In defense of the new nomenclature for homosexuality

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Front-page news was made when the American Psychiatric Association announced on Dec. 15, 1973, that its Board of Trustees had voted unanimously (with two abstentions) to remove homosexuality from the APA Diagnostic and Statistical Manual (Second Edition, 1968—referred to as DSM-II). The category was replaced by “sexual orientation disturbance,” and the APA stated that homosexuality “...by itself does not necessarily constitute a psychiatric disorder.” Two hundred dissenting psychiatrists signed a petition to hold a referendum on the issue. The vote, reported on April 8, 1974, gave a majority to the board’s ruling, with 5,855 members for the trustees’ position, 3,810 against, and 367 abstentions.

The controversy has not yet abated. Here, Dr. Robert L. Spitzer, author of the proposal to change the nomenclature, offers his views, which are followed by those of Dr. Irving Bieber, who opposes the change.

In this article I will present questions commonly asked about the APA’s historic decision removing homosexuality from the DSM-II. I will attempt to answer the questions as objectively as possible.

What did the decision specifically do? The DSM-II provides a list of mental disorders with definitions for use by psychiatrists and other mental health professionals. This manual is widely read and has an important influence on the organization of psychiatric textbooks. The decision removes homosexuality per se from future printings of this manual and inserts in its place a new category, sexual orientation disturbance, which is defined as follows: “This is for individuals whose sexual interests are directed primarily toward people of the same sex and who are either disturbed by, in conflict with, or wish to change their sexual orientation. This diagnostic category is distinguished from homosexuality, which by itself does not necessarily constitute a psychiatric disorder. Homosexuality per se is one form of sexual behavior and, with other forms of sexual behavior which are not by themselves psychiatric disorders, is not listed in this nomenclature.”

Do all psychiatrists support this change? Definitely not. In fact, a group of psychiatrists were so opposed to the change that they initiated the first referendum in the history of the APA. They claimed that the decision was a misguided attempt to aid the civil rights struggle of homosexuals but was without scientific merit. Proponents of the referendum wanted to reverse the change in nomenclature by restoring homosexuality to the DSM-II as a mental disorder. Many other psychiatrists felt that the referendum, which received a lot of attention in the lay press, was a source of embarrassment. They argued that it was inappropriate for the membership to be voting on a presumably scientific issue that had already been decided upon by the board and the appropriate committees within the association—the Task Force on Nomenclature and Statistics, the Council on Research and Development, and the Reference Committee.

One good result of the referendum, however, was that it did provoke a lot of discussion regarding a very complex problem, both within and outside of the profession. The referendum was defeated, 58% to 42%, by the voting membership. Thus, the decision to remove the term homosexuality from the DSM-II and replace it with the term sexual orientation disturbance is now final.

There are two main scientific issues: What is the criterion for a mental disorder, and does homosexuality per se fulfill this criterion?

Why is there a problem in definition? The problem of what constitutes a mental disorder has no parallel in other branches of medicine. The reason is simple: Nonpsychiatric medical conditions are manifested by physical pain or disability and may directly cause death. And there is a clear consensus within our society and the medical profession that these manifestations are inherently undesirable. Therefore, except for members of some religious sects who deny the concept of illness (although they acknowledge that pain, physical disability, and death are undesirable), everyone agrees that physical illnesses are undesirable and should be treated. Consequently one never hears of individuals with painful, swollen, rheumatoid joints or migraine headaches insisting that the medical profession remove these conditions from the International Classification of Diseases.

On the other hand, psychiatric conditions are manifested primarily by alterations in behavior (including ideation and mood) from some normative concept. There is no longer a consensus within our society as to whether all of the manifestations of the traditional mental disorders, such as homosexuality, are necessarily undesirable or sufficiently undesirable to warrant designation as illnesses.

Is there a standard definition accepted by most psychiatrists? No. In fact, one can search in vain through the standard textbooks of psychiatry for a comprehensive definition of mental disorder. However, by examining the diagnostic practices of psychiatrists, two approaches can be identified: According to the first, or broad approach, a mental disorder is any significant departure from an
ideal state of positive mental health. Thus, conditions such as homosexuality, racism, asexuality, and vegetarianism might be categorized as mental disorders, since most psychiatrists and society at large regard these "conditions" as less than optimal forms of functioning.

The second, or narrow approach, also incorporates the concept of a continuum of conditions from positive mental health (desirable) to negative mental health (undesirable). However, the demarcation for mental illness is placed much closer to the undesirable end of the spectrum so as to include only those conditions clearly associated with either subjective distress or generalized impairment in social functioning or effectiveness.

Which of these two approaches is generally reflected in the standard nomenclature of the DSM-III? The narrow approach. It is for this reason that the DSM-III does not contain as mental disorders such conditions as asexuality, frigidity, Don Juanism, or other heterosexual conditions that are generally viewed as less than optimal yet are not considered per se mental disorders. Similarly, the manual does not list as mental disorders racism, male chauvinism, or vegetarianism. In fact, the only exception to the narrow approach toward defining mental disorder in the manual is the inclusion of homosexuality and perhaps some of the other sexual "deviations" with relatively mild manifestations. What about the inclusion of personality disorders in the DSM-III? Is that not an example of the broad approach toward defining mental disorders, since individuals with mild personality disorders do not always have subjective distress or generalized impairment in functioning? Personality disorders should not be confused with personality traits. It is true that individuals with various personality traits (for example, obsessional or hysterical features) may not exhibit subjective distress or generalized impairment in functioning. It is only when a patient does, that it is correct to speak of the condition as a personality disorder.

Why does homosexuality not qualify as a mental disorder according to the narrow approach? Because many studies have shown that a significant proportion of homosexuals are apparently satisfied with their sexual orientation, show no significant signs of manifest psychopathology (other than their homosexuality, if that is considered by itself psychopathology), and are able to function as effectively as matched groups of heterosexuals (Saghir MT, Robins E: Male and Female Homosexuality, Baltimore, Williams & Wilkins, 1973; Weinberg MS, Williams CJ: Male Homosexuals: Their Problems and Adaptation. Oxford University Press, 1974; and National Institute of Mental Health Task Force on Homosexuality: Final Report and Background Papers, DHEW Publication No. (HSM) 72-9116, 1972.

What about the failure to function heterosexually? Is this not a dysfunction and sufficient reason for categorizing homosexuality as a disorder? No it is not. First of all, many homosexuals can function heterosexually but prefer to function homosexually (in varying degrees). Second, no one would claim that a heterosexual who was unable to function homosexually and had no desire to do so had a homosexual dysfunction. Therefore, homosexuals who have no desire to function heterosexually should not be categorized as suffering from a heterosexual dysfunction. On the other hand, if a homosexual wishes to function heterosexually and is unable to do so, that is a dysfunction—a sexual orientation disturbance.

Isn't it true that homosexuality is unnatural in the biological and evolutionary sense? This argument is frequently used but sheds little light on the issue because of the difficulty in defining what is meant by "natural." Certainly homosexuality is less common than heterosexuality in the animal kingdom, but the same can be said about genius and average intelligence among humans. Further, it can be said that shaving and birth control are biologically unnatural, but that does not mean that these activities are pathologic. Wouldn't the species die if everyone were homosexual? It is no more likely that everyone would become homosexual than it is that everyone might become a carpenter or a gynecologist or a psychoanalyst. Any of these unlikely situations would seriously jeopardize the survival of the species.

Isn't it true that certain kinds of pathologic family patterns lead to homosexuality? Many studies have shown that male homosexuals, as children, often had distant or absent relationships with their fathers and had mothers who were either seductive or intimidating. However, almost all of these studies were retrospective, and it is difficult to know if the relationships observed were not at least partially caused by the parents' reactions to the sons' deviant behavior.

But even if this finding is supported by prospective studies and can be shown to have etiologic significance, it does not prove that the condition of homosexuality per se is pathologic. The etiology of a condition, although it may be of great interest, does not involve the issue of whether the condition is inherently undesirable. If it could be shown that psychiatrists come from families with more psychiatric disturbance than do physicians from other medical specialties, this would not be proof that being a psychiatrist is pathologic.

Aren't all homosexuals phobic toward sexual relations with members of the opposite sex? This is the view of many psychoanalysts. However, their experience with homosexuals is almost invariably limited to homosexuals who are also patients. Many homosexuals deny any intrinsic fear of members of the opposite sex or of their genitals and claim that whatever fear exists is failure to perform heterosexually in accordance with the standards of our heterosexually oriented society. A recent study of male homosexuals' and male heterosexuals' reactions to nude pictures of both sexes failed to confirm the hypothesis that male homosexuals are phobic toward the female body (Freund K, Langevin R, Cibiris S, et al: Br J Psychiatry 122:163, 1973).

Does the change in nomenclature mean that homosexuality is now regarded as "normal"? No it does not. No one as yet has provided a satisfactory definition of what constitutes normal behavior, particularly as it applies to sexual behavior. Unfortu-
nately, strong personal preferences often are disguised in scientific lingo by the use of such words as "normal" or "abnormal."

Can homosexuality be cured? Many homosexuals object to the term cure since it implies that homosexuality by itself is an illness. However, if the question is whether individuals with a homosexual arousal pattern can be helped to develop a heterosexual arousal pattern, then the answer is that strongly motivated individuals wishing to change have a fairly good chance (perhaps 20% to 40%) of doing so with psychotherapy (Frank J, in NIMH Task Force on Homosexuality report, op. cit). On the other hand, such treatment is lengthy and generally expensive and, when not successful, may often leave the patient feeling hopeless.

What advice should a physician give a teen-ager who is upset about having predominantly homosexual impulses? Honesty is the best policy. I would tell him that if he is truly disturbed by his homosexual feelings and wishes to get help to become more heterosexual, he should enter treatment with that goal. On the other hand, such treatment is not indicated if the patient is motivated merely to conform. Some exploration with a professional may be necessary. If there is no motivation for change, the physician should help all concerned understand that homosexuality by itself is not incompatible with a satisfying and effective life.

What effect will the APA decision have on the treatment of disturbed homosexuals who come to psychiatrists? Psychiatrists will be less inclined to impose their own values regarding the desirability of heterosexuality on such patients. Consequently, more homosexuals will feel less threatened when they see psychiatrists about problems that may be unrelated to homosexuality. The change in nomenclature should not discourage any homosexual from seeking psychiatric help to become more heterosexual. As already noted, such individuals can be properly diagnosed as having a sexual orientation disturbance.

The case against

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The recent decision by the APA to remove the term "homosexuality" from the DSM-II raises five questions of central importance: 1) What should the DSM-II include? 2) What criteria should determine the choice of syndromes and symptoms? 3) Is homosexuality merely a variant in a wide spectrum of normal sexual behaviors, or is it a manifestation of psychopathology? 4) Was the inclusion of homosexuality in the DSM-II actually a major cause for the perpetuation of social, occupational, and legal discrimination against homosexuals as the gay activists have claimed? 5) Should a condition that meets the criteria for inclusion in the DSM-II be excluded because it compromises the interests of certain patients?

In my view, every psychiatric condition and all manifestations of psychopathology should be included in a psychiatric diagnostic manual. Symptoms such as sexual frigidity, impotence, premature ejaculation, and retarded ejaculation do not appear in the present manual though they, too, should be included. Nosological decisions would best be made by a task force on nomenclature or, better yet, by several task forces consisting of selected experts with divergent viewpoints in each specific area.

In the course of discussions as to whether to remove homosexuality from the DSM-II, Dr. Robert L. Spitzer (see page 16) introduced new criteria for determining which conditions should be included in a psychiatric diagnostic manual. The condition must regularly cause distress, or it must regularly interfere with social effectiveness. Apparently, it was these criteria that guided the APA in making its decision. But these criteria seem inadequately inclusive. Psychopathology may exist without regularly causing distress or without compromising social and work effectiveness.

My own evaluation as to whether a behavior or mental process is psychopathologic is based on two criteria: Is the behavior or mental process a consequence of fear? If so, do the behaviors or mental processes become more adaptive psychologically and physiologically with the extinction of the fear? Sexual impotence is based on fear, but if the fear is resolved penile erection occurs as part of a physiologic arousal process. Certain behaviors may, however, be the consequence of fear, yet not be pathologic behavior—that is, taking flight from real danger.

Elsewhere I have defined homosexuality as repetitive sexual behavior occurring between same-sex partners during or after adolescence (Bieber I, Dain H, Dince P, et al: Homosexuality: A Psychoanalytic Study of Male Homosexuals. New York, Basic Books, 1962). Homosexuality in men and women is always pathologic because it is established and maintained by unrealistic fears—fears of which the individual is usually not aware. The majority of homosexuals present a history of pathologic parent-child relationships. Typically, the mothers of male homosexuals are close-binding, inappropriately intimate, and usually dominating. Such a mother’s preference for the homosexual son over male siblings and often over the father, seriously disturbs the boy’s relationships with the other males in the family. The fathers are generally detached and hostile. These findings have been established for patient and nonpatient populations (Westwood G: A Minority. London, Longmans, 1966; Bieber et al, op. cit.; Evans RB, J Consult Clin Psychol 33:129, 1969; Snortum JR, Marshall JE, Gillespie JF, et al, Psychol Rep 24:783, 1969). In their developing years, homosexuals experience a continuity of traumatic relations with male figures—fathers, brothers, peers.

The combination of the adhesive relationship with the mother and the
If society becomes more accepting of homosexuality will it become more widespread? Probably there will be more overt homosexual and bisexual behavior, but I very much doubt that more individuals will have predominantly homosexual arousal patterns. In fact, in the past many individuals who have had isolated homosexual experiences have incorrectly labeled themselves homosexual, and sick, and then felt that heterosexuality was unattainable—all because of the tremendous stigma attached to homosexuality.

With the destigmatization of homosexuality, such individuals will have a better chance of finding out that they are more heterosexual than homosexual. Thus, the incidence of exclusive homosexuality may decrease.

What about the charge that this decision was only the result of pressure from militant homosexuals and that the prime motivation for the change was an effort to help them in their civil rights struggle? First of all, it should be remembered that for years many respected psychiatrists have argued that it makes no scientific sense to consider homosexuality per se as a mental disorder. Although it is true that militant homosexuals influenced many of us to seriously consider this issue for the first time, those of us directly involved in the decision resent the implication that it was made for primarily political reasons. The change in nomenclature will greatly aid the civil rights struggle of homosexuals. However, the decision to remove homosexuality is justified entirely on scientific grounds.

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negative quality of relationships with males produces a profound fear of men, specifically aggressive ones. Fears of hostility and rejection by men perceived as stronger and more powerful maintain the homosexual adaptation. Homosexual men generally are not afraid of women. In fact they tend to trust women more than men. In many cases the homosexual's mother is the only person he loves and trusts. Homosexuals mainly fear sexual relationships with women. This comes about as a consequence of fear of aggressive male competitors for heterosexual fulfillment.

Homosexuality subserves three major needs: It provides substitutive sexual gratification when heterosexual gratification has become inhibited; it serves as a defensive, submissive adaptation against male hostility and/or rejection and is a way of coping with such perceived threats; and it is a reparative attempt to correct defective relationships with other men and thus to strengthen a sense of damaged self-esteem and “weak” masculinity. It is not the lack of social acceptance that defines homosexuality as pathologic; it is pathologic because it develops as a consequence of unremitting, unrealistic, and distorted beliefs about the dangers of male aggression.

Though I view homosexuality as pathologic, as I do sexual impotence or frigidity, I do not consider any of these conditions mental illnesses.

Confusion and misunderstanding were introduced during the APA discussions about homosexuality when journalists and some psychiatrists stated or implied that we who regard homosexuality as pathologic also treat it as a mental illness. In general, the term mental illness connotes psychosis. I know of no psychiatrist who believes that homosexuality per se is a psychosis. In the DSM-II, all nonorganic psychiatric conditions are listed, not as illnesses but as mental disorders including nonpsychotic conditions. Perhaps we should reconsider the meaning of the term mental disorder, but as it stands, it does not connotate a psychotic process.

Homosexuals, of course, have been the targets of discrimination. The first real break from the traditional practice of regarding homosexuality as sinful and illegal came through psychiatry—more specifically, through psychoanalysis. In his classic, Three Contributions to Sexual Theory, published in 1905, Freud was the first to describe homosexuality as a disorder of sexual development, not as a mental illness or a condition that deserved social condemnation and ostracism. Yet the Gay Activist Alliance has, from its beginnings, insisted that the psychiatric profession is largely to blame for perpetuating discriminatory practices against homosexuals. Inclusion of the term in the DSM-II was cited as discriminatory and socially damaging. Since the APA Board of Trustees voted to remove homosexuality from the DSM-II, the Council of the City of New York has twice defeated a bill designed to end discrimination in housing and in employment.

But even if it could be established that the inclusion of homosexuality in the DSM-II was, in fact, instrumental in maintaining prejudice against homosexuals, this by itself would not be an adequate basis for deleting the term. Medical conditions such as venereal disease, tuberculosis, and even cancer were, and often still are, considered shameful and socially unacceptable, but they have not been removed from the diagnostic manuals of the medical profession.

When irrational prejudices affect the lives of any group, civil rights legislation is required and mass education is a necessary corollary to protect civil liberties. We have the means to achieve such goals.

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