A Symposium: Should Homosexuality Be in the APA Nomenclature?

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A session of the annual meeting of the American Psychiatric Association in Honolulu, Hawaii, on May 9, 1973, was devoted to "Should Homosexuality Be in the APA Nomenclature?"

The participants were:
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Their papers are abstracted below. The session was organized and chaired by Robert L. Spitzer, M.D., Director, Evaluation Section, Biometrics Research, New York State Department of Mental Hygiene, 722 West 168 St., New York, N.Y. 10032, and Associate Professor of Clinical Psychiatry, Department of Psychiatry, Columbia University. His paper, which is also abstracted below, was written after the meeting. Reprint requests should be directed to Dr. Spitzer.

Criteria for Psychiatric Diagnosis

BY ROBERT J. STOLLER, M.D.

IS HOMOSEXUALITY a diagnosis? A diagnosis is supposed to be a highly compact explanation. To make a proper diagnosis in any branch of medicine there should be: a syndrome—a constellation of signs and symptoms shared by a group of people, visible to an observer; underlying dynamics (pathogenesis)—pathophysiology in the rest of medicine, neuropathophysiology or psychodynamics in psychiatry; and etiology—those factors from which the dynamics originate. When these exist, one can save time by using shorthand, knowing that a word or two—a label, a diagnosis—communicates to others what we know. Unfortunately, the conditions for which our specialty was developed do not usually fulfill these three criteria.

If one uses the above criteria for considering a condition a diagnosis, homosexuality is not a diagnosis because: 1) there is only a sexual preference (noticeable because it frightens many in our society), not a constellation of signs and symptoms; 2) different people with this sexual preference have different psychodynamics underlying their sexual behavior; and 3) quite different life experiences can cause these dynamics and behavior. There is homosexual behavior; it is varied. There is no such thing as homosexuality. In that sense it should be removed from the nomenclature.

As regards pathogenesis, probably no one these days, not even among those favoring the diagnosis, believes in a unitary cause for homosexual behavior; that would make it a thing. The fine reviews of the literature on etiology by Bieber and associates and Socarides, plus their own findings (1, 2), reinforce the impression that many paths lead to one's preferring members of his own sex. This is true even, and especially, with analytic theories of etiology.

Part of a Natural Realm

However, there is something disreputable in using our feeble method of diagnosis and psychiatrists en masse as the whipping boys for the cruel manner in which homosexuals have been and still are treated. These diagnostic issues are not the real source of homosexuals' mistreatment (although they can be borrowed for such use). At our best, we—since Freud's lead—are partly responsible for the fact that homosexuals can begin fighting back against society. Even though we are inaccurate when we call homosexuality a diagnosis, doing so has signified that the homosexual is part of a natural realm and not a member of the species of damned sinners. If homosexuals hate psychiatrists who would oppress them, let them also concede their debts to those who wish them free. If these niceties are bad for strategy, then let homosexuals—and other minorities—continue to flail us; the cause is honorable although the technique may be crude.

In the search for the multiple causes of homosexual behavior, I believe data can be found demonstrating that for many homosexuals the preferences in object choice and some essential, habitual nonerotic behavior (e.g., the effeminacy of some male homosexuals) were developed...
as the result of trauma and frustration during identity development. Of course, these observations must be understood in the context that I believe they also hold true for most heterosexuals, although the traumas and frustrations are of different sorts and intensities.

Perhaps one can divide humans into two types, heterosexuals and others, as is the custom; if so, we might sort the two in the following idiosyncratic manner (rather as Freud did). I would consider the sexual styles of most humans, including most who prefer homosexual relations, as would-be heterosexual. (Analysts have also shown how heterosexuality may also contain homosexuality.) I believe that the sexual neuroses—the obvious perversions and even most variants of overt heterosexuality, e.g., compulsive promiscuity, use of pornography, preference for prostitutes, masturbation—are heterosexual distortions, compromises nonetheless filled with excitement, that allow one to give up certain desires if only others can be salvaged. If it will make the oppressed minorities more comfortable, we can all be given a diagnosis; such pronouncement would certainly not often distort the case. Everyone has his own style and distinctive fantasy content that he daydreams or stages with objects. Everyone is entitled to a category.

But why claim that heterosexuality is mankind's preference? The evidence for this as a biological given is certainly flimsy (although I would guess that it is innate in some mild, reversible form). Yet I think that up to the present (not necessarily forever) heterosexuality has been the norm. It is the dominant presence in the ambiance of almost every human in infancy and childhood, because he is created in a family and families are palpably heterosexual (2, pp. 5–6). That sets the standard: heterosexuality is the product of the institution called the family. Then, too, even in childhood we know we are the result of an intimate, highly charged, astonishing, mysterious, unquestionably heterosexual act. So I see perversions (but not all sexual deviations and not all homosexual behaviors) as modifications one must invent in order to preserve some of one's heterosexuality. The form the perversion may take is far from the extreme of a male preferring a female and vice versa, in which both wholeheartedly enjoy the sexual and loving aspects of their relationship. Yet, while unseen, that ideal may well be buried there in most of us, even if it is manifest in only a few.

**A Holding Action**

Until the day we know what we are doing, I suggest that—as a holding action—we try the following descriptive syndrome classification system:

**A. The personality (character) type, habitual since childhood, e.g., obsessive-compulsive, schizophrenic, hysterical, depressive.**

1. The presenting syndrome, e.g., drug dependence, anxiety neurosis, schizophreniform psychosis.

a. Subsidiary syndromes also present, e.g., alcoholism; nonpsychotic organic brain syndrome with senile brain disease; psychophysiological respiratory disorder (asthma).

**Sexual preference, e.g., heterosexual, monogamous, with accompanying fantasies of being raped by a stallion; homosexual, with foreskin fetishism; heterosexual, with preference for cadavers; homosexual, with disembodied penises (tearoom promiscuity); heterosexual, voyeurism; homosexual, expressed only in fantasies during intercourse with wife.**

Only when diagnoses fail to describe succinctly and accurately should they be removed. Since that is the case for homosexuality, it cannot function as a true diagnosis; remove it. And since that is true for most of the rest of the “diagnoses” of psychiatry, let us scrap the system (although not yet all the labels) and start afresh.

**Homosexuality and Cultural Value Systems**

**By Judd Marmor, M.D.**

**Proponents** of the mental illness label for homosexuality base their arguments on three major themes: 1) that homosexuality is the consequence of “disordered sexual development,” 2) that it is a deviation from the biological norm, and 3) that psychodynamic studies of homosexuals always reveal them to be deeply disturbed individuals.

The disordered sexual development theme is based on the finding that a certain type of disturbed parent-child relationship is a background factor in most cases. There seems to be an assumption in this theme that if there is a disturbed parent-child relationship in the background of someone with variant sexual behavior this proves that the disturbed relationship is causally responsible and that the individual with such variant behavior must be mentally ill.

There are a number of fallacies in this argument. First, we know that although most homosexuals show the “typical” family constellation, by no means do all of them. Secondly, not all people who do have such family constellations in their background become homosexual. Third (and most importantly) to call homosexuality the result of disturbed sexual development really says nothing other than that you disapprove of the outcome of that development. All personality idiosyncrasies are the result of background developmental differences, and all have specific historical antecedents. The concept of illness cannot be extrapolated on the basis of background but must rest on its own merits.

**Deviant Behavior not Necessarily Psychopathology**

It is my conviction that we do not have the right to label behavior that is deviant from that currently favored by the majority as evidence per se of psychopathology. And, as a matter of fact, we do not do so except where we are reflecting our culture’s bias toward a particular kind of deviance. In a democratic society we recognize the rights of individuals to hold widely divergent religious or ideological preferences, as long as their holders do not attempt to force their beliefs on others who do not share them. Our attitudes toward divergent sexual preferences,
however, are quite different, obviously because moral values—couched in "medical" and "scientific" rationalizations—are involved.

There are some psychiatrists who would argue that individuals who adhere to unusual life-styles are indeed neurotic and that they suffer from various developmental fixations or arrests that account for their inability to adhere to the behavioral or ideational standards of the majority. Such labeling tends to define normality in terms of behavioral adjustment to cultural conventions rather than in terms of ego strengths and ego-adaptive capacities, and it puts psychiatry clearly in the role of an agent of cultural control rather than of a branch of the healing arts.

Moreover, the relativity of our contemporary sexual mores should not be ignored in any scientific approach to sexual behavior. In a cross-cultural study of 76 societies other than our own, Ford and Beach (3) found that in nearly two-thirds of them homosexual activities were considered normal and socially acceptable at least for certain members of the community. Nor were all these societies necessarily "primitive" ones. In ancient Greece—a society that we admire and feel indebted to culturally, philosophically, and scientifically—overt homosexual relations between older men and youths was not only considered acceptable but was an institutionalized practice cultivated by heterosexual, healthy, honorable, normal men.

Bisexuality—Our Mammalian Inheritance

The second major argument for the illness viewpoint is that homosexuality, in contrast to other forms of behavioral deviance, is biologically unnatural. Dr. Frank Beach, the eminent biologist, has summarized the evidence on this by pointing out that bisexual behavior has been observed in more than a dozen mammalian species and "undoubtedly occurs in many others not yet studied." He concluded: "Human homosexuality reflects the essential bisexual character of our mammalian inheritance. The extreme modifiability of man's sex life makes possible the conversion of this essential bisexuality into a form of unisexuality with the result that the member of the same sex eventually becomes the only acceptable stimulus to arousal" (4).

Thus, from an objective biological viewpoint there is nothing "unnatural" about homosexual object choice. To illustrate how specious the argument is concerning the supposed biological unnaturalness of homosexuality let us consider some other conditions that are also outside of the presumably customary biological patterns. What about vegetarians? After all, most human beings are "naturally" meat-eaters, but we don't automatically label vegetarians as mentally ill. Or what about celibacy? Do we automatically assume that all people who choose a life of sexual abstinence are mentally ill simply because they do not follow the "natural" biological mating patterns? Obviously, we do not.

The third argument that is often advanced is that any careful study of the personality of homosexuals will show that they are really disturbed individuals. In contrast to Socrarides, who holds the view that all homosexuals are practically borderline psychotics, Bieber concedes that many homosexuals can be well-adjusted individuals, but he argues that they still suffer from "pathology."

Happy, Constructive, and Realistic Homosexuals

What does constitute the intrinsic "pathology" of a socially well-adjusted homosexual? I submit that in the view of Bieber, Socrarides, and others who share their viewpoint, it is primarily that his sexual preference differs from that of the majority of society. I do not deny that there are homosexuals who, just like heterosexuals, suffer from a wide variety of personality disorders and serious mental illnesses, although much of the dis-ease that they suffer from is not intrinsic to their homosexuality but is a consequence of the prejudice and discrimination that they encounter in our society.

But I believe there is now an incontrovertible body of evidence that there are homosexual individuals who, except for their variant object choice, are happy with their lives and have made a constructive and realistic adaptation to being members of a minority group in our society.

I consider the kind of evidence that Socrarides marshals from his clinical practice as essentially meaningless in this regard. As I have often pointed out, if our judgment about the mental health of heterosexuals were based only on those whom we see in our clinical practices we would have to conclude that all heterosexuals are also mentally ill.

The final absurdity of this is the impossibility of trying to define at what point a person becomes a homosexual who is labeled as having a mental disorder. Some defenders of the illness theory try to justify it by saying that it applies only to obligatory homosexuality. Does this mean that only type 6 homosexuals are mentally ill and all the others are not? Or that type 4, 5, and 6 are ill but not 1, 2, and 3? The whole process of such labeling is unpleasantly reminiscent of the Hitlerian process of trying to determine what fraction of black or Jewish ancestry a person might be permitted to have and still be considered an acceptable member of society with full legal rights.

Surely the time has come for psychiatry to give up the archaic practice of classifying the millions of men and women who accept or prefer homosexual object choices as being, by virtue of that fact alone, mentally ill. The fact that their alternative life-style happens to be out of favor with current cultural conventions must not be a basis in itself for a diagnosis of psychopathology. It is our task as psychiatrists to be healers of the distressed, not watchdogs of our social mores.

Homosexuality—An Adaptive Consequence of Disorder in Psychosexual Development

BY IRVING BIEBER, M.D.

THREE QUESTIONS seem most relevant to the question of...
HOMOSEXUALITY AND THE APA NOMENCLATURE

removing the term "homosexuality" from the Diagnostic and Statistical Manual of Mental Disorders or changing the current designation:

1. Is homosexuality a normal variant of sexual development and sexual functioning? The long-term study that my colleagues and I reported in 1962 (1), further investigations of colleagues, and the extensive clinical experience of myself and others since then leave no doubt that homosexuality is not merely a variation of normal adult sexuality. Observations on ollaction offer supporting evidence that humans born with normal gonads and genitals are biologically programmed for heterosexual development. From early life, ollaction plays a central role in sexual organization and functioning: it steers the infant toward heterosexual objects and works as an important triggering mechanism in sexual arousal (5, 6). Homosexuality does not occur without antecedent heterosexual development; it appears only after sexual responsivity to heterosexual objects has been established. Psychoanalytic evidence of heterosexual responses in homosexuals can almost always be demonstrated.

I have repeatedly emphasized that the dislocations in heterosexual organization of biologically normal children occur as a consequence of pathological family contexts—more specifically, pathologic relationships between parents and child. Typically, mothers of homosexuals are inappropriately close, binding, often seductive, and tend to inhibit boyish aggressiveness. The fathers are overtly or covertly hostile; this is expressed in detachment, streaks of cruelty, or frank brutality. The relationship between the parents is generally poor; often the husband is held in contempt by a wife who prefers her son. The pre-homosexual child may be exposed to rejection and hostility from other significant males, such as brothers and peer mates. Defective masculine relationships deprive such a boy of needed masculine figures for identification and modeling that are ultimately sought, in part, in homosexuality. It then becomes a substitutive adaptation, replacing the heterosexuality that is made inadequate or unavailable by a network of induced fears about hetero-sexual behavior. Within a substitutive adaptation, attempts are made to acquire missing sexual and romantic gratification. Through various homosexual maneuvers and activities, reparative attempts are made to strengthen masculine self-esteem and to alleviate profound feelings of rejection from men. Through homosexuality, reassurance and acceptance are sought from other men. Contrary to popular notions, homosexuality is not an adaptation of choice; it is brought about by fears that inhibit satisfactory heterosexual functioning.

Inherent Psychological Pain

The gay activists and their proponents among some psychiatrists claim that many men are neurotic about their homosexuality only because society is prejudiced. Extinct cultures, such as the ancient Greek, are held up as prejudice-free examples, while cultures and present-day societies where there is no homosexuality are disregarded. The animal evidence has rested heavily on statements by Frank Beach. His position on animal ho- mosexuality has changed, however, and in 1971 he wrote, "I don't know any authenticated instances of males or females in the animal world preferring a homosexual partner, if by homosexuality you mean complete sexual relationships including climax.... It's questionable that mounting in itself can be properly called sexual" (7).

Opponents of my views have accused me and other colleagues with similar ideas of being prejudiced, reactionary, and homophobic. The trouble with such ad hominem attacks is that they do not get to the heart of the matter but serve merely as diversionary methods to discredit without risking an objective engagement with the evidence. As I see it, society at large does not produce a homosexual condition nor can it mitigate the inherent psychological pain. If all discrimination against homosexuals ceased immediately, as indeed it should, I do not think their anxieties, conflicts, loneliness, and frequent depressions would be short-circuited.

2. If homosexuality is not normal, how should it be categorized? In the past century, psychiatry and the allied behavioral sciences have amassed an enormous body of data, although psychiatric diagnostic classification is the weakest part of this extraordinary development. Our present nosology is based on very different categories of criteria. The diagnoses of mania and depression are based on the salient symptom; of schizophrenia, on a constellation or cluster of signs and symptoms; of personality disorders, on psychodynamic formulations; and of sociopathy, on sociologic criteria. Classification of homosexuality has reflected this medley of psychiatric criteria. It is often referred to as "sexual deviation." Literally, deviation is a statistical term denoting movement away from a median or statistical norm. Deviation and pathology are not necessarily related; genius is as deviant as is mental deficiency. In my opinion, the term "sexual deviation" is ambiguous, vague, and not useful as a diagnosis or as a nosologic category.

Homosexuality: Sexual Inadequacy

Masters and Johnson (8) used criteria that qualified as functional and dysfunctional to classify sexual disorders, and they introduced the term "sexual inadequacy." Under this rubric, they included frigidity and sexual impotence. The psychodynamic common denominator of frigidity, impotence, premature ejaculation, and homosexuality consists of a network of fears about being effective in heterosexual activity. I suggest that homosexuality be characterized as a type of sexual inadequacy since most homosexuals (especially those who are exclusively homosexual) cannot function heterosexually.

I think, too, that adaptational concepts are very useful in formulating broader diagnostic contexts. Homosexuality could be classified as an adaptation to inhibited, dislocated heterosexual functioning; this would leave room for an expanded description of the patient's heterosexual difficulties.

3. Does the inclusion of homosexuality in the diagnostic manual make homosexuals "sick," as they claim? Discrimination against homosexuals existed long before modern psychiatric and diagnostic manuals. Psychiatry,
particularly psychoanalysis, has contributed significantly toward altering archaic, moralistic, and pseudoscientific concepts. Freud (9) was the first to discard the notion that homosexuality was a degenerative disease. He classified it as a disorder of psychosexual development rather than as sinful and antisocial.

There is no reason to believe that if homosexuality were removed from the diagnostic manual there would be a significant alteration in existing social attitudes. Even if it could be shown that improved social attitudes would eventuate, this would not be reason enough to exclude the term if we agree that homosexuality is not normal and is a treatable condition.

Removal of the term from the manual would be tantamount to an official declaration by APA that homosexuality is normal. Undoubtedly it would be interpreted that way. More importantly, dropping the term would be a serious scientific error. Such an action would also interfere with effective prophylaxis. Prehomosexual boys are easily identifiable and should be treated. Further, young men in conflict about their sexual direction may be discouraged from seeking treatment by those who would reassure them that their homosexual proclivities are normal and that it is only "society," with its outdated value system, that makes them reject a homosexual preference.

Stop It, You're Making Me Sick!

BY RONALD GOLD

I have come to an unshakable conclusion: the illness theory of homosexuality is a pack of lies, concocted out of the myths of a patriarchal society for a political purpose. Psychiatry—dedicated to making sick people well—has been the cornerstone of a system of oppression that makes gay people sick.

To be viewed as psychologically disturbed in our society is to be thought of and treated as a second-class citizen; being a second-class citizen is not good for mental health. But that isn’t the worst thing about a psychiatric diagnosis. The worst thing is that gay people believe it.

Nothing is more likely to create neurotic anxiety than "a lack of feeling of wholeness," and nothing is more likely to alienate you from a major aspect of yourself than to be told incessantly that it’s sick.

At 14 years of age I discovered what the "experts" said about the way I love: "infantile sex," "inevitable emotional bankruptcy," "a masquerade of life filled with destruction and self-deceit." So I went to my older sister and she sent me to a psychiatrist. He shot me full of sodium pentothal and scared me out of my wits. It is amazing how I could have kept on believing this nonsense about homosexuality when so little of it had anything to do with my life. But I went willingly to other psychiatrists and learned from them that a part of me I didn’t want to give up needed to be excised. I was ready for "psychic annihilation"; I became a heroin addict. This time I was sent to the Menninger Clinic, and there I was convinced that my "cure" must include a change in sexual orienta-

tion. So when it was agreed that I was through with treatment, it seemed to me I’d done only half a job. But I soon found that all I needed for another person to love me was to like myself better. I met a young man, and we had a good, happy life for 12 years. When we broke up, our conflicts weren’t out of the psychiatric literature. They were just like the tales of heterosexual divorce you read about in Redbook.

The man I live with now is a warm, loving, open person. For the past two years we’ve been going through the joyful process of discovering the full repertory of mutuality—easier for two members of the same sex.

Psychological Growth Through Resisting Oppression

There are advantages to being gay. I learned that in the gay movement. And I learned something else: that I was oppressed and must make the choice to do everything I can to cease being an accomplice in my own oppression. I’ve had an immense sense of psychological growth through this decision. I’ve fought through to a sense of myself as a whole person—a good, concerned, loving, fighting-mad homosexual. I’m fighting the psychiatric profession now, but I know that a false adversary situation has been drawn between psychiatry and Gay Liberation. We can save you the trouble of treating some people, and we can be a helpful adjunct for many of your patients by pointing them along the road to self-esteem.

After our meeting with your Committee on Nomenclature and Statistics, its chairman said that "whether a person prefers to have sexual relations with a member of the same or of the opposite sex is in itself not an indicator of mental disorder." But, he added, "What are we to do about the homosexual who comes to us and says he’s miserable, that he wants to change?" Such people do need help. But is it their homosexuality that’s doing them in? Or is it something that psychiatry has helped to create: irrational fear and hatred of homosexuality? Instead of acceding to requests for brainwashing, what you can help these people realize is that there are many successful, well-adjusted people in various professions (including psychiatry) who are homosexual. You can help them to see that successful sexual adjustment of any kind cannot be achieved in a climate of guilt and fear.

When these patients see themselves as people, not sets of stereotypical patterns, I suspect that most of them (about as many as you get with your current techniques) will go on being gay. Only they’ll be happy about it. Perhaps the same percentage you have now will wind up predominantly heterosexual. And many of those who had been exclusively homosexual—many more than you now count as treatment "successes"—will discover a heterosexual component in themselves. We have found that such things happen frequently in the Gay Liberation movement.

I feel better since I’ve joined Gay Liberation. I work better, I’m happier in love. Would you rather have me the way I am? Or would you suggest another round of therapy? I think you really know that I’m not sick now, that my homosexuality is simply a part of me that in the past I wasn’t allowed to accept. And I think you’re prepared to
agree that my previous illness was at least in part a direct result of the crimes perpetrated on me by a hostile society. You have been willing accomplices in such crimes. It is now time for you to prevent them. Take the damming label of sickness away from us. Take us out of your nomenclature. Work for repeal of sodomy laws, for civil rights protections for gay people.

Most important of all, speak out. You've allowed a handful of homophobes to tell the public what you think. It's up to you now to get on the talk shows and write for the weeklies, as they do. You've got to tell the world what you believe—that Gay is Good.

Homosexuality: Findings Derived from 15 Years of Clinical Research

BY CHARLES W. SOCARIDES, M.D.

I've got to get this homosexual monkey off my back. I just frankly can't live with it. I must either extinguish it, if I can, or maybe by religion extinguish all sex. And the other thing is to be dead. To have anonymous sex with other sick men, I can't make a life out of that. The homosexuals I know think I'm coping out, and if it's not hereditary they feel at least that it's impossible to change. They say to me, "Once homosexuality is established you can't get out or if you do try to get out you're going nuts." They tell you that you will be isolated and they keep telling you you're a traitor trying to leave the group, turning against your own kind, that you're trying to do something and be something that you're not. They say you're self-indulgent and selfish, feeding your ego in a very selfish kind of way in that you're enjoying your neurosis in trying to get well.

That quotation from a patient is why some of us treat homosexuals: because people come to us voluntarily and seek our help. They are in agony over their condition.

The Task Force on Homosexuality appointed by the New York County District Branch of the American Psychiatric Association, of which I was the chairman, unanimously agreed in April 1972 that homosexuality arises experientially from a faulty family constellation. (Some few homosexuals come from an institutional background, but in our opinion they present special problems.) It was our finding that homosexuality represents a disorder of sexual development and does not fall within the range of normal sexual behavior. Further, between one-third and one-half of male homosexuals who seek treatment, including those who had formerly been exclusively homosexual, become exclusively heterosexual as a result of psychoanalytically oriented psychotherapy.

The most extensive comparison study oriented to establishing the etiology of male homosexuality was published in 1962 (1). It is a report on 106 male homosexuals and 100 male heterosexuals, distributed in psychoanalytic treatment with 77 members of the Society of Medical Psychoanalysts.

This study established a continuity and severity of pathological parent-child relationships in the background of all the homosexuals studied to an extent not found in the comparison group. The frequency of a parental combination consisting of a close-binding, overintimate mother and a hostile, detached father statistically differentiated the homosexuals from the heterosexual group at the .01 level of confidence.

The majority of mothers of homosexuals interfered with the development of their sons' peer group relationships, heterosexual development, assertiveness, and decision making; the fathers were demasculinizing. One conclusion of this study was that the son who becomes homosexual is the focal point of this intrafamilial pathology.

Preoedipal Theory of Causation

In 1968 (2), after 15 years of clinical research, I introduced the concept that in all homosexuals there has been an inability to make the progression from the mother-child unity of earliest infancy to individuation. This was called the preoedipal theory of causation. This failure in sexual identity, normally achieved by the age of three, is due to a pathological family constellation in which there is a domineering, psychologically crushing mother who will not allow the child to attain autonomy from her and an absent, weak, or rejecting father who is unable to aid the son to overcome the block in maturation. As a result there exists in (obligatory) homosexuals a partial fixation with the concomitant tendency to regression to the earliest mother-child relationship.

It is my conviction that it is necessary for all human beings to complete the separation-individuation of early childhood (10) in order to establish gender identity. Failure to do so results in a deficit in emancipation for boys, with a corresponding intensification and continuation of the primary feminine identification with the mother; thus begins the course toward homosexual development. It may well be clear now why homosexuality is prevalent, has existed since the beginning of recorded history and spans all sociocultural levels.

While there was total agreement among members of the task force that the parents, consciously or otherwise, are the primary architects of the homosexual psychic organization, some placed major emphasis on the mother's influence in the preoedipal period, while others stressed the inordinate fears of male aggression coupled with a yearning for male acceptance and affection stemming from the deleterious parental attitudes and behavior. Those who subscribe to preoedipal origin emphasize primitive fears of injury by women.

A sound scientific basis for deciding whether the homosexual suffers from a psychosexual disorder has been handicapped by reports of psychological testing that were offered as proof that there are no discernible differences between homosexuals and heterosexuals insofar as such protocols are concerned (11, 12). Having reviewed these data in detail, we strongly recommend that these tests, dating back to 1957 and 1958, be repeated by other investigators with a much more rigorous methodology than was originally used.
Not a "Sexual Dysfunction"

Scientific knowledge is also damaged when attempts are made to classify homosexuality simply as "sexual dysfunction," a term regularly applied to loss of erection, premature ejaculation, retarded ejaculation, or total impotence. These impairments constitute disturbances of the standard male-female pattern. It is characteristic of the standard or normal sex experience that it take place between a male and a female. It is also characteristic that orgasm produced by intravaginal penetration is fully within the capability of the male partner, and that this coital activity has the potentiality for reproduction. These criteria are basic to elementary human biology and are not subject to change by social or political movements. Individuals unable to achieve sexual release within this standard pattern, with all its possible variations of foreplay, etc. (of which there are an infinite number), turn to modified patterns for orgasmic relief, and these constitute sexual deviations. Thus the immutable distinctions between sexual deviations and sexual dysfunctions cannot be semantically blurred without incurring formidable scientific chaos.

As to the contention that in homosexuality there are no clinical symptoms, no course of development, and no treatment, we strongly disagree. There are symptoms and there is a course and there is a treatment—often a very effective treatment. The limitations of space do not allow me to comment on these here beyond observing that in addition to the uncovering techniques of depth therapy, treatment requires educational and retraining measures, interventions, and modifications in the handling of transference, resistance, and regression.

Let us bear in mind that psychiatrists have been in the forefront in helping homosexuals. It was Freud who opened the gates of freedom and humanity to the homosexual. And it was others after him—investigators who dared, who were not afraid of homosexuals, who had no "homophobia"—of which we are accused—who could therefore treat homosexuals who want to be treated. I urge that all persecutory laws against the homosexual be abolished at once. It is unthinkable that homosexuals be persecuted for something over which they have no choice. Such laws are a direct contradiction to psychiatry as well as humane values.

Should Heterosexuality Be in the APA Nomenclature?

BY RICHARD GREEN, M.D.

Four major criteria are typically called upon to classify behavior as emotionally disordered. First is gross social dysfunction. Here an individual's behavior is such that to any but the most cynical of observers there is objective evidence that the individual is dysfunctional. The mental functioning of the regressed schizophrenic, the manic, the profoundly depressed, the severely retarded, and the patient with chronic brain syndrome precludes effective social survival.

Second, there exist the less socially obvious emotional limitations. Here inner discord that reduces the efficiency of behavioral functioning is experienced by the individual. Examples include severe anxiety and phobias of various types. Classification of the latter, however, becomes problematic when one considers the relative social consequences of snake phobia, germ phobia, and agoraphobia.

The third criterion of diagnosis is somewhat softer science. This focuses on culturally variant behavior. Using statistical deviance per se as a diagnostic basis evokes problems. Geniuses are deviant. So are the left-handed, vegetarians, pacifists, the celibate, and the esoterically religious. The relationship of idiosyncratic and delusional thinking to cultural accommodation comes into focus when one considers the different view of a religion adhered to by one person, a thousand, or a million. Then too there is the sociopath. His behavior is also deviant and, further, may result in undesirable effects on society. This person may feel no anxiety and not appear grossly dysfunctional. However, his behavior is at odds with external societal values and is labeled as an emotional disorder.

Next, there is a criterion that is scientifically the softest yet. Behavior is judged to be sick or healthy, ordered or disordered, based on a theoretical model of human psychological development. A theory may define specific behavioral phenomena as evidence of disorder. In this regard, classic psychoanalytic theory deems homosexual object choice as psychological immaturity, an arrest of psychosexual development. Castration fear and penis envy are universally posited developmental facts, and resolution of the oedipal crisis is the developmental rite of passage to mature sexuality. The scientific merits of psychoanalytic theory have been debated at length (13).

Heterosexuality as a Disorder

The title of this paper asks the question whether heterosexuality should be in the APA nomenclature. There are in fact some places where heterosexuality and its derivatives are cited. These include pedophilia (presumably this includes children of the opposite sex), exhibitionism (typically the object is a person of the opposite sex), voyeurism (same as the preceding), sadism and masochism (if it is with a partner of the opposite sex), and transvestism (most transvestites are heterosexual).

One additional diagnostic term in our current nomenclature can refer to heterosexuality. This term is under the heading of psychophysiological genitourinary disorder. Here psychogenic dyspareunia and impotence can be cited, and presumably also nonorgasmia in the female and premature ejaculation in the male.

Are there other places where heterosexual behavior might be considered worthy of diagnosis and classification? Styles of heterosexual conduct do indeed form much of what is dealt with by psychiatrists. Instability in maintaining a love relationship and neurotic uses of sexuality—in which sexuality is used to control others,
as a substitute for other feelings of self-worth, or as a defense against anxiety and depression—constitute a significant bulk of the disorders treated in outpatient psychiatry. Yet there is no specific mention of such ego-dystonic, neurotic uses of heterosexuality in the nomenclature. By contrast, the homosexual is considered to be manifesting a disorder, whether or not he or she is able to maintain a stable interpersonal relationship, feels comfortable about his or her sexuality, and does not utilize it in a self-destructive manner.

*Homosexuality as a Disorder*

Where in the above gross criteria of mental disorder, other than as a derivative of a theoretical model of personality development, do we place homosexual behavior when it is engaged in by two consenting adults in private? In terms of gross psychologic social functioning the homosexual typically appears no different from his heterosexual counterpart. He or she may hold a responsible occupational and social position. Psychiatrists, other physicians, lawyers, ministers, politicians, authors, etc., may be homosexual. Clearly there is no gross impairment of the kind seen in acute schizophrenia, mania, or organic brain syndromes. With respect to intrapsychic adjustment, the studies that have used comparable samples of nonpatient heterosexual and homosexual subjects typically find no significant differences between the groups on such factors as anxiety and depression (14). With respect to civil issues, homosexual conduct between consenting adults is not illegal in most Western European countries, Canada, and some of the United States.

*Proposed New Classification*

Can we attain a compatible coalition between those who consider homosexuality a profound mental disorder and those who view it as an alternate life-style beyond the legitimate purview of the medical profession?

The past few years have witnessed an explosion in the research and treatment of various aspects of sexual behavior. Due to the work of Masters and Johnson, considerable professional attention is now being paid to the problems of sexual dysfunction, particularly impotence and premature ejaculation in the male and nonorgasmia in the female. Sexual dysfunction is externally maladaptive and is accompanied by anxiety, depression, and other inner distress.

The more traditional model of emotional disorder considers sexual relationships as dynamic interpersonal phenomena within the scope of ego functioning. Again, compatibility between the phenomena of the homosexually oriented and the heterosexually oriented can be attained. The classification I am proposing here would include the heterosexual or the homosexual who finds it difficult to maintain desired object relationships, who compulsively uses sexuality to ward off anxiety or depression, or whose sexuality typically leads to depression or anxiety. Within this same general category would also be classified those persons who request reorientation or modification of sexual object preference.

The following classification is proposed:

**Sexual Dysfunction I**. This term is applied when physiological dysfunction of psychogenic origin is the primary presenting symptom.

- A) Male impotence: 1) with same-sexed partner, 2) with other-sexed partner; B) male premature ejaculation: 1) with partner of same sex, 2) with partner of opposite sex; C) female nonorgasmia: 1) with partner of same sex, 2) with partner of opposite sex.

**Sexual Dysfunction II**. This term is applied when psychogenic distress is the primary presenting symptom. Physiologic dysfunction may or may not be an accompanying factor.

- A) Anxiety, depression, and other neurotic reactions secondary to interpersonal aspects of sexuality, not primarily related to physiologic dysfunction: 1) with partner of same sex, 2) with partner of opposite sex; B) dissatisfaction with sexual orientation: 1) dissatisfaction with exclusive or primary homosexual orientation, 2) dissatisfaction with exclusive or primary heterosexual orientation.

The nomenclature would retain exhibitionism, voyeurism, sadism, masochism, pedophilia (and sex rapism) when such behavior is of a repetitive nature.

With this new classification, psychiatry would have an objective basis for categorizing sexuality that is free of cultural bias, not based on partially accepted theoretic models, not based on the judgment of an external professional agent, but, rather, is patient-activated. Further, it would not stigmatize the individual and would not reinforce legal, religious, and other forms of social discrimination that are a product of the current classification.

**A Proposal About Homosexuality and the APA Nomenclature: Homosexuality as an Irregular Form of Sexual Behavior and Sexual Orientation Disturbance as a Psychiatric Disorder**

*BY ROBERT L. SPITZER, M.D.*

Controversy rages as to whether homosexuality should be regarded as a pathological deviation of normal sexual development or as a normal variant of the human potential for sexual response. Recently this controversy has focused on the American Psychiatric Association’s *Diagnostic and Statistical Manual of Mental Disorders*, second edition (*DSM-II*), in which homosexuality is listed as an official diagnosis in the section on sexual deviations.

The proponents of the view that homosexuality is a normal variant of human sexuality argue for the elimination of any reference to homosexuality in a manual of psychiatric disorders because it is scientifically incorrect, encourages an adversary relationship between psychiatry and the homosexual community, and is misused by some people outside of our profession who wish to deny civil
For a mental or psychiatric condition to be considered a psychiatric disorder, it must either regularly cause subjective distress or regularly be associated with some generalized impairment in social effectiveness or functioning. With the exception of homosexuality (and perhaps some of the other sexual deviations when they occur in a mild form, such as voyeurism), all of the mental disorders in DSM-II fulfill either of these two criteria. (While one may argue that the personality disorders are an exception, on reflection it is clear that it is inappropriate to make a diagnosis of a personality disorder merely because of the presence of certain typical personality traits that cause no subjective distress or impairment in social functioning.) Clearly homosexuality per se does not meet the requirements for a psychiatric disorder since, as noted above, many homosexuals are quite satisfied with their sexual orientation and demonstrate no generalized impairment in social effectiveness or functioning.

The only way that homosexuality could therefore be considered a psychiatric disorder would be the criterion of failure to function heterosexually, which is considered optimal in our society and by many members of our profession. However, if failure to function optimally in some important area of life, as judged by either society or the profession, is sufficient to indicate the presence of a psychiatric disorder, then we will have to add to our nomenclature the following conditions: celibacy (failure to function optimally sexually), revolutionary behavior (irrational defiance of social norms), religious fanaticism (dogmatic and rigid adherence to religious doctrine), racism (irrational hatred of certain groups), vegetarianism (unnatural avoidance of carnivorous behavior), and male chauvinism (irrational belief in the inferiority of women).

If homosexuality per se does not meet the criteria for a psychiatric disorder, what is it? Descriptively, it is an irregular form of sexual behavior. Our profession need not now agree on its origin, significance, and value for human happiness when we acknowledge that by itself it does not meet the requirements for a psychiatric disorder.

**Sexual Orientation Disturbance**

Having suggested that homosexuality per se is not a psychiatric disorder, what about those homosexuals who are troubled by or dissatisfied with their homosexual feelings or behavior? These people have a psychiatric condition by the criterion of subjective distress, whether or not they seek professional help. It is proposed that this condition be given a new diagnostic category, which will replace the current undefined category of homosexuality in subsequent printings of *DSM*. Defined as follows: "Sexual orientation disturbance. This is for people whose sexual interests are directed primarily toward people of the same sex and who are bothered by, in conflict with, or wish to change their sexual orientation. This diagnostic category is distinguished from homosexuality, which by itself does not constitute a psychiatric disorder. Homosexuality per se is a form of irregular sexual behavior and, with other forms of irregular sexual behavior that are not by themselves psychiatric disorders, are not listed in this nomenclature."
HOMOSEXUALITY AND THE APA NOMENCLATURE

What will be the effect of carrying out such a proposal? Homosexual activist groups will no doubt claim that psychiatry has at last recognized that homosexuality is as "normal" as heterosexuality. They will be wrong. In removing homosexuality per se from the nomenclature we are only recognizing that by itself homosexuality does not meet the criteria for being considered a psychiatric disorder. We will in no way be aligning ourselves with any particular viewpoint regarding the etiology or desirability of homosexual behavior.

By creating a new category, "sexual orientation disturbance," we will be applying a label only to those homosexuals who are in some way bothered by their sexual orientation, some of whom may come to us for help. We will no longer insist on a label of sickness for individuals who insist that they are well and who demonstrate no generalized impairment in social effectiveness. We will thus help to answer the charge of some members of our own profession who claim that mental illness is a myth and that by labeling individuals with psychiatric diagnoses we are merely acting as agents of social control. Furthermore, we will be removing one of the justifications for the denial of civil rights to individuals whose only crime is that their sexual orientation is to members of the same sex. In the past, homosexuals have been denied civil rights in many areas of life on the ground that because they suffer from a "mental illness" the burden of proof is on them to demonstrate their competence, reliability, or mental stability. (By linking the removal of homosexuality from the diagnostic nomenclature with an affirmation of the civil rights of homosexuals, no implication is intended justifying the irrational denial of civil rights to individuals who do suffer from true psychiatric disorders.)

This revision in the nomenclature provides the possibility of finding a homosexual to be free of psychiatric disorder, and provides a means to diagnose a mental disorder whose central feature is conflict about homosexual behavior. Therefore, this change should in no way interfere with or embarrass the dedicated psychiatrists and psychoanalysts who have devoted themselves to understanding and treating those homosexuals who have been unhappy with their lot. They, and others in our field, will continue to try to help homosexuals who suffer from what we can now refer to as "sexual orientation disturbance," helping the patient accept or live with his current sexual orientation, or, if he desires, helping him to change it.

REFERENCES


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