A Clash In Worldviews:

INTERVIEW WITH DR. MICHAEL WERTHEIMER

Michael Wertheimer is the son of the late Max Wertheimer, one of the founders of the Gestalt school of psychology. He is a Harvard-educated experimental psychologist, a retired full professor at the University of Colorado, and the author or editor of approximately forty psychology books, as well as several hundred articles. He specializes in the history of psychology.

A longtime member of the American Psychological Association's Council of Representatives, he also served as president of four A.P.A. divisions, and has been an A.P.A. "insider" for over thirty years.

Dr. Wertheimer is in sympathy with NARTH, in that he strongly supports the right to sexual-reorientation treatment.

However, he holds a another, postmodern theoretical position that is representative of many psychologists today, but not typical of NARTH therapists: that concepts of psychological health and disorder are largely socially constructed, rather than objectively true or false. Even pedophilia is not, he believes, necessarily a disorder, nor is there any clear evidence that it is harmful to the child.

Dr. Wertheimer believes that the American Psychiatric Association was correct in removing homosexuality from the category of psychopathology. The distress often associated with the condition, Dr. Wertheimer believes, is essentially due to a homophobic society—not to the condition itself.

The following conversation reveals the wide--and possibly irreconcilable—divergence of views within psychology. It also reveals some of the vastly different interpretations of the scientific literature. Dr. Wertheimer is interviewed here by Dr. Joseph Nicolosi.

JN: You have quite a resume, including your work inside the APA.

MW: I was only briefly "inside the A.P.A.," when in 1970 I spent a year on sabbatical as Acting Administrative Officer for Educational Affairs. I got a feel for the amazing, intense, and total devotion—and extremely hard work—typical of the folks in APA's Central Office.

JN: What is your view of the A.P.A.'s resolution on sexual orientation?

MW: As you know, I have talked with Mark Stern, who is on your Scientific Advisory Committee, and we find each other's positions largely compatible. However, I totally endorse the position of both APA's in denying that homosexuality is a disorder.

JN: You're saying, as far as you're concerned, homosexuality is perfectly normal.

MW: That's right. The American Psychiatric Association and Psychological Association, I think appropriately, more than a quarter of a century ago decided that homosexuality alone is not, in and of itself, evidence of pathology. But there is a second part--I have known a fair number of students and other acquaintances who found their own homosexual leanings tremendously problematic, and have sought change. And from that point of view, if what NARTH and others are interested in doing is making available to people whose homosexuality is troubling them, the opportunity to work on it—then I'm all in favor of that.

I can support efforts to either to get a client to accept the sexual orientation and live with it in reasonable peace, or to try to change it to a heterosexual form.

JN: And of course, that should ultimately be a decision of the client.

MW: Yes.

JN: I'm going to be devil's advocate for a minute here. Is there any normal developmental model of homosexuality?

MW: Yes. The one I find most compelling is the genetic one. No known genetic mechanism has as yet been identified. But from what I've read, and I'm not really an expert on this field at all, homosexuality is a condition for which there may be some genetic contribution. That alone raises a big red flag for me.

JN: But most experts would agree that homosexuality is not biologically determined.

MW: Would they?

JN: The consensus is essentially that homosexuality appears to be a mix of psychological, social and biological factors. Biology gives some people a predisposing *tendency*, or risk factor; with a particular family and social environment, an individual with biological risk factors would be more likely to become homosexual.

MW: That's the case, I guess, with any partly genetically-determined characteristic.

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JN: But if you agree that homosexuality is only *partly* genetically determined—like most other psychological conditions—why do you say you find the genetic model "compelling"? And how do you account for the remaining influences?

MW: What's compelling is the substantial evidence of a genetic component in concordance studies and the like. I grant that what is inherited is only a predisposing tendency, not the full-blown syndrome. But I am unaware of any clear-cut data about the remaining influences. Are there empirical or other convincing data that that family and social environment contribute to the etiology of homosexuality? None that I have heard of. My suspicion is that no hard data compel belief in such speculative environmental or social factors, any more than in nutritional factors, brain chemistry, or other yet undemonstrated influences on homosexuality.

Perhaps you should reconsider your principles in light of such classical scientific findings as those of the late Evelyn Hooker—that homosexuals show no more signs of psychopathology than heterosexuals, and that homosexuals are just as productive members of society as heterosexuals.

JN: I'm glad you mentioned the Hooker study, because in fact, the study was never designed to prove such a thing—although it's a general misconception that it did. Simon LeVay, in his 1996 book *Queer Science*, admits that in looking back, we now see that the study had "distinct limitations."

And Sociologist Steven Goldberg, in his 1991 book *When Wish Replaces Thought*, said:

> "Virtually every homosexual spokesman who has argued that homosexuals demonstrate no greater pathology has rested his case on an article by Evelyn Hooker—without noting that Professor Hooker *selected* for individuals who did not manifest any of a number of signs of pathology...to invoke this study as demonstrating that homosexuals demonstrate no greater pathology than heterosexuals is like selecting a sample of 30 six-foot-tall women and six-foot-tall men, and concluding that women are as tall as men."

Other studies *have*, in fact, been able to discriminate homosexuals from heterosexuals on the basis of psychological distress.

MW: I'm not surprised if some studies *have* been able to find more psychological distress in homosexuals, on average, than in heterosexuals. Our society is, in general, very intolerant of homosexuals, and the prejudice against them can, of course, be very stressful for them.

As for the Hooker studies, I believe, based on a recent film about her and on my discussions with the late Dr. Hooker, that the criticism is incorrect and unwarranted. She did *not* select for individuals who did not manifest signs of psychopathology; she interviewed and studied volunteer members of the then-secret Mattachine society, membership in which was open to any avowed male homosexual. Furthermore, in one of her studies, she obtained Rorschach protocols from homosexual males and control males, and asked Rorschach experts (who were convinced they could do so) to identify which protocols came from homosexuals, and which from controls—and they could do no better than chance.

JN: In fact, *Hooker herself* says she eliminated any subject who showed evidence of "considerable disturbance." She did not insist on a random sampling. In fact, *she never tested* the idea that homosexuals and heterosexuals are equally likely to be normal and well-adjusted. In her report, she said she was only interested in "whether homosexuality is *necessarily* a symptom of pathology."

Thomas Landess did a very detailed study of the Hooker research for the Family Research Council, and he contends the subjects themselves were the instigators of the study, and were well aware of, and had a vested interest in, its ultimate goal. This could very easily have had an impact on the Rorschach test.

But on to another subject: We agree, then, that homosexuality is biologically determined *to some extent*, but how does that make it normal and natural?

MW: Normality is a matter of definition in a given society. What is considered normal or appropriate in one society, may not be so in another. One obvious extreme is classical Greek society, when the norms reportedly allowed an older, wealthy, prominent man to have a young boy as his preferred sexual partner.

JN: In other words, the Greeks normalized homosexual pedophilia.

MW: Apparently so. In that society, it seems to have been considered normal and desirable.

JN: So basically, you're saying that normality is not something objective—normality is determined by a society, a culture.

MW: I think that's probably true.

JN: Then you don't think there *is* any universal truth of what is normal or abnormal.

MW: That's right, I really don't. In fact, I just reviewed a book by Kurt Danziger called *Naming the Mind* for the *Journal of the History of the Behavioral Sciences*. He argues that in the case of virtually all concepts in psychology and the behavioral sciences, there was originally an assump-

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tion that they were absolute, universal, and permanent. And he makes a compelling case that that isn't true for any concepts. They are all products of their intellectual and social environments. And in the case of homosexuality, our understanding of it is basically a product of a time, and place, and culture.

JN: So when a person is anxious or depressed, or obsessive-compulsive, or suicidal, or has violent fits—none of these are really disorders *in the absolute sense.* They're only problems *if a society thinks they're problems.* These are nothing more than culturally-defined pathologies.

MW: I think so.

JN: Wow...But that's deconstructionism, and what does that leave the client with? If psychology buys deconstructionism, it will de-construct itself from within. Psychology always represented the practical application of a philosophy. You have no philosophy, you have no meaningful psychotherapy.

Most clients come in with a problem. There's something going on their life that is not working for them, and they want the therapist to help them with that. They don't want to waste time and money having a professional tell them that their problem is just a "social construct." A lot of psychologists are playing this phenomenology game, but how does that meet the needs of clients who are looking for concrete answers?

Let me ask you this: is ANYTHING, in your view, an objective disorder? Would you consider pedophilia normal and desirable, if a particular society says it is? *Could a pedophilic relationship ever be "good"?*

MW: I'm sure that various somatogenic problems due to severe brain trauma may be close to "objective" disorders. But I know of no convincing evidence that even pedophilia is harmful to the boy. In ancient Greece, for example, a pedophilic relationship with a young boy was viewed as the ideal kind of relationship for an older man. What's the actual evidence—not just principled moral prejudgment—that such a relationship is damaging to the boy?

JN: First, the Greek understanding of pedophilia was very different from that of today's pedophile advocates. I refer to Marjorie Rosenberg's paper, "The Greeks had No Name for It" (described in the *NARTH Bulletin*, September 1994).

Second, children tend to interpret sexual use of them by an adult as a betrayal. Later in their own adulthood, they often feel compelled to reenact the molestation again with children who trust them. And there *is* an overwhelming body of literature, as well as much personal testimony from adults—including many of my own clients—who were traumatized by sexual molestation as children.

I've always believed that the restraints against pedophilia would be the next to fall within the American Psychological Association. The social-constructionist view leaves the door open to acceptance of a range of behaviors that fifty years ago, would simply have been unimaginable.

What treatment options should be available for a homosexual client?

MW: It seems to me that a wide variety of alternatives should be available, depending on the individual. On the one hand, it would be appropriate to try to make the client less uncomfortable about the homosexual urges, and to value himself despite his culturally disapproved preferences. On the other hand, he might also explore the possibility of changing the orientation so that the drive towards homosexual contacts can somehow be diverted to heterosexual. That's also perfectly reasonable.

JN: Then why was there such debate in the American Psychological Association? They almost passed the resolution *banning* sexual-reorientation treatment.

MW: Yes. It almost passed. The reason for it, I think, was a kind of simplistic attempt to be consistent with the early 1970s decision to de-pathologize homosexuality: the idea being that if homosexuality isn't pathological, it shouldn't be treated. But clearly, if a client is deeply troubled by a condition—including homosexuality—then any responsible clinician should help the client deal with that condition. So I'm glad the resolution didn't pass.

JN: But what is frightening is that it *almost* passed. For the sake of consistency with the 1973 decision, they were willing to sacrifice so many lives.

MW: That would have been tragic, I agree.

JN: And if it wasn't for people like yourself and Mark Stern and a few others—who really became aware of what was happening at the last minute, and pulled together a strategy to respond—that bill might very well have passed.

MW: It might have, yes. I'm not sure you're right, though, in giving any credit to me; to Mark, yes. Mark has been at the center of this and has also tried to get through some fairly modestly-stated resolutions that *acknowledge the appropriateness* of psychotherapy to induce sexual-reference change in homosexual clients who wish to try to achieve it. Unfortunately, Mark hasn't succeeded. If you're interested in strategy that might work, you should try to come up with wording that might be acceptable to the tremendously diverse constituency of the Council.

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JN: How do you see the role of NARTH on this issue?

MW: Some APA members find offensive the existence of an organization whose premise is that homosexuality is disordered. But at the same time, there is an overriding principle we must respect--namely, that we must provide options for those who seek change.

I suspect that if there were some subtle, relatively minor changes in NARTH's Statement of Purpose—a slight rewording—then a number of APA members would find NARTH acceptable. That is, if you advocate the availability of treatment for homosexuals who wish to explore the option of changing their sexual preference, but don't automatically stigmatize homosexuality as a pathological condition.

But if you actually manage to help homosexuals who would like to explore the possibility of changing their orientation, obviously, that's great.

JN: Yes—this is a point of contention with some of our allies. There are some very strong NARTH members who strongly support the right to change—like you do—but don't go the rest of the way to see the condition as a developmental deficit. We are willing to make room for both theoretical positions, and the *Bulletin* articles written by our members have reflected that difference of opinion. But NARTH's official position is that the condition does represent an objective developmental deficit.

MW: But calling homosexuality a developmental deficit can contribute to the negative self-image of a number of your clients, and could interfere with successful psychotherapy. Other than that, I resonate a lot with what you and NARTH and Mark Stern have said and stood for. But NARTH is conceiving of "growth" only in one sense. Other alternative forms of growth include accepting the homosexual identity and at the same time achieving a strong positive self-image—rather than the negative one that the larger society casts onto homosexuals.

NARTH, in fact, promotes this stigma with its position that homosexuality is abnormal and a developmental disorder. I believe this is counter-productive, and indeed destructive. Clients who wish to deal with their deviant sexual preferences have a sufficient challenge without the "expert" assertion that they are abnormal. Gays should be treated with the same respect, dignity and tolerance as any other human being.

JN: Absolutely. But you are confusing the *condition* with the *person*. If the client is open to hearing my opinion, I will tell him what I believe about the homosexual condition. This doesn't mean I don't like, respect and tolerate him *as a person*. Which is more important—the truth, or his feelings? This was the trap of the 1973 decision. Psychiatrists compromised the commitment to an understanding of normal vs. abnormal in order to relieve the suffering of gays. But we must not sacrifice a clear vision of what is normal and what is abnormal. Psychology cannot function as a science without a model of healthy human development. If we compromise on this, then we are just a group of intellectual cowards who are oversensitive to hurting people's feelings.

MW: Now it's my turn to say, "wow!" I know of no scientist who would assert that a model of healthy human development is a necessary condition for psychology to be a science. Science doesn't deal with absolute ideals; it is a matter of taking an objective approach to interesting phenomena from the stance of dispassionate and humble curiosity, looking for facts and their theoretical implications. "Normal" and "abnormal" are, from a scientific point of view, *tentative categories* that some may find useful for certain purposes in certain settings. They are not absolute and immutable, but are constructions by people living in a given time in a given society who are trying to make sense of certain phenomena. And such constructions change appropriately as convincing evidence becomes available that bears upon their tenability and utility.

JN: That's the basic difference in worldview between us, and as we know, it is probably unresolvable. I don't take the subjectivist stance that I, or society, arbitrarily "construct" normality. I believe a model of normality exists in objective form, "out there." While our *understanding* of the objective state of what is healthy and normal may be refined over time, that understanding is based on new data which has enlightened the discourse and brought us closer to perceiving that unchanging, external truth. I don't believe man simply "constructs" what is healthy and normal from his imagination, according to his own subjective taste.

Of course in the purest sense of the term, science *doesn't* have to be grounded in a philosophy. But traditionally, psychological inquiry was based in an overarching philosophy, without which it is reduced to mere data-collecting--observing and recording events—with no means of assessment. And that kind of social science sounds quite useless to me.

In spite of our differences, NARTH is very grateful for your support of the right-to-treatment. Thank you very much for participating in this interview.

I think we both agree that this sort of exchange should occur more often within the professional forum—perhaps as a public debate at an A.P.A. convention. There are a few NARTH members, myself included, who would enthusiastically welcome that opportunity. ■