabeth Moberly's experience with homosexuals led her to state that the deficits causing homosexuality were often surprisingly obvious.[32] Throckmorton and Yarhouse's dismissal of the etiological evidence is not sound in that respect and appears to be used to limit sexual identity therapy to a cognitive behavioral approach to therapy.

The goal of giving the client information to make a "truly informed decision" is worthy and needed, but how the information is presented is very subjective and easily distorted. For example, stating that the mental health organizations do not consider homosexual attractions a mental disorder is at the top of Throckmorton and Yarhouse's informed consent document. That is sure to please the American Psychiatric and American Psychological Associations along with the gay professionals, but a 'truly

informed decision' on the mental health organization's position includes knowing the politics that brought about that position. A truly informed decision includes knowledge that it is possible to be in a stable same-sex relationship as well as the knowledge that these relationships are less likely to remain stable and that stable may not include sexual fidelity. It would seem a truly informed decision would look at the known etiological factors of homosexuality and assess how, if any, they applied to the client. A truly informed decision must consider the reality that homosexuals not only have greater incidence of disorders and sexually transmitted disease, but that this greater incidence of disorders and disease is likely linked to the homosexual condition.

Currently, many reparative therapists give a detailed and accurate presentation of the facts to clients and they do help clients with more traditional values live with unwanted same sex attractions. Whether a sexual identity therapist gives more information to a client than a reparative therapist depends on the individual therapist. If the etiological factors of a client's homosexual attractions can be determined by a reparative therapist, then a reparative therapist will give a client more facts than the sexual identity therapist or the gay affirmative therapist.

Throckmorton and Yarhouse state that the role of the therapist to those under the legal age of consent is a "consultative role," advising the parents and adolescent that "uncertainty and/or confusion concerning sexual identity is not uncommon and that there should be no rush to declare a sexual identity at a young age."[33] This position seems to be a good strategy. It is comparable to a reparative psychotherapy approach, except a reparative therapist would advise the parents on ways to help their child identify with

their biological gender. In contrast, the gay affirmative therapist would urge the parent and the child to accept and encourage the gay alternative.

Sexual identity therapy has other similarities to reparative psychotherapy. Reparative therapists under Nicolosi's leadership encourage clients to "clarify and re-clarify the direction of their identity commitment," which is similar to sexual identity therapy. In addition, reparative therapists affirm the right of clients to pursue the sexual identity of their choice. For those clients that seek help in building a gay identity, Nicolosi has stated, "Gay-affirmative therapy should, of course, be available for any such client." Reparative therapists do not consider a gay identity a healthy sexual identity, but affirm gay identified individuals "in their right to define themselves as they wish."[34]

Throckmorton has discussed the neutral position of sexual identity therapy with reparative therapist Joseph Nicolosi. Nicolosi told Throckmorton that he found his approach "naïve and ultimately unworkable." In defending reparative psychotherapy over sexual identity therapy Nicolosi agreed with Charles Socarides' statement that "the therapist must be neutral in judging the client, his behavior, and his choices; but he cannot be neutral about the condition of homosexuality." Nicolosi contended, "When the therapist takes a 'neutral' position ('I see gay and straight as equally OK'), this dilutes the power of the transference and leaves the client feeling incompletely understood and incompletely supported."[35]

AIDS update

In 2011 the Center for Disease Control and Prevention (CDC) did a study that analyzed data from the National HIV Surveillance System from the beginning of the first cases of AIDS in 1981 through 2008. AIDS diagnoses and deaths rose sharply during the first fourteen years. From 1981 to 1995 the estimated annual number of deaths among persons with AIDS increased from 451 to 50,628. The figures declined after 1995 and leveled out from 1998 to 2008 to "an average of 38,279 AIDS diagnoses and 17,489 deaths per year respectively. ... At the end of 2008 an estimated 1,178,350 persons were living with HIV, including 236,400 (20.1 percent) whose infection was undiagnosed."[36] Of those living with HIV nearly 50 percent are gay men.[37] Another study conducted at Howard University Hospital in Washington in 1992 supported the troubling CDC undiagnosed statistic. The Howard University Hospital study found that "41 percent of the people who died there of AIDS had never been diagnosed with it."[38]

In all the CDC estimates that 617,025 people in the United States have died with AIDS through 2008, although they qualify that a person who dies with AIDS may possibly have died from some other cause. In 2009 the CDC estimated that there were 48,100 new infections of HIV in the United States, "most (61 percent) of these new infections occurred in gay and bisexual men."[39] The statistics specifically estimated that 23, 846 of the 41,845 new HIV diagnoses were given to homosexual men, while 4,399 of the new diagnoses were to heterosexual men who had sex with a woman known to be HIV positive or at risk, such as a prostitute.[40] The above referenced figures excluded male injection drug users, which were estimated at 3580 new diagnoses of HIV in 2009. Using the figures for males that did not inject drugs into their body, if homosexual men constituted 2% of the male population of the United States in 2009, a homosexual man

was 265 times more likely to get the HIV virus than a heterosexual man who had sex with women at high risk of HIV infection (.98 heterosexual males ÷ .02 homosexual males) x (23,846 new homosexual HIV ÷ 4,399 new heterosexual HIV) – (1). If homosexual men constituted 3% of the male population, then a homosexual man was 174 times more likely to become infected than a heterosexual man. Women, on the other hand, were mainly contracting HIV from heterosexual relationships with men known to have HIV or were at high risk of having it.[41]

Three decades after the outbreak of AIDS in the United States, "HIV infection is no longer inevitably fatal. Highly active antiretroviral therapy suppresses viral replication for decades, allowing patients to enjoy longer and healthier lives and making them less infectious to others." However, a late diagnosis of HIV infection dramatically increases the probability of early death.[42]

In 2011 the federal government's Office of National AIDS Policy had a national strategy that claimed to have refocused its "efforts toward intensified HIV *prevention* in communities where HIV infection is most prevalent, using a combination of effective strategies that seek to optimize entry into and retention in care and maintenance of viral suppression."[43] With the emphasis on the care and maintenance of viral suppression it appears the government is not refocused on prevention as it claimed. Instead, the government's refocus is on getting viral suppression drugs to those newly infected with HIV.

Two studies of special interest

A whole series of books could be written on the many studies and surveys done on homosexuality. Of interest to any academic review of these studies and surveys should be the bias of the researchers - what they set out to prove and why. Two particular studies on homosexuality are unique in that the researchers were both major players in the removal of homosexuality from psychiatry's list of disorders in 1973, and both their studies came to conclusions that were heavily criticized by gay psychoanalysts and gay activists. Psychiatrists Richard Green and Robert Spitzer still remained advocates of gay rights, but their published research undermined the normal variant foundational basis that homosexuality is not a disorder and it cannot be cured. Green's research supported the reparative psychotherapy theory that a dysfunctional family environment can be a major factor of homosexual causation. Even more revolting to gay psychoanalysts and gay activists, Green supported the rights of parents to clinical advice aimed at maximizing the possibility that their children develop a heterosexual orientation. In the other study, Spitzer's research simply sought to find out if individuals who identified as ex-gay really experienced a change in their sexual orientation. Because he concluded that most of the ex-gays he questioned did experience sexual orientation change in varying degrees, he too was vilified by gay psychoanalysts and gay activists.

Richard Green's "sissy boy syndrome" (1987)

Richard Green's major contribution in the early 1970s, according to Bayer's historical account of the American Psychiatric Association saga, was the philosophical accusation that the clinical evidence of those who saw homosexuality as a disorder should be dismissed on the grounds that the clinicians had "heterosexual biases."[44]

Green's accusation was a derivative of psychologist Robert Lindner's (1955) and psychiatrist Thomas Szasz's (1970) philosophical revelation that psychiatrists and physicians had assumed the societal moral authority that the clergy once held. To that effect Lindner and Szasz believed the medical profession was using its influence to uphold traditional morality by classifying aberrant behavior as mental disorders only because the behavior was different or considered sinful by the culture's religion. From that base Green rationalized that any clinical research by a clinician who upheld the concept of traditional morality must be irreparably biased. Accordingly, Green could be given the distinction of the creator of 'heterosexism.'

In 1987 Green published the results of his own fifteen year study of "44 extremely feminine boys" that he had "followed from early childhood to adolescence or young adulthood." Three-quarters of these feminine boys "matured as homosexuals or bisexuals, as against only one bisexual among a comparison group of more typically masculine boys." Green had originally thought that these extremely feminine boys would identify as transsexuals and was surprised that only one of the 44 became a transsexual.[45]

The feminine boys spurned rough-house play and sports, preferring to play with Barbie dolls for hours. They frequently donned female clothing and nearly always assumed "a female role when playing house. Many followed their mothers around the house, mimicking the mothers' activities." Green believed the study suggested "that some boys are born with an indifference to rough-and-tumble play and other typical boyhood interests and that this indifference alienates and isolates them from their male peers and

often from their fathers as well." These boys "may grow up 'starved' for male affection, which prompts them to seek love from men in adolescence and adulthood."[46]

The main hypothesis that Green ascertained from his study was that "certain parental attitudes and actions were correlated with a stronger homosexual orientation." The earliest parental influence documented "was the prenatal desire on the part of either parent, and the father in particular, that the child be a girl. After the boy was born, the parents often considered their son to be an especially beautiful infant. ... One of the most important factors related to a more homosexual orientation in adolescence and adulthood was how parents responded to the boys when they dressed up as girls and pretended to be girls. Many of the parents, Dr. Green said, thought it was cute and directly or indirectly encouraged the cross-gender behavior."[47]

Although "no relationship was found between later homosexuality and the amount of time a boy spent with his mother," a correlation was found with the time the father spent with the boy. "In the first year of life, the fathers tended to spend somewhat less time with their effeminate sons than did the fathers of masculine boys. During the next four years, however, the differences increased. By the time the boys were 3 to 5 years old, fathers of feminine boys were spending significantly less time with their sons than were fathers of the masculine boys." Green surmised that this did not mean "that the father rejected the son and that this rejection turned the boy into a sissy. Rather, Dr. Green suggested that the boys' feminine behaviors and rejection of male activities contributed to the fathers' indifference."[48]

Green also believed that there were correlations between lesser degrees of feminine behavior in boys and homosexual development. He argued that boys who are "athletically inept or prefer music to cars and trucks, often have difficulty making friends with other boys and identifying with typically male activities." Green advised, "to help the boys think of themselves as male, parents might assist them in finding boy friends who are similarly unaggressive and that the fathers might share in activities the boys enjoy, such as going to the zoo or a concert, rather than insist on taking the boys to athletic events." He even suggested that "counseling to guide such parents and enhance the child's masculine self-image may also be helpful.[49]

The publishing of the Green's sissy boy syndrome received ridicule from the gay community he had fought for and accolades from the sexual reorientation therapists he had accused of heterosexual biases. Judd Marmor, like Green, a heterosexual professional who supported the gay equality movement, saw the Green study as "another indication there is a biological element involved in the genesis of homosexuality, at least for those homosexuals with effeminate qualities." Marmor was quick to point out Green's study contradicted the Bieber group's causation scenario of the overprotective mother and the absent or ineffectual father. "An innate sissiness is 'not the answer to all homosexuality, but it is a factor that plays a role in a substantial number of male homosexuals.'" Marmor then qualified his response with regard to the Bieber causation scenario by stating that homosexuality "could also develop from a seriously distorted family environment but that 'it is much harder to develop that way, without a biological predisposition.'"[50]

Gay psychiatrist Jack Drescher (1998) was particularly critical of Green's defense of parents who want to prevent their children from becoming homosexual. Green associated the rights of parents who want to maximize the possibility of a heterosexual outcome in their children to the rights of parents who want to raise their children to be atheists or priests. In response, Drescher gave his support to the argument that "the treatment of the anxiety, depression, and family stress associated with gender identity disorder does not necessarily require prophylactic measures against adult homosexuality." Drescher contended that Green's position was in effect "rationalizing parents' homophobia in their attempts to prevent adult homosexuality in effeminate boys." In addition, Drescher argued "the successfully treated ex-sissy now shares his parent's homophobic values and stereotypes."[51]

For reparative therapists Green's study was another piece of the puzzle of homosexual development, albeit from an unlikely source. Reparative psychotherapy's causation factors of homosexuality already had included predispositions in personality like high sensitivity, as well as environmental factors related to parent-child and child-peer relationships. The direct correlation between the distant relationship between the father and the son fits perfectly into the defensive detachment theory of Moberly and even into the Bieber study findings. Green's hypothesis that the parents reaction to the boys effeminate behavior correlates directly to the severity of the effeminate behavior also fits into reparative psychotherapy theory, especially in preventative theory. Just the parents' failure to discourage effeminate behavior in their boys, was interpreted by the boys as "implicitly condoning it."[52]

Psychologist Joseph Nicolosi interviewed Green during his research on the prevention of homosexuality. Nicolosi said the two "disagreed on one important point: the disordered nature of the homosexual condition. But at one point I asked Dr. Green if he would want his son, then three years old, to grow up as a homosexual. 'Oh, no,' he said quickly, 'His life would be too difficult.'"[53]

The Spitzer study (2003)

Psychiatrist Robert Spitzer "zealously assumed a central role"[54] in the American Psychiatric Association (APA) Nomenclature Committee's effort to remove homosexuality from its list of disorders. When the gay graduate student Charles Silverstein gave his presentation before the APA's Nomenclature Committee in February of 1973, Spitzer was moved by the message "that the only way gays could overcome civil rights discrimination was if psychiatry would acknowledge that homosexuality was not a mental illness."[55]

In those years Spitzer was just beginning to meet gay identified individuals and see them as "human people." Individuals that Spitzer did not meet in 1973 were those who had unwanted homosexual attractions and had been helped through conversion therapies such as Irving Bieber's group and Charles Socarides. Approximately twenty-five years later Spitzer did meet a contingent of individuals who identified as ex-gay. They were protesting at an APA convention. Spitzer took an interest in their claim that they had changed their homosexual desires through different types of therapy. In addition the APA published a statement in 2000 on "Attempts to Change Sexual Orientation," which encouraged and supported research "to further determine 'reparative' therapy's

risks versus its benefits." Spitzer's "study attempted to contribute to that research by focusing on the possible benefits to some gays of reorientation therapy."[56]

(The study)

Announcements were sent out by Spitzer through ex-gay religious ministries and the National Association for Research and Therapy for Homosexuality (NARTH) in January of 2000. "Over a 16-month period, 274 individuals were recruited who wanted to participate in the study. ... In all but a few cases, these individuals were not chosen by these organizations; the individuals decided on their own to participate after reading repeated notices of the study that these two organizations had sent to their members." For the individual to be accepted into the study, they had "to satisfy two criteria: (1) predominately homosexual for many years" and (2) after therapy the individual had to have sustained a significant shift toward heterosexuality that lasted at least 5 years. 200 of the 274 individuals met Spitzer's requirements.[57]

The study consisted of 143 male participants with a mean age of 42, and 57 female participants with a mean age of 44. "Seventy-six percent of the men and 47 percent of the women were married at the time of the interview," while "twenty-one percent of the males and 18 percent of the females were married before beginning therapy." Spitzer conducted his interviews over the phone using "114 closed-ended questions" that he developed and several open ended questions. The interviews took about 45 minutes to conduct and Spitzer had a research assistant independently listen to a sample of 43 interviews and rate the questions on the scale Spitzer had set up. Spitzer and the assistant were in agreement 98 percent of the time, "indicating very high interrater

reliability for coding of the subjects answers." Most of the "questions focused on two time periods: the year before starting therapy (called PRE) and the year before the interview (called POST)."[58]

The participants differed on what type of therapy "was only or most helpful." 47 percent said it was "seeing a mental health professional," 34 percent said it was "attending an ex-gay ministry or religious support group," 19 percent said it was "repeated meetings with a heterosexual role model, bibliotherapy, or rarely, on their own, changing their relationship to God." The mean amount of time from the beginning of therapy "to the participant beginning to feel a change in their sexual orientation was 1.9 years." Of the 79 percent no longer in "reparative therapy the mean duration of the therapy was 4.7 years."[59]

70 to 85 percent of the participants reported that their motivation to change sexual orientation included not finding "life as a gay man or lesbian emotionally satisfying" and that they were conflicted "between their same-sex feelings and behavior and the tenets of their religion." The results of the study found significant shifts in sexual attraction and self-identity from homosexual to heterosexual in both the men and the women, while the magnitude of change varied. Spitzer concluded that "change in sexual orientation should been seen as complex and on a continuum." Only 11 percent of the males and 37 percent of the females recorded complete change - zero homosexual feelings throughout the previous year. For those with very few homosexual feelings during the previous year the percentages rose to "twenty-nine percent of the males and 63 percent of the females." The other participant's indicators of sexual attraction change were still significant.[60]

Spitzer found that the changes in the participants "encompassed sexual attraction, arousal, fantasy, yearning, and being bothered by homosexual feelings. The changes encompassed the core aspects of sexual orientation. Even participants who only made a limited change nevertheless regarded the therapy as extremely beneficial. Participants reported benefit from nonsexual changes, such as decreased depression, a greater sense of masculinity in males, and femininity in females, and developing intimate non-sexual relations with members of the same sex." The findings of the study, Spitzer said, suggest that those seeking to change their homosexual orientation are not necessarily doing so because of "societal pressure and irrational internalized homophobia. For some individuals, changing sexual orientation can be a rational, self-directed goal." In addition, Spitzer argued that the findings of his study "suggests that the mental health professionals should stop moving in the direction of banning therapy that has as a goal a change in sexual orientation."[61]

(The debate over the study)

Needless to say the Spitzer Study got the attention of both the gay affirmative therapists and the reparative therapists. Gay affirmative psychiatrist Jack Drescher lamented that the Spitzer study gave new life to the reparative therapists who had been successfully "marginalized from the mental health mainstream." Drescher argued that the reparative therapists' anti-homosexual arguments were not "directed toward a mental health mainstream that vigorously supports gay and lesbian civil rights, but toward lay audiences and policymakers. They are intended to counter growing public and political

acceptance of homosexuality by challenging the popular belief that homosexuality is 'biological' and 'immutable.'"[62]

Gay psychiatrist, Lawrence Hartmann, labeled the Spitzer Study "too flawed to publish," and "a failure at establishing what it says it establishes: that some gay people can be changed straight." Hartmann was another major player in the APA's removal of homosexuality as a disorder in 1973. Hartmann was the leader of the Northern New England District Branch of the APA which officially advocated for the deletion of homosexuality from psychiatry's list of disorders. In arguing against Spitzer's suggestions, Hartmann stated, "even if 'reparative therapy' helps a few people in some ways, as I think it may, it nearly certainly harms a far larger number of people, and that is a major ethical issue relevant to Spitzer's study but apparently not seriously considered by him." Hartmann's response insinuated that the 200 participants in Spitzer's study were the only individuals who had ever benefited from reparative therapy.[63]

Another gay mental health professional who played a key role in the 1973 APA decision, Charles Silverstein, sounded the alarm that the Spitzer study was "being used as the spearhead for a third wave attempt by the Christian religious right to repathologize homosexuality." Silverstein warned, "The religious right wants the reinstitution of shame in gay people. If they have their way, we will all be attending ex-gay meetings and Sunday church, and will be jailed if we do not!" From Silverstein's perspective the rights of individuals with unwanted same-sex attractions were an obstacle to the gay rights movement. He lamented, "Those of us fighting for gay and lesbian civil rights and dignity won the ethical treatment battle in the 1970s. Why has it reappeared in the

twenty-first century?"[64] From another pro-gay perspective, a group of researchers (sexual orientation unknown) in the social and behavioral sciences went so far as to imply that Spitzer had "violated the Nuremberg Code of medical ethics" by conducting his study.[65]

Silverstein challenged Spitzer's results because they contradicted another study done by two gay researchers, Shidlo and Schroeder. The research intent of Shidlo and Schroeder's study was to track "the harmfulness" of reparative therapy and ex-gay ministries. These gay researchers "had been funded by two gay organizations," but claimed their study procedure was not bias. Shidlo and Schroeder recruited individuals through the gay media and mailings to ex-gay ministries. Similar to Spitzer's study their subject group was 202 subjects, mostly male with a mean age of 40 years old, and phone interviews were used to rate variables in two time periods - before the individual's first conversion therapy and at the time of the interview. The Shidlo and Schroeder study achieved its goal of documenting harm caused by reparative therapy, but the harm was subjective and labeled to "three broad areas: Psychological, social/interpersonal, and spiritual."[66] Interestingly, through their study Shidlo and Schroeder "became convinced of the possibility of change in some gay men and lesbians."[67]

Sptizer was defensive and probably a little mad at the tone of his accusers. He had addressed the conflicting results of the Shidlo and Schroeder study (2002), along with the Beckstead study (2001), in his report. Whereas Shidlo and Schroeder concluded that 8 percent of the ex-gays in their study achieved sexual orientation change, Beckstead concluded that none of the ex-gays he interviewed had achieved a change in sexual orientation. Spitzer personally contacted Beckstead (a gay psychiatrist) and found that

Beckstead had different criteria of assessing a heterosexual orientation change. If the ex-gay was only attracted to one woman, usually the wife, or the heterosexual sex was not as intense as the former homosexual sex, Beckstead concluded that sexual orientation change had not taken place. In response to Beckstead's criteria, Spitzer argued in his report that it was probable that "reparative therapy rarely, if ever, results in heterosexual arousal that is as intense as a person who never had same-sex attractions. However, advocates of reparative therapy do not make that claim."[68]

Reparative therapist Joseph Nicolosi concurred with Spitzer's assessment that, in general, heterosexual sex for ex-gays is not as intense as their former homosexual sex. Nicolosi attributed the added intenseness of homosexual sex to the "deficit-driven nature of homosexual attraction" that results in "constant cycles of intense infatuation." His homosexual clients had reported "incredibly intense" anonymous gay sex only to be followed by feeling "wiped out, depressed, sad, and discouraged." Although those able to change their sexual orientation usually found heterosexual sex less intense, "these experiences are richer, fuller, and more emotionally satisfying." Nicolosi also concurred with Spitzer that sexual orientation change "should be viewed not in terms of erasing all unwanted desires but as a matter of diminishing homosexual attractions and increasing heterosexual responsiveness," [69]

Furthermore, Nicolosi's statements on the Spitzer Study addressed the observance that married ex-gays, while attracted to their wives, were usually not attracted to other women. Over the years Nicolosi had come "to realize that this was not so much a problem of arousal as of trust." He attributed this phenomenon to the "narcissistic

emotional enmeshment" the man had as a boy with his mother. Nicolosi elaborated, "The resulting fear and anger is projected onto all women, whom he expects will be manipulative and engulfing and will take away his masculine power." For this reason, "almost without exception, the ex-gay man cannot develop a sexual relationship with a woman unless he first develops a friendship."[70]

In response to the different percentages of sexual orientation change between the Spitzer study and the Shidlo/Schroeder study, Spitzer pointed out that participants in his study were required to have claimed some degree of sexual orientation change, whereas the other studies only required a participant to claim they were an ex-gay.[71] In actuality, the requirements had a greater degree of difference. The Shidlo/Schroeder study only required the participants to have been in a minimum of six sessions of therapy to change their sexual orientation and to have been predominately homosexual before the therapy.[72] No change in sexual orientation was necessary, because the purpose of their research was to document the harm caused by conversion therapies.

Psychologist Mark Yarhouse was in the philosophical camp that believed those with unwanted same-sex attractions should be given the opportunity to change their sexual orientation. Yarhouse also believed that a client's religious objections to homosexuality should be honored, rather than criticized. He saw a comparison between the Spitzer Study and the Hooker Study of the 1950s. Evelyn Hooker wanted to document the psychological healthiness of those who positively identified as a homosexual. All of the participants of her study were referred to her directly or indirectly through a gay organization. The research question her study asked was "whether all

homosexuals are manifestly disturbed to the extent that a panel of health professionals could distinguish them from heterosexuals."[73] For the most part the health professionals could not tell the homosexuals from the heterosexuals using the various tests that were administered.

In comparison, Spitzer wanted to document sexual orientation change from homosexual to heterosexual. The Spitzer Study asked the question "whether *anyone* had *ever* experienced a change in sexual orientation." Yarhouse recognized that Spitzer "was not studying how likely it is that someone will experience change of orientation." That was "a crucial distinction." Yarhouse argued that "her [Hooker] study did not prove that all homosexuals are healthy, just as Spitzer did not prove that all homosexuals can change their sexual orientation." The Spitzer Study did suggest that it is possible to change homosexual orientation to heterosexual, and in doing so Yarhouse claimed Spitzer had given a voice to ex-gays who have been "disenfranchised" by the gay and lesbian subculture.[74]

Related American Psychiatric and American Psychological Association events

1994

In 1994 the American Psychiatric Association's (APA) Board of Directors entertained a proposal to "make it a violation of professional conduct for a psychiatrist to help a homosexual patient become heterosexual *even at the patient's request.*" Gay

political forces within the APA had hoped to make a new ethical standard that would eventually be applied to psychologists, counselors, and even ministers. The proposal was presented to the Board of Trustees by a gay-activist psychiatrist in the association who was at the time the chairman of the APA Committee on the Abuse and Misuse of Psychiatry. Richard Isay not only chaired the Committee on the Abuse and Misuse of Psychiatry, he also had chaired the Committee on Gay, Lesbian, and Bisexual Issues and "used his influence to link their activities."[75] Isay argued, "Efforts to change homosexuals to heterosexuals, I believe, represent one of the most flagrant and frequent abuses of psychiatry in America today."[76]

Psychiatrist Charles Socarides and other NARTH [National Association for Research and Therapy of Homosexuality] members made it clear to the APA Board of Trustees that if this resolution made it to the floor of the convention they would "call for a renewed debate on the 1973 decision to take homosexuality off the APA's list of disorders." Socarides contended that those who treated homosexuality as a disorder never had the "chance to debate that 1973 decision on theoretical and clinical grounds." NARTH members also made the case that the proposed resolution was an abridgement of their First Amendment rights. In response the APA leaders tabled the resolution. On the last day of the 1994 APA convention a group of former homosexuals came to the convention to tell the psychiatrists present that "reparative therapy had worked for them."[77]

The 1994 effort by Isay led to "a heated exchange of letters" between Isay and Socarides "on the subject of homosexual change." Isay dismissed all literature on

homosexual change as lies. He argued that the psychoanalysts and psychiatrists who claimed to have helped homosexuals change their sexual orientation were naively deluded or bigoted, dishonest, and abusive. In response, Socarides and Benjamin Kaufmann, both officers of NARTH, argued that to not help a person with unwanted homosexuality try to change their sexual orientation would be "untruthful, cruel, and intellectually dishonest." These NARTH officers contended that the efforts by gay psychiatrists to discredit their work amounted to the suppression of intellectual freedom and the subversion of the psychoanalytic knowledge on homosexuality.[78]

2000

A debate on whether homosexuality could be changed through therapy was scheduled for the May 2000 American Psychiatric Association's annual convention in Chicago. The debate was organized by psychiatrist Robert Spitzer, the "architect" of the 1973 decision which removed homosexuality from psychiatry's list of disorders. Spitzer had walked a tightrope as he worked to put the debate together, "trying to keep both sides engaged in this polarizing discussion." The debate was to have addressed two questions: "Is reorientation therapy ethical?" and "Can it be effective?" Reparative therapist Joseph Nicolosi wrote that the efforts of Spitzer in organizing the debate were "always scrupulously fair and impartial."[79]

Two panelists originally proposed to represent the reparative therapy side of the debate were psychologist Joseph Nicolosi and psychiatrist Jeffrey Satinover. However, "the gay-activist psychiatrists refused to participate," if either Nicolosi or Satinover took part in the discussion.[80] Spitzer recruited two other psychologists, Warren Throckmorton

and Gerald E. Zuriff, to represent the side of the debate defending reparative therapy as ethical and effective. The debate was part of the convention agenda, but was abruptly cancelled by the American Psychiatric Association when the gay psychiatrists refused to participate.[81]

Following the news of the cancelled debate 45 ex-gay leaders flew to Chicago to protest. A press conference was held by leaders of NARTH with Spitzer present. Nicolosi, then president of NARTH, used the occasion to defend the rights of homosexuals who seek reorientation change. He argued that gay activists are blocking the rights of individuals with unwanted same-sex attractions to have profession support "toward fulfilling the goal of sexual reorientation." Nicolosi contended that gay opposition to sexual reorientation change was fear based, because gays feel their own rights are threatened in some way by people who come out of homosexuality. Nicolosi challenged that mindset by stating that granting ex-gay men and women their right to self-determination doesn't equate to diminishing the rights of gay men and women to pursue a different lifestyle.[82]

Nicolosi directed these next comments to the American Psychiatric Association Board of Trustees. "*Look at the data.* It's either one way or the other: If people *do* change, then you have a responsibility to change your policy. If they *don't* change--that is, no behavioral or identity shift is accomplished, and they leave therapy feeling worse about themselves than when they came in---then we really *are* doing harm to our patients. We're ready to open the debate; let's put the evidence on the table."[83]

2001

In 2001 Joseph Nicolosi was encouraged when the president of the American Psychological Association (APA), Norine Johnson, "made a passionate plea for intellectual freedom." She wrote, "I am strongly supportive of open debate in the APA regardless of the volume or intensity of the debate. Debate is healthy. Disagreement is healthy." The motivation behind Johnson's appeal for "intellectual freedom" was the criticism that the APA had received by publishing "an article that found pedophile relationships are, surprisingly often, remembered by the molested boy as positive."[84] The criticism had been going on for over two years, every since Laura Schlessinger had been informed of the Bruce Rind article in an APA journal and condemned the research on her radio show. The uproar over the article led to the United States Congress passing resolutions that condemned the suggestions of the researchers.[85]

The controversy over the publication of the Rind Study by the APA resembled the controversy over homosexuality with passionate advocates on both sides. Many mental health professionals condemned the research, while those seeking to legitimize adult-child sex used it to support their position.[86] Also similar to the issue of homosexuality, the psychiatric list of disorders (*DSM-IV*) had been revised in 1994 to associate mental illness to pedophilia "only if the pedophile was distressed by his actions or negatively affected in his work or social relationships."[87]

Nicolosi pointed out the hypocrisy of the APA which was willing to defend "its right to publish a study that will, unfortunately, be used in our courts to show that 'consensual' molestation is not substantially harmful to boys," while at the same time the Association remained opposed to scientific openness regarding sexual orientation.

Nicolosi also issued the complaint that "NARTH members have been excluded from APA panel discussions, and NARTH has never been permitted to announce its national conferences in APA publications."[88]

Persuaded by Johnson's plea for intellectual freedom Nicolosi wrote to Johnson for permission to announce NARTH's "scientific meetings in American Psychological Association publications, just as gay organizations do."[89] NARTH had been denied a similar request in 1995.[90] Johnson did not respond to Nicolosi directly. The response came instead from the head of the Office of Gay, Lesbian, and Bisexual Concerns – Clinton Anderson. Request denied.[91]

The American Psychological Association eventually apologized for publishing the Bruce Rind article. An official statement was released acknowledging that "no matter what the research showed about the psychological effects of pedophile relationships--pedophilia remained, in its opinion, 'morally' wrong." Linda Nicolosi, co-author of *A Parent's Guide to Preventing Homosexuality*, responded that "This was an odd statement indeed from a *scientific* organization. … The very fact that APA admitted to holding a *moral* viewpoint on a *psychological* issue ought to have opened up a broad new challenge to psychology's authority and its presumptions as our culture's arbiter of practically every social and moral issue now under debate."[92]

Soon after the uproar over the Rind Study the American Psychiatric Association stealthily revised the text on pedophilia in the *DSM-IV*. Pedophilia was returned to its "previous standard, now, *merely acting upon* one's pedophilic urges is sufficient for a diagnosis of disorder." Those in charge of the revision went on the record saying that "no

substantive changes" had been made. NARTH Scientific Advisory Board member Russell Hilliard and psychiatrist Robert Spitzer disagreed. They commented that a substantive change had been made in its criteria for pedophilia. It would have been better, they argued, if the text revision editors had acknowledged that the revision corrected a mistake that had been made in the classification of pedophilia.[93]

2006

At the 2006 Annual Conference of the American Psychological Association (APA) fifty ex-gay men and women picketed the entrance with signs like, "Diversity Includes Us!" Showing their lack of knowledge of what goes on in the association, "most of the psychologists who spoke to the picketers expressed surprise that their profession would wish to restrict reparative or reorientation therapies." Then president of the association, Gerald Koocher, was asked in a Town Hall type meeting about the APA's position toward the efforts to restrict reorientation therapies to those with unwanted homosexuality. Koocher replied that the American Psychological Association did not have a "conflict with psychologists who help those distressed by unwanted homosexuality," as long as proper informed consent was obtained and there was no coercion.[94]

Psychologist A. Dean Byrd, Chair of NARTH's Scientific Advisory Committee, was encouraged by the APA president's support for client autonomy. His hope was expressed in this statement: "Dr. Koocher's statements were clear and unambiguous in support of the rights of those who are distressed by their unwanted homosexual attraction. In fact, the message conveyed by Dr. Koocher today is identical to NARTH's mission

statement. I hope that APA and NARTH can now begin a fruitful dialogue about this very important issue."[95]

As he left the Town Hall meeting "Koocher was surrounded by angry gay-activist psychologists." He quickly issued a clarification insisting that "homosexuality must not be presented to the client as a mental illness." He later re-clarified that statement by stating that the data showed "that gay and lesbian people do not differ from heterosexuals in their psychological health. By that I mean that they have no greater instance of mental disorders than do heterosexuals."[96] Like a flip-flopping politician Koocher had turned his statement of support for those with unwanted homosexuality into a position that completely avoided the ethical issues related to restricting reorientation therapies.

Contrary to Koocher's claim that the incidence of psychological health between homosexuals and heterosexuals does not differ, NARTH cited a number of studies that showed male homosexuals have a "greater prevalence of pathology than the general population." The studies found that male homosexuals had on average three times as much suicidal risk, unprotected sex, violence, antisocial behavior, substance abuse, promiscuity, paraphilias, prostitution, sexual addiction, and personality disorders. Lesbians also have greater problems than heterosexual women particularly in health issues. These include higher rates of substance abuse, suicide attempts, and being victims of sexual and physical abuse.[97]

2007

Sexual identity therapy creators Warren Throckmorton and Mark Yarhouse were able to present their neutral framework of treating homosexuality at a symposium during

the American Psychological Association's 2007 annual conference in San Francisco. The symposium was titled "Sexual Identity Therapy to Address Religious and Spiritual Conflicts," and was co-chaired by Yarhouse and A. Lee Beckstead.[98] It was an interesting dynamic that Beckstead, a gay psychologist and critical of reparative therapy, would co-chair a symposium on the treatment of homosexuality that was not gay affirmative.

Throckmorton reported the symposium went well with approximately 130 people in attendance. Throckmorton's presentation described sexual identity therapy as guidelines that "provide conceptual and empirical support for clinical interventions leading to sexual identity outcomes that respect client personal values, religious beliefs, and erotic orientation." Sexual identity therapy was offered as an alternative treatment to homosexuality that can resolve "identity conflicts in ways that preserve client satisfaction with services, client autonomy and professional commitments to diversity."[99]

Throckmorton and Yarhouse presented sexual identity therapy as a treatment for homosexuality that was neither pro-gay nor anti-gay, but it was anti-reparative therapy. Throckmorton's presentation included a slide that said many modalities of psychotherapy are compatible with sexual identity therapy, except reparative therapy. It appears that attendees were led to believe that gay affirmative therapy was compatible with sexual identity therapy.

2007

At the same American Psychological Association conference in San Francisco psychologist Dean Byrd chaired a symposium entitled "Reforming APA Advocacy." Byrd was president of NARTH at the time of the symposium. The panel consisted of

three prominent psychologists in the association. Two panelists, psychologists Nicholas Cummings and Frank Farley, were former presidents of the American Psychological Association. The third panelist, psychologist Rogers Wright, was a former member of American Psychological Association's Board of Directors. Though the symposium had been relegated by conference organizers to a Monday-morning slot, it was well attended and "the audience response to the symposium was overwhelmingly positive."[100]

Cummings began his presentation by comparing American Psychological Association president Gerald Koocher's 2006 statement "Psychological science is not politically correct" to President Richard Nixon's statement at the height of the Watergate Scandal, "I am not a crook." He continued, "Even though they are light years apart in the level of importance to society," there is a "similarity in the absurdity of both statements in the face of the existing facts." Cumming regretted that the Association was focused on making proclamations from "boxing to Zionism ... all without one shred of scientific evidence." Candidly, Cummings stated, "APA proclamations have the effect of ending debate -- carving into stone ignorance and lack of scientific understanding."[101]

Cummings concluded his presentation with the revelation that "a large number who remain in the APA are demoralized and detached, maintaining their membership because they need the benefits such as malpractice insurance." He also revealed that from his insider perspective "the APA is a bloated bureaucracy run by an oligarchy of about 200 who recycle themselves through various offices in a kind of musical chairs." The members are "essentially disenfranchised" because they only get to vote for one office – the president. In 2006 Cummings proposed that the control of the American

Psychological Association should be stripped from its divisions and returned "to the membership based on a one-member, one-vote democratic principle for all the offices." The proposal was supported by another past president of the association, psychologist Patrick DeLeon, but the proposal disappeared without consideration. Cummings predicted that if the politically correct trend in the American Psychological Association persists it will soon "be too late for reform, and will require desperation."[102]

Wright began his presentation by admitting that "after more than 50 years of active membership and substantial commitment ... he was agonizing about resigning from the membership of APA." His reasons were weighted on the associations "abuse of its public stature in the interest of advancing controversial social and/or political goals," and the recent leaders' "fecklessness."[103]

Wright professed grave concern over the American Psychological Association's "continued violation of the Leona Tyler Principle." This principle was adopted by the Council of Representatives and was intended to forbid the association "from taking positions or issuing proclamations where there is inadequate science and/or demonstrable clinical experience." The Leona Tyler Principle does not prevent individual psychologists "from taking a position or advocating for particular issues either individually, or in groups. However, when there is an absence of data derived from science or practice, APA as a group must remain silent."[104]

Wright cited the previous attempts "to ban psychotherapy aimed at reducing unwanted homosexuality" as an example of the associations violation of the Leona Tyler Principle. "The causation of homosexuality remains unknown," and "success/failure rates

of sexual-identity change as a function of psychotherapy are equally unknown, (perhaps currently unknowable)." Because the science on homosexual causation is inadequate and the clinical experience has shown both success and failure at changing sexual orientation, the Leona Tyler Principle should have "found any consideration of this anti-therapy proposal 'out of order' from the very outset."[105]

2008

David Scasta, a former president of the American Psychiatric Association and a gay psychiatrist, organized a symposium on homosexuality, religion, and therapy for the 2008 American Psychiatric Association's annual meeting in Washington. The title for the symposium was "Homosexuality and Therapy: The Religion Dimension." Included in the panel of speakers was: Bishop Gene Robinson, a gay Episcopal leader; Rev. Albert Mohler, the president of the Southern Baptist Theological Seminary; and Warren Throckmorton, a sexual identity therapist and past president of the American Mental Health Counselors Association.[106]

A week or so before the symposium was to have taken place the gay press began to condemn the upcoming event. They claimed that Throckmorton was unqualified and a "spin doctor of the ex-gay myth." Robinson became convinced by the gay press that just by showing up he was going to give credibility to reparative therapy. The gay press was also infuriated by the selection of Rev. Albert Mohler who also served on the board of Focus on the Family. Focus on the Family was the organization that originally sponsored the Love Won Out conferences which featured ex-gay testimonies and therapists who help those with unwanted same-sex attractions try to change their sexual orientation.

Robinson withdrew from the symposium at the last minute with the intent "to shut down the discussion of homosexuality and religion." He succeeded. The symposium was canceled.[107]

Scasta believed the panel he had put together would provide a "balanced discussion about religion and how it influences therapy." He was quoted as saying, "We wanted to talk rationally, calmly and respectfully to each other, but the external forces made it into a divisive debate it never intended to be."[108] The external forces were all related to gay activists.

2009

In 2007 six mental health professionals were chosen by American Psychological Association (APA) president Sharon Brehm to serve on a Task Force on Appropriate Responses to Sexual Orientation. The Lesbian, Gay, Bisexual, Transgender Concerns Office of APA had initiated the task force with predictable biases. A formal invitation was sent out seeking nominations for the task force and NARTH submitted the names of four highly-qualified psychologists. President Brehm rejected all the candidates proposed by NARTH and appointed six professionals with direct ties to gay organizations and causes.[109]

Three members of the task force openly identified as gay and lesbian. Jack Drescher and Judith Glassgold were outspoken LGBT [lesbian, gay, bisexual, transgender] activists. Lee Beckstead was a gay psychologist who worked with LGBT identified clients and was openly skeptical of the results of reorientation therapy. It is probable that at least two of the other three task force members also self-identified as

homosexual. Beverly Greene worked for the gay lobbying division of the APA as the co-editor of a series entitled *Psychological Perspectives on Lesbian, Gay, and Bisexual Issues.* Roger Worthington was the recipient of an award from the LGBT Resource Center at the University of Missouri, Columbia, for "Speaking up and out and often regarding LGBT issues." The other member, Robin Lin Miller had "worked for the Gay Men's Health Crisis in New York City" and written for gay publications.[110]

In 2009 the task force completed its work by urging the American Psychological Association to adopt a resolution which instructed mental health professionals to "avoid telling clients that they can change their sexual orientation through therapy or other treatments." The resolution was approved by the APA's governing Council of Representatives at the annual convention in 2009. The chair of the task force, Judith Glassgold, stated that "Contrary to claims of sexual orientation change advocates and practitioners, there is insufficient evidence to support the use of psychological interventions to change sexual orientation. … At most, certain studies suggested that some individuals learned how to ignore or not act on their homosexual attractions. Yet, these studies did not indicate for whom this was possible, how long it lasted or its long-term mental health effects." As for whether sexual reorientation therapies were harmful, Glassgold responded, that there were 'no methodologically sound studies" for the task force "to make a definitive statement."[111]

Not surprisingly, NARTH was critical of the resolution and the task force. NARTH criticized the task force and the APA for basing a resolution on "insufficient evidence." Insufficient evidence also meant that they could not prove that reorientation

therapies did not work. NARTH accused the APA of violating the Leona Tyler Principle which required the APA to remain silent on issues where there was "insufficient evidence." Julie Harren-Hamilton, president of NARTH at the time, charged the APA of bias because "the task force was composed only of members opposed to sexual-orientation change efforts." Specifically, she argued, "We believe that if the task force had been more neutral in their approach, they could have arrived at only one conclusion, that homosexuality is not invariably fixed in all people, that some people can and do change."[112]

A few months later NARTH issued a document with more detailed criticism of the APA resolution. The document argued that the APA task force demanded "an impossibly high standard of proof for reorientation therapy which [the] APA does not demand for therapies dealing with other difficulties such as alcoholism, obesity, or behavioral addictions." NARTH also brought out the fact that many of the studies dismissed by the task force "met the acceptable professional and scientific standards of the time." The NARTH document pointed out the hypocrisy of the task force. While dismissing reparative therapy because of insufficient evidence, "the report pushes 'gay affirmative therapy' – a virtually untested model – as the way to offer psychological care to those with unwanted homosexuality." NARTH also claimed that the task force was in error by claiming that homosexual behaviors and orientation are normal variants of human sexuality "equivalent to heterosexual relationships and families in essential respects." The task force report cited no evidence to support its normal variant claims. NARTH argued that the political efforts of gay activists to normalize homosexuality is

not evidence that homosexuality is a normal variant of sexuality and equal to heterosexuality.[113]

In contrast to the criticism of reparative therapists, sexual identity therapist Warren Throckmorton found it heartening that the task force considered his sexual identity therapy (SIT) an "appropriate application of affirmative therapeutic interventions" for homosexuality. Throckmorton stated, "In general, I think the APA strategies and the SIT framework are quite compatible." Throckmorton believed that the task force report affirmed his sexual identity therapy with this sentence, "Practitioners can assist clients through therapies that do not attempt to change sexual orientation, but rather involve acceptance, support and identity exploration and development without imposing a specific identity outcome."[114]

Throckmorton's position was that the task force had produced "a high quality report of the evidence regarding sexual orientation and therapy." He seemed to agree with the task force reasoning that because attempts to change sexual orientation "have been viewed as helpful by some and harmful by others," the negative view of reparative therapy was logical and appropriate.

Closing Remarks

Gay activists won a big victory in 2009 when the American Psychological Association adopted the Task Force resolution that clients entering psychotherapy should not be told they can change their sexual orientation. The resolution was a direct assault on

reparative psychotherapy. Gay activists had attempted to professionally condemn reparative psychotherapy before, but 2009 was the year they succeeded. Former American Psychological Association [APA] board member Rogers Wright's description of the 2006/2007 APA leadership as "fecklessness" gives some explanation as to how a gay task force could be allowed to judge reparative psychotherapy and to why the resolution was adopted. It remains to be seen as to whether the gay activists have won the war or just a major battle.

Throckmorton and Yarhouse's sexual identity therapy mirrored the normal variant post-1973 paradigm in two critical ways. First, it dismissed the clinical evidence that had shown some cases of homosexuality to be the result of a pathological parent-child relationship. Second, sexual identity therapy gives homosexuality equality with heterosexuality. The neutral position of the sexual identity therapist as to what direction the client seeks as his sexual identity is inferred as a neutral position that heterosexuality is not a healthier sexual orientation or sexual identity than homosexuality. When the new American Psychological Association guideline is added that clients should not be told sexual orientation is changeable, sexual identity therapy is very compatible with gay affirmative therapy. Sexual identity therapy has become the gay affirmative therapist's accepted alternative for those with unwanted same-sex attractions.

The proof that sexual identity therapy has become the "approved" alternative can be gleaned from the actions within the American Psychiatric Association and the American Psychological Association. In 2007 the co-chair of the symposium that introduced Throckmorton and Yarhouse's sexual identity therapy to the American

Psychological Association's annual conference was gay psychologist A. Lee Beckstead. The 2008 American Psychiatric Association symposium on homosexuality, religion, and therapy that gay psychiatrist David Scasta organized was to feature Throckmorton promoting neutrality in the midst of a gay bishop and a conservative evangelical seminary president. In addition, Throckmorton and Yarhouse's sexual identity therapy was approved by the same American Psychological Association task force that ostracized reparative therapy in 2009, with Throckmorton and Yarhouse cited several times in the task force report.

Unfortunately, Throckmorton and Yarhouse's untested alternative to treating unwanted same-sex attractions has been used by the gay faction as another tool to dismiss and discredit the work of many reorientation therapists over the last seventy years. Sexual identity therapy has not been proven more effective or helpful than reparative psychotherapy for treating unwanted same-sex attractions, but it is currently politically correct.

In addition to the assault by the gay task force in 2009 reparative therapists have been somewhat abandoned by a number of leaders in the ex-gay movement. Typically, the religious based ministries to those with unwanted same-sex attractions have focused on a spiritual healing, rather than a psychological healing. Exodus president Alan Chambers's comment in January of 2012 that complete sexual orientation change occurs very rarely put NARTH back on its heels a little bit, causing them once again to address the issue of what change is. In late January of 2012 NARTH issued a statement addressing what they consider sexual orientation change is and is not.

The first point made by the NARTH statement was that "how change is conceptualized has vast implications for our thinking about change." NARTH does not view change in sexual orientation as simply a homosexual client renouncing a homosexual lifestyle and NARTH does not negate a client's claim of sexual orientation change simply because the client experiences future same-sex attractions, "however fleeting or diminished" they may be. "NARTH believes that it is far more helpful and accurate to conceptualize such change as occurring on a continuum." In fact most modern research, starting with the Kinsey scales, defines sexual orientation on a continuum.[115]

Many clients of NARTH therapists were "able to achieve sustained shifts in the direction and intensity of their sexual attractions, fantasy, and arousal that they consider to be satisfying and meaningful." The NARTH statement claimed "that a profound disservice is done to those with unwanted same-sex attractions by characterizing such shifts in sexual attractions as a denial of their authentic (and gay) personhood or a change in identity labeling alone." To deny the client testimonies of change "insults the integrity of these individuals."[116]

NARTH believed that much of the pessimism regarding sexual orientation change was coming from individuals who define sexual orientation change as never experiencing anymore same-sex attractions. "What needs to be remembered is that the de-legitimizing of change solely on the basis of a categorical view of change is virtually unparalleled for any challenge in the psychiatric literature. For example, applying a categorical standard for change would mean that any subsequent reappearance of depressive mood following treatment for depression should be viewed as an invalidation of significant and genuine

change, no matter how infrequently depressive symptoms reoccur or how diminished in intensity they are if subsequently re-experienced."[117]

The NARTH statement also brought up the point that studies have not been done comparing reparative psychotherapy to religious based ministries, as well as to a comparison of individuals who go through both at the same time. "Most of the recent research on homosexual sexual orientation change has focused on religiously mediated outcomes which may differ significantly from outcomes derived through professional psychological care. It is not unreasonable to anticipate that the probability of change would be greater with informed psychotherapeutic care, although definitive answers to this question await further research." The NARTH statement concluded, "NARTH remains committed to protecting the rights of clients with unwanted same-sex attractions to pursue change as well as the rights of clinicians to provide such psychological care."[118] The war over philosophies and treatments for homosexuality does not appear to be over.

Notes

[1] Silverstein, "Wearing Two Hats," 24.

[2] Cummings, Preface to *Destructive Trends*, xiii.

[3] American Psychological Foundation, "American Psychological Foundation." 94.

[4] Moberly, *Homosexuality: A New Christian*, 3, 16.

[5] Ibid., 9, 21, 27.

[6] Ibid., 19, 37.

[7] Ibid., 22, 28-9, 35-6, 41, 44.

[8] Ibid., 42, 45, 47, 52.

[9] Ibid., 25, 31, 44.

[10] Satinover, *Homosexuality and the Politics*, 205.

[11] Ibid., 205-7.

[12] Ibid., 206.

[13] Comisky, *Guide - Pursuing Sexual Wholeness*, 9.

[14] Ibid., 10.

[15] Ibid., 207-9, 211.

[16] Chambers, "Alan reflects on GCN," February 3, 2012.

[17] Ibid.

[18] Ibid.

[19] Yarhouse, "Understanding Sexual Identity Therapy," March 10, 2010.

[20] Throckmorton, "On the application," March 10, 2012.

[21] Nicolosi, *Reparative Therapy*, 145.

[22] Throckmorton, "On the application," March 10, 2012.

[23] Throckmorton and Yarhouse, "Sexual identity therapy," 13-15.

[24] Yarhouse, "Understanding Sexual Identity Therapy," March 10, 2010.

[25] Throckmorton and Yarhouse, "Sexual identity therapy," 6, 17, 19.

[26] Ibid., 14-17.

[27] Ibid., 20.

[28] Throckmorton, "Sexual Identity Therapy Framework," slide 16. Throckmorton used this PowerPoint presentation at the *Sexual Identity Therapy to Address Religious & Spiritual Conflicts* symposium at the American Psychological Association's annual convention on August 17, 2007.

[29] Throckmorton and Yarhouse, "Sexual identity therapy," 8.

[30] Ibid., 18.

[31] Ibid., 9.

[32] Moberly, *Homosexuality: A New Christian*, 4.

[33] Throckmorton and Yarhouse, "Sexual identity therapy," 12.

[34] Nicolosi, "Why I Am Not," April 23, 2007.

[35] Ibid.

[36] Morbidity and Mortality, "HIV Surveillance – United States," June 3, 2011.

[37] Ibid.

[38] Socarides, *Homosexuality A Freedom Too*, 225.

[39] Center for Disease Control, "Basic Statistics," 2009..

[40] Ibid.

[41] Ibid.

[42] Morbidity and Mortality, "HIV Surveillance – United States," June 3, 2011.

[43] Ibid.

[44] Bayer, *Homosexuality & American Psychiatry*, 112.

[45] Brody, "Boyhood Effeminacy," December 16, 1986.

[46] Idid.

[47] Ibid.

[48] Ibid.

[49] Ibid.

[50] Ibid.

[51] Drescher, *Psychoanalytic Therapy*, 88-9.

[52] Nicolosi, *Shame and Attachment Loss*, 52.

[53] Nicolosi and Nicolosi, *Parent's Guide*, 243.

[54] Bayer, *Homosexuality & American Psychiatry*, 123-4.

[55] Drescher, "An Interview with Robert," 328.

[56] Spitzer, "Study Results Should Not," 224-5.

[57] Spitzer, "Can Some Gay Men," 40.

[58] Ibid., 41-3.

[59] Ibid., 44-5.

[60] Ibid., 43, 45, 48, 58-9.

[61] Ibid., 55, 57.

[62] Drescher, "Spitzer Study," 108.

[63] Hartmann, "Too Flawed: Don't Publish," 125-8.

[64] Silverstein, "Religious Conversion," 252, 266-7.

[65] Spitzer, "Study Results Should Not," 223-4.

[66] Silverstein, "Religious Conversion," 259, 260, 262.

[67] Ibid., 261. Silverstein is quoting the researchers directly from the article "Ethical issues in sexual orientation conversion therapies: An empirical study of consumers," by M Schroeder and A. Shidlo, published in *Journal of Gay and Lesbian Psychotherapy*, 5(3/4):131:166.

[68] Spitzer, "Can Some Gay Men," 56-7.

[69] Nicolosi, "Finally, Recognition," 160-2.

[70] Ibid., 161-2.

[71] Spitzer, "Study Results Should Not," 227.

[72] Silverstein, "Religious Conversion," 259.

[73] Yarhouse, "How Spitzer's Study Gives," 220.

[74] Ibid., 217, 219-20.

[75] Satinover, *Homosexuality and the Politics*, 35-6, 180.

[76] Socarides, *Homosexuality A Freedom Too*, 76.

[77] Socarides, *Homosexuality A Freedom Too*, 181-2.

[78] Satinover, *Homosexuality and the Politics*, 36, 181-3.

[79] NARTH, "Psychiatric Association Schedules May."

[80] Nicolosi and Nicolosi, *Parent's Guide*, 171.

[81] NARTH, "Psychiatric Association Schedules May."

[82] NARTH, "On the Right to," May 17, 2000.

[83] Ibid.

[84] Nicolosi and Nicolosi, *Parent's Guide,* 171-2.

[85] Ibid., 127.

[86] The Leadership Council, "Controversial Study Defending," November 29, 2001.

[87] Nicolosi and Nicolosi, *Parent's Guide*, 128.

[88] NARTH, "APA Defends Scientific Freedom," August 2001.

[89] Nicolosi and Nicolosi, *Parent's Guide*, 172.

[90] NARTH, "APA Defends Scientific Freedom," August 2001.

[91] Nicolosi and Nicolosi, *Parent's Guide*, 172.

[92] Nicolosi, L., "Pedophilia Debate Continues."

[93] Ibid.

[94] Nicolosi, *Shame and Attachment Loss*, 21-2.

[95] NARTH, "President Koocher Says," August 16, 2006.

[96] Nicolosi, *Shame and Attachment Loss*, 22.

[97] Phelan, James, "Comprehensive Response," 2007.

[98] American Psychological Association, "Programming Highlights," June 2007.

[99] Throckmorton, Warren, "APA sexual identity therapy," August 18, 2007.

[100] Byrne, "NARTH'S President Chairs Symposium."

[101] Ibid.

[102] Ibid.

[103] Ibid.

[104] Ibid.

[105] Ibid.

[106] Unruh, "Gays' shut down discussion," May 2, 2008.

[107] Ibid.

[108] Ibid.

[109] Hatfield, "New APA Task Force," May 23, 2007.

[110] Ibid.

[111] American Psychological Association, "Insufficient Evidence," August 5, 2009.

[112] NARTH, "NARTH President is Given," October 2009.

[113] NARTH, "The NARTH Response," January 2010.

[114] Throckmorton, "APA sexual orientation task," August 5, 2009.

[115] NARTH, "NARTH Statement on Sexual," January 25, 2012.

[116] Ibid.

[117] Ibid.

[118] Ibid.

Chapter 10

Chronological Summary and Conclusions

"But progress means getting nearer to the place where you want to be. And if you have taken a wrong turning, then to go forward does not get you any nearer. If you are on the wrong road, progress means doing an about-turn and walking back to the right road; and in that case the man who turns back soonest is the most progressive man."[1]

C. S. Lewis – author and educator (1952)

A chronological summary of the professional division over homosexuality and its role in the culture war over homosexuality

Political maneuvering and philosophical bias has influenced much of the recorded history on the condition and treatment of homosexuality. The American Psychiatric Association's and the American Psychological Association's current position on homosexuality is the outcome of that political fight and it has come at a high cost.

1910-1935

In the second decade of the twentieth century two divergent views on the condition and treatment of homosexuality were proposed. The first came from Sigmund Freud who postulated that all individuals went through a "'homoerotic' phase in the process of achieving heterosexuality. Certain kinds of life experiences could arrest the evolutionary process, and the individual would then remain 'fixated' at a homosexual level."[2] This fixated state could start in the earliest stages of development with a male child having a "very strong mother fixation."[3] Although Freud categorized homosexuality as a "deviation in respect to the sexual object" similar to bestiality and pedophilia,[4] he told the mother of a homosexual that homosexuality "is nothing to be ashamed of, no vice, no degradation, it cannot be classified as an illness; we consider it to be variation of the sexual function produced by a certain arrest of sexual development."[5]

A second view on the condition and treatment of homosexuality was postulated by a German physician named Magnus Hirschfeld. Hirschfeld was a homosexual activist who advocated that homosexuality was an innate incurable condition. It was that simple for Hirschfeld. He argued in 1914 that the only misfortune of being homosexual was the unjust evaluation society had of homosexuals. Hirschfeld treated troubled homosexuals with what he called 'adaptation therapy.' He would encourage his clients to accept their homosexual attractions by showing them references of homosexuals throughout history. His advice to his clients was to give up the idea of marriage, engage in homosexual sex without guilt, and be involved in "regular intensive work."[6] Adaptation therapy also included Hirschfeld giving advice on how to tell one's parents and friends that they were homosexual. Hirschfeld founded the world's first Institute for Sexology in 1919.

1940s

It was Sandor Rado in the 1940s who made the giant leap to understanding many cases of homosexuality as a reparative adjustment. Rado postulated that homosexual behavior for some counteracted an inhibition caused by the affect of anxiety. He contended that for individuals with this inhibition, "sexual activity is not a promise, but a threat; he is predisposed not to sexual fulfillment but to sexual failure." [7] Rado surmised that this type of homosexual found he could obtain orgasm satisfaction in an altered scheme of homosexual sex. Consequently, the homosexual attraction and sex became the reparative adjustment to the inhibition. The reparative adjustment theory was significantly different than Freud's theory that homosexuals had an arrest in sexual development along the continuum to heterosexuality. Yet, there was a similarity. Rado also argued that people may engage in homosexual sex for reasons of sexual variety and due to "situational inaccessibility of the opposite sex."[8] When Rado's theories on homosexuality were published and became recognized in the 1940s, Freud's and Hirschfeld's theories on homosexuality became outdated.

1950s

In the late 1940s and throughout the 1950s Alfred Kinsey, Evelyn Hooker, and Edmund Bergler were key figures in a new division over the condition and treatment of homosexuality. Alfred Kinsey was the most influential of the three, primarily because he was funded and promoted by the Rockefeller Foundation. Kinsey was a man with an agenda to change the sexual norms of America. In fact, the Reese Committee, a United

States Congressional investigation into non-profit foundations, concluded that Kinsey's reports were "deliberately designed as an attack on Judaic-Christian morality."[9]

Kinsey had a fascination with aberrant sexual behaviors. He sought out homosexuals, sadomasochists, pedophiles, and rapists; the more sexual partners a person had and the more bizarre the behavior, the more he seemed drawn to the person. Kinsey's higher education was in zoology and biology. He had specialized in the study of wasps. His method of transforming the sexual mores of America was to study sex like he studied wasps. Kinsey rationalized that the human sex act was simply a biological function and in that sense all orgasms were essentially the same. How an individual achieved an orgasm was statistically interesting to Kinsey, but of no moral relevance to him.

Kinsey watched homosexuals and heterosexuals perform sex acts. He maintained correspondence with pedophiles without contacting authorities. There is even evidence that he encouraged pedophiles to keep records of their acts. To Kinsey the damage done to children from sexual acts with adults was the fuss others made over it. Kinsey, an avowed atheist, promoted a sexual morality that mirrored the amoral position of pure science, which translated into a relativist moral code in which no sexual behavior was immoral.

With a promotional campaign designed and funded by the Rockefeller Foundation Kinsey's books on sexual behavior shocked the world. His statistics claimed that 10 percent of the American population was homosexual, and that 37 percent of the male population had engaged in a homosexual act to the point of orgasm. The public was led to believe that Kinsey's statistics represented the general public. What was not known at the

time was Kinsey's fascination with homosexuals, and the trips he made to homosexual enclaves in big cities and to prisons to get data through interviews. The data from the homosexual enclaves and prisons was indiscriminately put together with all of Kinsey's other interviews so that the total sample of over 5000 males never did represent the general population.

The Rockefeller Foundation knew that Kinsey's statistics were corrupted and that there was no way to review where they came from. Kinsey's chief statistician, Clyde Martin, was responsible for the statistical mess. Martin had no background or training in statistics, yet the Rockefeller Foundation not only continued to fund Kinsey, they promoted his results. Later surveys of the general population found the percentage of homosexuals in the United States to be anywhere from less than 1 percent to a maximum of 2 percent.

Despite the critical evaluation of Kinsey's books on sexuality by the Reese Committee and others, Kinsey's ideology was incorporated into an institution when the Kinsey Institute was founded in 1956. The Kinsey Institute was the first institute of sexology in the United States. It also held America's largest library of pornography, much of it shot under the direction of Kinsey.

Evelyn Hooker was a psychologist intrigued by male homosexuals and sympathetic to the psychological disorder classification that psychiatry and psychology had given them. In the mid 1950s Hooker designed a study to cast doubt into the accepted diagnosis that homosexuality was a psychological disorder, i.e. a symptom of pathology. She reasoned that if she found even one homosexual who was considered psychologically

sound, then homosexuality was not necessarily a symptom of pathology. Thirty homosexual men and 30 heterosexual men were evaluated by three personality tests in Hooker's study. The homosexual subjects in her study were selected by homosexual activist leaders in the Los Angeles area. Results of the study found that two-thirds of the homosexual sample matched very closely to the heterosexual sample. Therefore, the Hooker study was used as evidence that homosexuality was not necessarily a symptom of pathology.

There was other qualifying information in the Hooker study that was not mentioned by those who used the study to advance the normalcy of homosexuality. The personality tests given the subjects did not test whether homosexual behavior was a psychopathological impulse, but rather sought to determine if the personality structures of normal homosexuals were as well adjusted as heterosexuals. The term "well adjusted" was not even defined. Hooker qualified her results by stating that another way to look at the study results was that homosexual pathology may only occur in an erotic situation and not necessarily in nonerotic situations such as personality tests. The most unmentioned information of the Hooker study was that almost one third of the handpicked homosexual sample had observable pathological personality disorders that its heterosexual counterpart did not.

Hooker's study did not invalidate Rado's theory of the reparative function of homosexuality in any respect. Rado had not proposed that homosexuality was always a symptom of pathology. He had offered two alternatives of it not being pathological. Rado's theory even proposed that the reparative adjustment of homosexual behavior

"may enable the individual to recapture his losses in function, pride, and social usefulness."[10] Hooker's study was irrelevant to Rado's theory, but it was very important for social politics.

Edmund Bergler was a vocal critic of Kinsey in the 1950s and a therapist who documented success in helping homosexuals change their sexual orientation. Bergler called Kinsey's work "statistical fairy tales based on preconceived prejudices."[11] Bergler argued that Kinsey was totally lacking in psychiatric knowledge, yet by denying the existence of the unconscious and the validity of cultural standards he attempted "to equate – and without reservation – heterosexuality and homosexuality."[12] The homophile movement, as it was called in the 1950s, was enamored with Kinsey and offended by Bergler. Bergler was the first mental health professional labeled an enemy by the emerging homosexual movement.

Bergler treated homosexuality as a masochistic symptom of a deeper personality disorder and published case histories of individuals he helped move from a homosexual orientation to a heterosexual orientation. He also was one of the first, if not the first, to document a case history where a homosexual boss discriminated against a homosexual employee because that individual sought to change his sexual orientation. In analyzing that incident Bergler described the darker side of some homosexuals to exhibit "*Power misused, malice exaggerated, cynicism pronounced, subtle systems of emotional blackmail perfected.*"[13] Bergler also made the prophetic suggestion that when a homosexual author is writing on the subject of homosexuality, he should reveal his sexual

orientation so that the reader is aware of potential bias. In many respects Bergler was the antithesis of Kinsey.

1960s

Several people emerged in the 1960s that would define the division over the condition and treatment of homosexuality. Irving Bieber and Charles Socarides emerged as the leading mental health professionals to anchor the view that homosexuality was often a symptom of pathology. Judd Marmor, Thomas Szasz, and Hendrik Ruitenbeek were three influential mental health professionals who proposed that "normal" homosexuals were just as psychologically healthy as normal heterosexuals. Marmor went through a philosophical transformation throughout the sixties that would lead him to help transform the American Psychiatric Association into an ally of the gay rights movement. Based on strong circumstantial evidence it appears Ruitenbeek was a disguised homosexual who used his status as a psychologist to further the concept of homosexual normalcy. Szasz's philosophical arguments challenged the cultural ideals that the conditions of homosexuality, alcoholism, and suicidal efforts were disorders, if the individual did not want help.

In 1962 Bieber and nine other therapists published the first major study done by full time psychoanalysts on homosexuality. The Bieber group studied 106 male homosexuals and 100 male heterosexuals over a period of several years. From this study came the correlation between the adult male homosexual and a boyhood parental structure with an absent or hostile father combined with an overbearing mother. The

psychoanalysts in the study were able to help male homosexual clients alter their sexual orientation in 28 percent of the cases.

Socarides first book on homosexuality was published in 1968, although he had been involved in research on homosexuality as early as 1958. Socarides main contribution in his 1968 book was the revelation that in many cases homosexuality had its origins in the toddler years of the individual's life, when for some reason the child was not able to identify with the same-sex parent. Those reasons were usually related to anxiety. Socarides contribution to understanding homosexuality built upon both the Bieber study and Rado's theories.

In the mid 1960s Socarides attempted to initiate a governmental program that would have changed the course of history had it been implemented. He made several efforts urging the National Institutes of Mental Health (NIMH) to start "a national program for the prevention and treatment of homosexuality and other sexual disorders."[14] His first presentation in February of 1965 was dismissed. A second presentation before a NIMH audience led to a Task Force on Homosexuality being appointed, but Socarides and Bieber were not invited to be on it. Socarides was told later by a member of the task force that he and Bieber were considered "professionally biased" because of their "Freudian approach."[15]

Evelyn Hooker was chosen to be the chairman of the NIMH Task Force on Homosexuality. Judd Marmor was one of the three psychiatrists chosen and the Kinsey Institute was represented by Paul Gebhardt. The final report of the NIMH Task Force on Homosexuality released in 1969 failed to address whether exclusive homosexuality was a

form "of arrested psychosexual development or a pathological condition." Instead the report asked for "society's toleration and understanding of the homosexual condition and the gradual removal of persecutory laws against such activities between consenting adults."[16]

The most radical change in the growing division over homosexuality in the 1960s happened in the homophile movement. In the 1950s the homophile movement had accepted the psychoanalytic paradigm that homosexuality was a disorder. The movement used the disorder classification to argue that because homosexuality was a disorder, homosexual behavior should not be against the law. That perspective changed in the 1960s as the homophile movement became the gay rights movement. The new leaders did not see homosexuality as a disorder, but as a normal variant of sexuality equal to heterosexuality. They saw the plight of the homosexual as the plight of a persecuted minority. Equality with heterosexuality became the objective of the new gay rights movement and the goal of equality overpowered any individual concerns of unwanted homosexuality. The new leaders identified with the civil rights movement and in the late 1960s gay activists began their civil disobedience by disrupting the professional presentations of mental health professionals who treated homosexuality as a disorder.

At the academic level the assault on the Judeo-Christian morals of the nation became institutionalized nationwide with the formation of the Society for the Scientific Study of Sex in 1957 and the Sex Information and Education Council of the United States in 1964. Both organizations were dominated by those who agreed with Kinsey's scientific morality. Judd Marmor was one of the cofounders of the latter organization. In

addition, sexology degrees became available through a New York University school under the direction of a homosexual activist named Deryck Calderwood, and Kinsey collaborator Wardell Pomeroy directed The Institute for the Advanced Study of Human Sexuality in San Francisco, which offered advanced degrees in sexology.

1970s

The key professionals in the growing division over homosexuality in the 1960s continued to be key figures in the 1970s – Bieber, Socarides, and Marmor played major roles, while Hooker, Szasz, and Ruitenbeek had background roles related to their publications. 1973 was the turning point when the new "normal variant" view of homosexuality [post-1973 paradigm] overpowered the existing disorder view of homosexuality [1973 paradigm]; the key moment being the removal of homosexuality from American Psychiatric Association's (APA) list of disorders (*DSM-III*). Judd Marmor and three other mental health professionals were vital to the 1973 APA paradigm shift, along with the increased civil disobedience by gay activists and the access gay activists had gained within the APA.

The first of the three vital to the paradigm shift was psychiatrist George Weinberg. Like Ruitenbeek and Szasz his support of the normal variant view of homosexuality gave it more credibility. In addition he had a long term impact by inventing the disorders of homophobia and internalized homophobia. These were used to criticize opponents of the normal variant view and they offered a new explanation of the psychological problems observed in homosexuals. The second vital mental health professional was a gay graduate student by the name of George Silverstein, who prepared

the normal variant argument before the APA's Nomenclature Committee. Before the decade was over Silverstein would become a psychologist and co-author the book *The Joy of Gay Sex*, which promoted gay sexual behavior. The third vital professional was psychiatrist Robert Spitzer. Spitzer's influence was regulated to the pivotal 1973 decision process within the American Psychiatric Association. He is credited with almost single handedly creating the recommendation to delete homosexuality from the *DSM* and moving it through the channels to approval by the Board of Trustees. Spitzer worked directly with gay activists. He controlled the information coming into the APA committees so that the normal variant view of homosexuality was virtually unchallenged. At the end of 1973 the APA followed the philosophical example of the new gay rights movement - the cause of eliminating the stigma of homosexuality became more important than the client distressed over a sexual identity or unwanted attractions.

Sex clubs and public bathhouses for male homosexuals multiplied dramatically in the 1970s. The anonymous and promiscuous sexual patterns of many male homosexuals were known by all familiar with male homosexuality. Evelyn Hooker and Alfred Kinsey had documented it as well as the psychoanalysts who treated homosexuality as a disorder. It was consensual and often occurred in public bathrooms, parks, and establishments with back rooms for male homosexuals. With the NIMH Task Force on Homosexuality recommending the removal of persecutory laws against homosexual acts between consenting adults in 1969 and the APA declaring that homosexuality was no longer a disorder in 1973, establishments that provided a meeting place for male homosexuals to have consensual sex grew into a 100 million dollar industry throughout America and Canada by the end of the decade.

The largest concentrations of gay bathhouses (establishments catering to men seeking gay sex) were in New York City and San Francisco. A gay doctor in New York City was quoted in 1980 as saying that the number of male homosexuals having anonymous sex had visibly increased by ten to twenty times since 1960. He estimated that ten to twenty thousand male homosexuals engaged in these acts each night in New York City's bathhouses, bookstores, and porno theatres. Every new bathhouse that opened increased the public health problem caused by promiscuous sex, but gay liberation had become a reality. Young gay men could have multiple sexual contacts a night without fear. Sexually transmitted diseases did increase dramatically, but they were controlled with modern medicine.

The gay influence in the universities began to increase also. Gay organizations appeared on campuses, often providing gay counselors to students questioning their sexuality. On a similar note, the schools of sexology introduced a new educational tool called Sexual Attitude Restructuring (SAR) in the 1970s. Used as a way to desensitize students to sex, fast moving pornographic films were shown with all types of sexual situations. Heterosexual acts, homosexual acts, sadomasochistic sex, bestiality, and animals having sex were knitted together in an attempt to stun the student's conscious into seeing them all as equal forms of sexual expression. Child pornography was included in the earlier SAR films until tougher laws prohibited it.

1980s

Although the American Psychiatric Association (1973) and the American Psychological Association (1975) no longer considered homosexuality a disorder or

symptom of a disorder, many psychoanalysts still did. An important advancement in the understanding of homosexuality as a symptom of a disorder came from Christian psychologist Elizabeth Moberly in 1983. After working with homosexuals for eight years Moberly believed that the hurtful childhood relationship many male homosexuals had with their father resulted in a 'defensive detachment' that was carried into adult relationships with other men. The early defensive detachment was a protective maneuver against the trauma of rejection the boy felt from his father. As a consequence the boy rejected his father and the masculinity his father represented. This in turn isolated the boy from his male peers and his own masculinity. From this causation scenario Moberly saw the resulting homosexual attractions of the boy as a reparative striving for his father's love and non-sexual male bonding. Consequently, the corrective psychotherapeutic help for such men was the undoing of the defensive detachment and the development of healthy non-sexual male friendships.

The early 1980s also saw advancement in the normal variant view of homosexuality with psychologist Alan Maylon's development of "internalized homophobia." Weinberg had postulated that the homophobic partiality of society made a young person's homosexual desires unacceptable before they were even aware of the desires. The result was that every young homosexual harbored internalized homophobic sentiments toward their same-sex attractions. From that premise, Maylon argued that most young homosexuals initially rejected their homosexual proclivities and developed a false self in an attempt to conform to the prevailing heterosexual standard. Consequently, Maylon's model of gay affirmative psychotherapy helped such individuals go through a second epoch of identity formation referred to as "coming out." Maylon's psychotherapy

helped individuals with same-sex attractions accept their homosexual attractions, encouraged them to identify as a gay man or lesbian, and taught that the obstacles hindering a satisfying homosexual life were homophobia and internalized homophobia.

The main story surrounding homosexuality in the 1980s was the emergence of the deadly epidemic known as AIDS (Acquired Immune Deficiency Syndrome). Exactly how the HIV virus that causes AIDS came to America is unknown, but its exponential spread throughout America was the result of promiscuous male homosexuals and the proliferation of gay sex clubs and bathhouses. Gay airline stewards were shown to be early transmitters of the HIV virus from city to city. Due to a long incubation period averaging five and a half years this sexually transmitted disease was an epidemic before the first cases of AIDS sent gay men to their doctors. Homosexuals infected with the HIV virus who donated blood infected the blood supply. Infected homosexuals who also used intravenous drugs infected other intravenous drug users, which in turn infected prostitutes who used intravenous drugs. Infected bisexuals also spread the virus to heterosexual women. Internationally, the spread of the HIV virus to Europe was directly linked to European gay men traveling to the gay bathhouses in New York City and San Francisco.

Because the outbreak of AIDS in the United States first appeared in gay men, AIDS was originally called Gay-Related Immune Deficiency or GRID. The very first report on the epidemic by the Center for Disease Control (CDC) did not have any reference to homosexuality because CDC staff were worried about offending gays. That was a precedent that would later become institutionalized.

Gay rights leaders initially refused to acknowledge that the promiscuous gay male lifestyle was spreading the disease. Health officials or gay spokespersons who urged gay men to modify their promiscuous lifestyle were called sexual fascists or worse by the gay community. When it became obvious that gay men were contaminating the blood supply by donating blood, gay activists opposed the screening of gay men as donors. In 1984 the CDC suggested a registry of people with HIV or AIDS be kept similar to the registry kept for people with syphilis and hepatitis B. The gay community protested that suggestion on the grounds that such a list would be used to discriminate against gay men. Gay activists and their lawyers also restricted the use of the antibody test for the HIV virus when it became available in 1985.

Soon a politically correct language called 'AIDSpeak' evolved which went to great lengths not to offend gay men by confronting the issue of their promiscuity or sexual practices. In turn, forums on AIDS, which were dominated by gay activists, condemned homophobia instead of promiscuous sex. By the end of 1986 20,000 people had died of AIDS.

1990s

The gay political influence in the mental health associations and universities continued to grow through the 1990s. In opposition to this dominance of gay ideology several mental health professionals formed the National Association for Research and Therapy of Homosexuality (NARTH) in the early 1990s. The founders of NARTH included psychiatrist Charles Socarides, psychiatrist Benjamin Kaufman, and psychologist Joseph Nicolosi. NARTH had several purposes. One was to give voice to

the research on homosexuality that had been dismissed by the gay domination of the subject. A second was to continue the research on the causation and the treatment of homosexuality. The third reason was to be an advocate for those with unwanted same-sex attractions and for therapists who helped them try to change their sexual orientation.

The gay organizations within the American Psychiatric Association and the American Psychological Association sought to discredit NARTH and its conviction that homosexuality was often a disorder or symptom of a disorder. A major confrontation played out openly in 1994. Gay psychiatrist Richard Isay used his position as the chairman of the American Psychiatric Association Committee on the Abuse and Misuse of Psychiatry to present a proposal that would have made it a violation for a psychiatrist to help a homosexual client change their sexual orientation even at the patient's request. After a heated exchange between Isay and Socarides, along with a threat from NARTH to renew the debate on the association's 1973 removal of homosexuality from its list of disorders, the association tabled the resolution.

The early 1990s saw media attention directed on the publications of several gay researchers, all of whom concealed their sexual orientation at the time their research was published. In 1991 Simon LeVay's report of a brain anomaly found in gay men suggested that homosexuality was an innate condition. Dean Hamer's research looking for a gay gene led to headlines across the nation in 1993 suggesting that a gay gene was the cause of homosexuality. When the research was discredited the media response was subdued. As a result, much of the American population now believed that homosexuality was genetic like race and gender.

In the 1990s psychologist Joseph Nicolosi emerged as one of the most influential mental health professionals treating homosexuality as a disorder. In addition to being a founding member of NARTH, he used Elizabeth Moberly's perspectives on male homosexuality to develop a model of treatment that would be known as reparative therapy. The therapeutic goal of Nicolosi's model was to help homosexual male clients with unwanted same-sex attractions to grow into a male heterosexual identity. Part of reparative therapy's technique was to develop a non-erotic intimacy between the male therapist and the male client. This healthy same-sex relationship was the first step in undoing the defensive detachment formed in the adult homosexual's childhood. Its undoing offered the possibility of developing other non-sexual male relationships that could reinforce his growing masculinity. In the course of reparative psychotherapy the causal factors of the client's homosexuality would usually become evident in reparative therapy. The therapist's interpretation of the causal factors gave the client another cognitive reason to pursue the masculinity that he rejected in his youth.

Later in the 1990s gay psychiatrist Jack Drescher emerged as one of the most influential mental health professionals advocating the normal variant philosophy of homosexuality. Besides being an outspoken critic of reparative therapy, Drescher built upon Maylon's model of gay affirmative psychotherapy. Like Maylon, Drescher saw the major conflict for individuals with same-sex attractions as between their homoerotic and homophobic feelings. The principle therapeutic goal of Drescher's gay affirmative psychotherapy was to help the client make sense of his homoerotic feelings so that the psyche would accept them. As the client was helped to understand his homosexual feelings as normal and his problems as the result of homophobia, the therapist supported

the client's efforts to come out – accept the homosexual feelings and identify as a homosexual. From Drescher's perspective coming out was "an ongoing process that never ends,"[17] and only the normal variant view of homosexuality could sustain a positive homosexual identity.

2000s

Shortly after the turn of the century psychologist Joseph Nicolosi and his wife Linda published *A Parent's Guide to Preventing Homosexuality*. After forty years of talking about prevention, finally, a mental health professional offered an important advancement in the prevention of homosexuality. The Nicolosis' information was simple, yet profound. Using Moberly's understanding of the disconnection between the young boy and his father as a defensive detachment, the boy's parents could work to undo the defensive detachment and help the boy embrace his masculinity. The solution did not center on the boy seeing a psychoanalyst; instead, the solution centered on the parents being coached by the psychoanalyst! It was the father's responsibility, or another close male, to become a male figure worthy of trust by the boy. Parents were also advised to selectively put the boy in situations with other boys where he could feel safe and fit in. These simple steps, yet difficult at times, had the potential of reversing the boys rejection of his masculinity.

Other major advances in reparative psychotherapy occurred soon after the turn of the century. Affect-Focused Therapy techniques were ideally suited to uncover the trauma of rejection buried in the subconscious and body of troubled homosexuals. Once uncovered the analyst could re-experience the past trauma with the client in a supportive

way, helping to heal the old wounds and developing an intimate non-sexual same-sex relationship between the therapist and client. Eye Movement Desensitization and Reprocessing (EMDR) was a new treatment for trauma related disorders and it too proved to be an effective tool in the treatment of unwanted homosexuality.

A significant advancement in gay affirmative psychotherapy was its adoption of liberation psychology. Liberation psychology took the internalized homophobia hypothesis a step further by declaring that homosexuals also suffered from psychological oppression as an oppressed minority. This theory argued that the oppression of the majority culture over the gay and lesbian subculture produced shame in the individual homosexual. What followed from that analysis was the therapeutic solution to undo the homosexual's internalized oppression by encouraging the client to engage in political actions to end the oppression of homosexuals. Liberation psychology was openly Marxist in philosophy.

Toward the middle of the decade two psychologists, Warren Throckmorton and Mark Yarhouse, proposed an alternate psychotherapy for homosexuality. These two men envisioned a therapeutic setting where a gay identity could be affirmed as well as a religious belief that homosexual behavior was immoral. Their "sexual identity therapy" was directed toward the individual who was conflicted over their homosexual attractions and their religious beliefs. The neutral position of the sexual identity therapist was envisioned as not only neutral about which direction the client took, but neutral as to whether one outcome was preferable over the other. Unbiased information was supposed to be given to the client in order for the client to make an informed decision on which

sexual identity they would pursue. Once the client chose his or her direction, the therapist would help the client adjust to the sexual identity chosen or refer them to another therapist who would. Of interest, Throckmorton claimed that reparative psychotherapy was not compatible with sexual identity therapy, but, by omission, inferred that gay affirmative psychotherapy was.

The most controversial study on homosexuality in the first decade of the twenty-first century was the Spitzer study. Psychiatrist Robert Spitzer was the pivotal figure who orchestrated the resolution to remove homosexuality from the American Psychiatric Association's list of disorders. In the first years of the decade Spitzer contacted a sample of individuals who identified as ex-gays and created a study protocol which sought to document any possible benefits of reorientation therapy. Spitzer found that sexual orientation change did occur and that it occurred on a continuum. Additional benefits the study documented from reorientation therapy included "decreased depression, a greater sense of masculinity in males, and femininity in females, and developing intimate non-sexual relations with members of the same sex."[18] From the results Spitzer argued that "mental health professionals should stop moving in the direction of banning therapy that has as a goal a change in sexual orientation."[19]

In 2009 gay activists were able to get a resolution passed through the American Psychological Association which instructed mental health professionals "to avoid telling clients that they can change their sexual orientation through therapy or other treatments."[20] The task force that brought this resolution forward was appointed by the president of the American Psychological Association in 2007. Most, if not all, of the six

members appointed to the task force identified as gay or lesbian. The chair of the task force, Judith Glassgold, was an outspoken lesbian and an advocate of liberation psychology.

The decade ended with gay psychiatrists and psychologists continuing to guide the American Psychiatric Association and the American Psychological Association down the road taken by the post-1973 paradigm. By the end of 2008 the CDC estimated that 617,025 people had died of AIDS in the United States and over 17,000 more continued to die each year. 61 percent of new HIV infections were occurring in gay and bisexual men.

The damage done by the post-1973 paradigm

A loss of professional and academic integrity was one outcome from the post-1973 paradigm. Decades of clinical evidence was dismissed, not because it was inaccurate, but because it did not support the normal variant philosophy of homosexuality. Following 1973, therapies that reported successful homosexual orientation change were no longer given recognition. Individuals with unwanted same-sex attractions were disregarded as unimportant to the bigger picture of homosexual equality. Students and the general public were denied accurate information on homosexuality for the political purposes. Prevention of homosexuality was also disregarded, because homosexuality was no longer a disorder. In the last ten years, some of the mental health professionals who originally supported the post-1973 paradigm have realized its damaging effects on clinical science, psychotherapy, and the credibility of the American Psychiatric Association and the American Psychological Association.

Another outcome of the post-1973 paradigm and the promotion of Kinsey's scientific morality was the large number of individuals who died from AIDS. A gay doctor in New York City estimated that the number of male homosexuals having anonymous sex at bathhouses and other homosexual hangouts increased by ten to twenty times from 1960 to 1980. It is doubtful that establishments for consensual male homosexual sex would have grow into a 100 million dollar industry without Kinsey, the Rockefeller Foundation, sexology, the 1960s NIMH Task Force on Homosexuality, and the post-1973 paradigm supporting the normal variant view of homosexuality and calling for tolerance of consensual homosexual sex.

Consider what could have happened if the NIMH had followed Socarides suggestion in 1965 and researched the prevention of homosexuality. The Nicolosis' 2002 advancements in the prevention of homosexuality would probably have been discovered in the late 1960s and given to school counselors and mental health professionals. A significant number of individuals would not have become homosexual and the "born that way" theory would have been abandoned even by gay activists.

The wrong turn started in the late 1940s by Kinsey and the Rockefeller Foundation and legitimized by the 1973 paradigm shift in the American Psychiatric Association arguably could have accounted for 80 percent of the increase seen in the number of male homosexuals engaging in promiscuous sex. If that is an accurate estimation and male promiscuity was directly related to the spread of AIDS, the wrong turn started by Kinsey could be indirectly responsible for 450,000 to 500,000 of the approximately 650,000 AIDS deaths in the United States through 2011.

Critique of therapies for homosexuality today

Gay affirmative therapy

A tactic of psychotherapy used with unstable personalities is to give the client an inexact interpretation that gives him comfort while not giving him true insight into his psychological problem. Part of the tactic involves the therapist giving the client an intellectual idea to rationalize his own problem. The purpose is to lessen the patient's anxiety in order to restore a workable equilibrium in the client. Although the client's equilibrium becomes more workable in inexact interpretation therapy, his psychological problem remains.

This description of inexact interpretation therapy has a strong resemblance to gay affirmative psychotherapy. The first resemblance is gay affirmative therapies rejection of the causal evidence related to childhood tauma. Usually, the argument for the dismissal of the evidence has been that the clinicians who documented the evidence had anti-homosexual biases or favored Judeo-Christian morality. Yet, none of those critics seemed to understand how their own pro-gay biases had influenced their rejection of the evidence. A recent example of a gay affirmative therapist dismissing the etiological evidence is psychiatrist Jack Drescher. His model of gay affirmative psychotherapy uses the therapeutic sessions to help the client make sense of their homosexual feelings and behaviors, and purposely avoids trying to find out why they have those feelings and behavioral compulsions.

The second resemblance to inexact interpretation therapy is gay affirmative therapy's strategy to let a homosexual client believe that they were born homosexual. All the evidence to date points to the conclusion that homosexuality is not a condition with which an individual is born. It is generally conceded, even by pro-gay advocates, that a determining genetic or biological element will not be found as the cause of homosexuality. Yet, gay affirmative therapists encourage a client who believes their homosexuality is an innate condition to continue believing that falsehood. Gay affirmative therapist Jack Drescher has argued that to crush a client's belief that they were born homosexual is tantamount to crushing their "belief that being gay was good."[21] This is an explicit example of the avoidance of true insight in an attempt to lessen the client's anxiety.

A third resemblance to inexact interpretation therapy is gay affirmative therapy's use of the intellectual idea "internalized homophobia" to rationalize the problems associated with homosexuality. Homophobia was created to offer an alternative rationale to the pathological causation theories of homosexuality. Internalized homophobia does not necessarily give insight into the psychological problems related to an individual's homosexuality. It can always give the client and the therapist an idea to rationalize the client's psychological problems.

Reparative therapy

The two main criticisms of reparative psychotherapy are that its low success rate produces harmful results and what it actually considers a successful treatment is often a failure. Critics argue that because reparative psychotherapy cannot help most homosexual

clients change their sexual orientation, the experience for most homosexuals is a negative experience. The harmful effect is usually in the realm of disappointment and feelings of failure.

Reparative therapists view the homosexual act to often be a reparative attempt by the individual to correct the affects of childhood trauma. As a reparative bonus the homosexual act provides a pleasure reward in orgasm that affects the brain in much the same way as drugs do. In this respect treating homosexuality through psychotherapy is similar to treating people for drug use and drug addictions, alcoholism, food addictions, pornography addictions, etc. In those type of comparisons reparative therapy's success rate of 25 to 35 percent appears to be at least average and above average in some comparisons.

In addition, a successful comparative psychotherapy does not claim that the drug addict who quits the habit will never desire to use drugs again, or that the sober alcoholic will never desire to drink alcohol again, or the person who overcomes a pornography addiction will never be tempted by pornography. Desires can continue and relapses sometimes occur in all these types of psychotherapies for unwanted behavior. In the same way a successful sexual orientation change should not expect the individual to never have same-sex attractions or thoughts ever again. There should not be a double standard applied to sexual orientation change.

The most significant contribution that has been put forward by reparative therapists has not been utilized at all by society. Prevention of homosexuality is potentially a much easier task than changing sexual orientation, and prevention is age

relevant and less likely once puberty has begun. The potential of helping boys with defenses of dissociation that manifest into rebellion against their masculinity is exponential. The same potential exists for girls with similar defenses of dissociation. At a young age assistance to help these troubled children bond to their masculinity or femininity could heal wounds of rejection and build self-confidence. If this knowledge and skill were to be developed into a curriculum and used widely in society, the results could be astoundingly positive.

Sexual identity therapy

Sexual identity therapy is the new kid on the block, so to speak. It wants to appear neutral to any outcome in sexual orientation a client takes. Two criticisms stand out. Will the information given to the client be unbiased and give all viewpoints, and is it really healthy for a therapist to be completely unbiased? If the answers are no, then sexual identity therapy does not fulfill its objective as a psychotherapy.

Similar to gay affirmative therapists, sexual identity therapists do not try to uncover the causal factors of the client's homosexuality. Instead, therapists are advised to discuss the different versions of homosexual etiology with the client to get the client's reactions to how the different etiologies affect their choice of sexual orientation direction. This therapeutic tactic seems more like that of a salesperson than a psychoanalyst. The therapist helps the client pick out the right sexual orientation and behaviors for himself, and then the therapist proceeds to help the client become a happy consumer of his chosen sexual orientation and behaviors.

If the sexual identity therapist informs the male client that a choice of a gay identity may include a life-long search for a masculine identity he will probably never find, then the therapist will be honest. It is likely that the sexual identity therapist will inform the client that efforts to change sexual orientation are difficult and successful less than fifty percent of the time. Bias determines what one believes is honest information. It remains to be seen how many therapists can be completely unbiased about the condition of homosexuality, and how many will undertake the investigation necessary to learn and accurately present both sides of the division.

The second criticism is whether it is really healthy for the therapist to be completely unbiased and neutral on the condition of homosexuality. If internalized homophobia is the cause of distress for homosexuals, should not the therapist seek to undo it? If the underlying cause of an individual's homosexual condition is a defense of dissociation resulting from childhood trauma, should not the therapist try to resolve the buried trauma and defense of dissociation disorder? If sodomy is an unhealthy sexual practice, should not therapists and mental health professionals discourage it? If male homosexual promiscuity is responsible for the vast majority of new HIV infections, should not therapists discourage homosexual promiscuity?

While a therapist needs to let the client make his own decisions regarding his or her sexual orientation, and respect the client's decision, a neutral stance on the condition of homosexuality is not necessarily a good position. A neutral position on the condition of homosexuality implies that homosexuality is equal to heterosexuality. Most likely, that

is why sexual identity therapy has been embraced by many gay affirmative therapists and why it has been criticized by reparative therapists.

Getting back on the right road

There is significant evidence that the 1973-paradigm did not live up to its expectations. Its promise of alleviating homosexual distress by changing societal attitudes on homosexuality is questionable at best. Individuals with unwanted same-sex attractions were abandoned by the American Psychiatric Association and the American Psychological Association. The post-1973 paradigm has marginalized the psychoanalyst who views homosexuality as a symptom of a disorder in much the same way as society used to marginalize the homosexual. A new disorder has been created to replace the disorder of homosexuality. Judeo-Christian beliefs that homosexual behavior is a sexual perversion are now considered a disorder called homophobia. Simply not accepting the post-1973 paradigm that homosexuality is a normal variant of sexuality equal to heterosexuality also qualifies as a homophobic disorder.

It is doubtful that the American Psychological Association will accept reparative psychotherapy and rescind its 2009 resolution instructing therapists not to inform their clients that sexual orientation can be changed through therapy. It is also doubtful that the American Psychiatric Association will acknowledge that the deletion of homosexuality from its list of disorders in 1973 was based on political reasons rather than science. If a significant number of mental health professionals believe that the normal variant road taken by Alfred Kinsey and the 1973 paradigm shift in the American Psychiatric

Association was a wrong turn, then it begs the question, "How do mental health professionals get their associations back on the right road?"

Former president of the American Psychological Association, Nicolas Cummings, has stated that a large number in the American Psychological Association are "demoralized and detached" from the association because of its "ultraliberal agenda."[22] They remain members of the association mainly due to benefits such as malpractice insurance. Cummings proposal that the America Psychological Association take political power from its divisions and use "a one-member, one-vote democratic principle for all offices"[23] was not even entertained by the leadership. In addition, Cummings described the leadership of the American Psychological Association as "an oligarchy of about 200 who recycle themselves through various offices in a kind of musical chairs."[24] Political power systems of this type are designed to make it next to impossible to unseat those who hold the power.

The most logical and realistic alternative would be for the disfranchised members to start an alternative psychological association based on Cummings "one-member, one-vote democratic principle for all offices." There are precedents. Other professional disciplines have opposing schools of thought, which results in more than one source of accreditation.

A new psychiatric and psychological association would be removed from the liability the existing association has for its promotion of homosexual behavior and other ultra-liberal causes. Psychologist Joseph Nicolosi has made the distinction that tolerance of behavior and beliefs does not mean one needs to approve of them. That would be a

helpful philosophical distinction to define the new associations. In application, the neutrality in the therapeutic setting would not necessarily be transferred to behavioral goals or cultural norms.

Disfranchised professionals in other mental health associations will probably have to start alternative associations as well, because of how political power is generally concentrated and protected. Alternate mental health associations would directly affect the academic world, giving an alternative viewpoint. For public universities to distance themselves from ultra-liberal agendas, political battles will have to be waged in the universities as well. All new associations and attempted changes in the universities should expect to be the targets of militant protests and legal lawsuits, for those are the tactics that have made the gay political movement powerful.

Next, Charles Socarides idea of a governmental office supporting research into the prevention of aberrant sexual behavior needs reconsideration. The research aim should be limited to how trauma in childhood and adolescence results in aberrant behavior, but the resulting aberrant behavior should be expanded beyond sexual behavior to include violence, suicide, depression, drug use, and criminal behavior. A second focus of the research should seek effective methods of undoing the trauma and psychological distress of these adolescents. Third, a governmental program, maybe consisting only of guidelines and suggested programs for schools, should make the latest information on the prevention of homosexuality general knowledge.

Finally, Alfred Kinsey needs to be exposed as an idealistic fraud who intentionally weighted statistics as a way to promote homosexuality and alter the cultures

norms of sexual behavior. In addition, Kinsey's data collecting from pedophiles and his approval of adult-child sexual relations needs to be general knowledge.

An investigation needs to be conducted to find out if Kinsey's fraudulent statistics in the American Law Institute's Model Penal Code of 1955 still affect the law of the land today. On the academic front, the Kinsey roots of sexology need to be exposed to the public as well as sexology's early connections to Penthouse, Hustler, and Playboy magazines.

An alternative academic discipline needs to be created that studies sexuality for the purpose of developing healthy spousal relationships and healthy family dynamics. The alternative to sexology should uphold the traditional family dynamic, so that the public education systems and individuals seeking counselors have that option to choose from. A traditional values based discipline would look at sex as part of a life-long psychological relationship instead of the Kinsey view which compared human sex to the biological functions of an insect.

A modern dark age

Psychiatrist Thomas Szasz's arguments motivated some mental health professionals to join with gay activists in the 1970s. Szasz had built upon psychologist Robert Lindner's argument that non-conformity had become synonymous with mental illness by the 1950s. Lindner argued that medical professionals were wrongly coercing people to conform to norms set by the medical establishment. Szasz agreed. From Szasz's

perspective the mental health establishment was supplying a mental illness ideology that the government was using to oppress minorities. These oppressed minorities included alcoholics, drug addicts, and homosexuals. Szasz compared the mental health influence in society to the influence of the Church in medieval society. He argued that putting so-called mental patients into an asylum was the equivalent of the Inquisition's persecution of so-called witches. In many cases Szasz was right on.

On a similar front Szasz claimed that psychiatric opinion was based on prejudice that supported traditional morals. He made psychiatrists aware that society now looked to them to define acceptable behavior, instead of the powerful priests of the past. Szasz argued that by defining homosexuality, alcoholism, and drug addiction as disorders, psychiatrists were upholding the same morality priests imposed upon the people of the Dark Ages. It was a revelation to psychiatrists in the 1960s that they had the power to define what acceptable behavior in society was. It was also repulsive to some mental health professionals that their profession was upholding a value system based on Judeo-Christian beliefs.

In response to the philosophical revelations of Szasz a group of mental health professionals joined together to change the culture's norms. The 1973 removal of homosexuality from the American Psychiatric Associations list of disorders was a revolution. From that point on a relativist value system began to be advocated by some mental health leaders as an example for society to emulate. The new mental health priests espoused the doctrine that the past views of homosexuality were heretical to science and a disorder called homophobia.

What the new mental health priests overlooked was that their revolution was only political. It did not bring forth suppressed truth. Instead, it suppressed truth. The revolution disregarded the clinical evidence of homosexual causation and hid it from future generations. New information on the causation and treatment of homosexuality found by the opposition was labeled sacrilegious, treated with contempt, and condemned. Although the "born that way" theory of homosexuality had been discredited for over 70 years, the general public was led to believe it was true. The male homosexual promiscuity rationalized as normal by the new mental health priests contributed to a whole industry that provided venues for anonymous sexual contacts. That sexual scene provided the perfect venue to spread sexually transmitted disease. The true legacy of the new mental health priests and the post -1973 paradigm is the creation of a modern dark age.

Notes

[1] Lewis, *Mere Christianity*, 28.

[2] Marmor, Introduction to *Sexual Inversion*, 2.

[3] Socarides, *Overt Homosexual*, 23-6.

[4] Bieber, "Sexual Deviations. I. Introduction," 960.

[5] Freud, "Letter," 1.

[6] Hirschfeld, "Adjustment Therapy," 151-3.

[7] Rado, "An Adaptational View," 105-8.

[8] Ibid., 123.

[9] Reisman, *Kinsey: Crimes and Consequences*, 321.

[10] Rado, "An Adaptational View," 110.

[11] Bergler, *Homosexuality: Disease or Way*, 68.

[12] Ibid., 177.

[13] Ibid., 296-7.

[14] Socarides, *Beyond Sexual Freedom*, 84.

[15]Ibid., 86.

[16] Ibid., 86-7.

[17] Drescher, *Psychoanalytic Therapy*, 315.

[18] Spitzer, "Can Some Gay Men," 55.

[19] Ibid., 57.

[20] American Psychological Association, "Insufficient Evidence," August 5, 2009.

[21] Drescher, *Psychoanalytic Therapy*, 73.

[22] Byrne, "NARTH's President Chairs Symposium," 2007.

[23] Ibid.

[24] Ibid.

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