Is Homosexuality a Mental Disorder?

The following excerpt of the new book (reviewed on p. 4) by Stanton Jones, Ph.D. and Mark Yarhouse, Psy.D. offers a careful reconsideration of a matter that was assumed to have been settled in 1973.

Gay advocates are quick to point out that "science says that homosexuality is normal and healthy." But as these authors explain, the matter is much more complex.

The short answer to the question, "Is homosexuality a psychopathology?" is no, if a person were to mean that the answer can be found by a quick look through the *Diagnostic and Statistical Manual of Mental Disorders; Fourth Edition* (DSM-IV) of the American Psychiatric Association. Homosexuality is not listed as a formal mental disorder in the DSM-IV, and hence it is not a "mental illness." But, as we will see in this chapter, answering the question, "Is homosexuality a psychopathology?" is much more complicated than simply checking a manual...

> "Lurking behind every definition of adaptiveness is a hidden, implicit model of wholeness and health."

A Review of the Scientific Literature

It is widely known that in 1974 the full membership of the American Psychiatric Association (APA) followed the 1973 recommendation of its board by voting to remove homosexuality as a pathological psychiatric condition *as such* (or "in itself") from the DSM, which is the official reference book for diagnosing mental disorders in America (and through much of the world).

The removal of homosexuality from the DSM was in response to a majority vote of the APA. The original APA vote was called at a time of significant social change and was taken with unconventional speed that circumvented normal channels for consideration of the issues because of explicit threats from gay rights groups to disrupt APA conventions and research.

However, it appears that in contrast to the results of the vote, the majority of the APA membership continued to view homosexuality as a pathology. A survey four years after the vote found that 69% of psychiatrists regarded homosexuality as a "pathological adaptation." A much more recent survey suggests that the majority of psychiatrists around the world continue to view same-sex behavior as signaling mental illness.

The removal of homosexuality from the DSM does not answer the thorny question of the morality of homosexual behavior, as we will discuss later. It also does not answer the question of whether or not homosexual orientation is "healthy." Removal of the diagnostic category from the DSM is not the same thing as an endorsement of homosexual orientation or lifestyle as healthy or wholesome, as the two surveys conducted since the APA vote would indicate. By analogy, a person can certainly be in a condition where he or she fails to manifest an identifiable physical disease, yet also fails to be an exemplar of health and fitness.

The removal of homosexuality from the DSM does not conclusively decide the issue of the pathological status of homosexuality. There is no absolute standard for judging normality or abnormality. Four empirical (or at least partially empirical) criteria are commonly used to define behavior patterns as abnormal:

- statistical infrequency
- personal distress
- maladaptiveness
- deviation from social norms

Before we look at the research in each of these areas, we want to discuss the limitations or challenges of the research in this area.

Methodological Challenges

Perhaps more than in any area we have examined so far, deciding the question of whether or not homosexuality is pathological hinges on making valid generalizations about homosexuals as a group. To make such generalizations validly, you must have good information about the entire group. The major challenge that comes up again and again in making generalizeable statements about homosexuality is the challenge of finding a *sample* of homosexual persons that is representative of *all* homosexual persons.

The first major study that challenged the view that homosexuality was intrinsically abnormal was the study by psychologist Evelyn Hooker, who administered psychological tests on a group of "healthy" homosexuals and compared those results with results from a group of heterosexuals. To the surprise of the mental health establishment, skilled psychologists, who were trained to make such diagnoses, could not distinguish the heterosexuals from the homosexuals on the basis of their test results alone. By their test findings alone, this group of homosexuals appeared to be no different and had no worse problems than the heterosexuals.

The prevailing wisdom at that time was that to be homosexual was to manifest obvious signs of pathology. Common wisdom dictated that the homosexuals should have obviously differed from the heterosexuals. Hooker's study challenged this commonplace assumption. In this study Hooker refuted the generalization that all homosexuals are manifestly disturbed. This study was the logical equivalent of refuting the judgment that "all women are intellectually inferior to men" by demonstrating that a select sample of intellectually gifted women performed as well as a sample of men on a math test.

But, as we mentioned above, Hooker's study is often interpreted as having accomplished much more. Remember the church document on human sexuality we cited earlier? It stated that researchers have been unable "to differentiate homosexual from heterosexual subjects, suggesting that there is no greater pathology or tendency toward psychological maladjustment among homosexuals than heterosexuals."

Research on maladaptiveness is inconclusive, primarily because of the lack of agreement in defining it.

Is this interpretation of Hooker's research accurate? No. We would argue that it is valid to say that the findings from Hooker's study demonstrated that *it is not the case that all homosexuals are manifestly disturbed.* But many popular reports suggest or give the impression that what Hooker's study has proven is that homosexuals are as emotionally healthy as heterosexuals, or that homosexuality per se is not psychopathological.

Logically and methodologically, her study neither proved that homosexuals are as emotionally healthy as heterosexuals, nor did it prove that homosexuality per se is not pathological...

We are still left with the question, "Is homosexuality abnormal?" To answer this question we will now review the research on each of the four criteria for defining pathology to further our understanding of whether homosexuality is abnormal.

Statistical Infrequency

We mentioned in the chapter on prevalence rates that a lifelong exclusive or near-exclusive homosexual orientation is not common. Perhaps 2% of the combined male and female population manifest this pattern. Compare this percentage to the estimated lifetime incidence rates of some other major psychopathological disorders. In comparison, the prevalence of homosexuality is much less frequent than such common disorders as phobias (14.3%) and alcohol abuse and dependence (13.8%), about as frequent as some disorders that are less common, as is the case with panic (1.6%) and schizophrenia (1.5%), and much more frequent than somatization disorders (0.1%).

In comparison to these prevalence rates, homosexuality is not so common as to be eliminated as a possible pathology on frequency alone. But even with a lower estimate of homosexuality than public perception might indicate, we have no absolute cutoff for judging pathologically by frequency or infrequency alone; there is no rule stating that a pattern cannot be judged a pathology if it is manifested by more than X% of the population.

Personal Distress

Psychopathology is often accompanied by personal distress as is the case with depressive disorders and sexual dysfunctions. However, personal distress is not a necessary aspect of psychopathology. Some problems that we all recognize as pathological are also characterized by patterns of denial and minimization of distress, as is the case with some experiences of alcoholism or drug addiction.

Think of the alcoholic who refuses treatment and adamantly claims to have his or her drinking under control. The alcoholic may not report personal distress, and some alcoholics will be able to manage their various responsibilities, at least for the time being, which is why some professionals refer to them as "functional alcoholics." Some disorders, such as Antisocial Personality Disorder, are actually characterized at a fundamental level by a failure to be distressed about the patterns of behavior one manifests.

With homosexuality the claim is often made that "there is no evidence of higher rates of emotional instability or psychiatric illness among homosexuals than among heterosexuals." This claim has been made so often that it has taken on the status of a truth that "everybody knows"; however, the factual basis for this assertion is debatable.

The two most frequently cited studies in support of this claim are the studies by Hooker and by Saghir and Robins. As we discussed earlier, the study conducted by Hooker proved that a select sample of homosexuals were no more distressed than (and could not be distinguished based on psychological testing from) a hetero-

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sexual sample. We also demonstrated that because of the nonrepresentativeness of her sample, she *did not in fact prove* the conclusion that Masters and his colleagues claim.

The Saghir and Robins study has the same limitations as Hooker's. Their sample was also selected to minimize or exclude psychopathology. The authors note that their subjects were recruited from "homophile organizations," and presumably there was some self-selection operating given the announced objective of the project as the study of emotionally stable homosexual persons. They explicitly set out to recruit healthy homosexuals. After volunteering, subjects were further screened and excluded on the basis of prior psychiatric hospitalization.

Interestingly, 14% of the male homosexual sample and 7% of the female homosexual sample were excluded from the study because of prior psychiatric hospitalizations, yet none of the heterosexuals who volunteered (the control group sample) were excluded on that basis.

The best estimate we can obtain of lifetime psychiatric hospitalization comes from Robins, Locke and Regier, who report a lifetime prevalence of diagnosable mental disorder for women of 30% and report that on an annual basis only 2.4% of those with a diagnosable disorder are hospitalized for a psychiatric disorder. If we double this estimate of hospitalization to be conservative in our estimate and to compensate for the higher psychiatric hospitalization rates for women, these findings would suggest that no more than 1.5% of the American female population is hospitalized for psychiatric reasons in their lifetime (30% x 5%). This is probably an overestimate because many of the psychopathologies included in the study by Robins et al. (e.g., phobias, generalized anxiety, dysthymia) infrequently result in hospitalization.

So while Saghir and Robins conclude that the homosexual population experiences no increased incidence of psychopathology, their study must be interpreted within the context of their having screened out previously hospitalized individuals that, if included, would suggest a hospitalization rate for homosexuals approximately 450% higher than the general population, which in turn would suggest a conclusion opposite of that stated.

Ironically, then, this study, which is touted as proving that homosexuals are just as healthy as a group as heterosexuals, actually provides evidence suggesting higher rates of psychiatric disorder among homosexuals.

A recent study provides similar evidence. Bradford and her colleagues reported findings from the "National Lesbian Health Care Survey." They minimized differences between homosexual and heterosexual women. The authors argued that the two groups were similar except for elevated use of alcohol and drugs and elevated use of counseling for lesbians (77.5% for the lesbian sample). But a closer look at their results tells a different tale. The data actually suggest that the lesbians studied experience elevated incidence of a number of significant problems.

The authors reported that 37% of the lesbians surveyed had experienced significant depression in their lifetime, that 11% were experiencing depression at the time of the survey, and that 1% were currently in treatment for their depression.

The best estimate for the general female population are 10.2% lifetime incidence of major depression, 3.1% current major depression, and probably less than 1% obtaining treatment for that depression in the year before the survey. The lesbian sample actually appears to experience significantly more depression.

Related to depression, Bradford and colleagues reported that 57% of the lesbians surveyed had experienced thoughts about suicide in their lifetime and that 18% had attempted suicide at least once. The best estimates for the general population are that 33% of women report lifetime "death thoughts" (a category much milder than thoughts about suicide, as it included answering yes to having "thought a lot about death" at any point in life, something that you can do when a grandparent dies), while the frequency of suicide attempts was so infrequent that it was not reported.

Finally, Bradford and colleagues reported that 30% of the lesbians surveyed currently abused alcohol more than once a month, 8% abused marijuana more than once a month and 2% abused cocaine, tranquilizers or stimulants more than once a month.

In contrast, Robins and Regier estimated for the general population that 4.6% of women had abused alcohol in their lifetime and 1% in the last month, while 4.4% reported lifetime abuse of marijuana and less than 1% reported current abuse and abuse of other substances was very infrequent. These comparisons are consistent in suggesting over 300% increases in incidence of serious personal distress among lesbians.

Objective assessment of other research suggests a similar pattern. Studies have found higher rates of depression and loneliness among male homosexuals, as well as "more paranoia and psychosomatic symptoms." Further, 18% of white homosexual males (like the 18% of lesbians) reported attempting suicide at least once, compared to a much lower rate among heterosexual respondents. In addition, Kus reported elevated substance abuse rates among homosexual males. ...

Clearly some behaviors that suggest distress are more common among homosexuals. Still, it cannot be generally concluded that *all* homosexuals experience personal distress, nor can it be concluded that such distress is an *inevitable* part of the homosexual experience. Most homosexuals in the Bell and Weinberg study (which was not a random sample) did not regret being homosexual and were not judged to exhibit psychopathological symptoms. But this conclusion begs the question of whether they are, on average, more disposed than the heterosexual population to experience distress. All of the available empirical evidence would seem to point in that direction.

It was thus for good reason that Baumrind, speaking only of gay and lesbian adolescents, remarked that "non-heterosexual youths manifest many symptoms of distress and problem behavior peculiar to, or exacerbated by, their lifestyles."

We should note too that some pro-gay authors do not deny these indications of elevated distress. They move the argument, perhaps rightly so (at least in part), in a different direction. Perhaps, they suggest, distress is not the result of homosexuality itself, but the result of the way *society* treats homosexuals; perhaps elevated levels of distress among homosexuals are a reality but occur not because of any discomfort inherent to the orientation itself, but rather in response to the interaction of gays and lesbians with a rejecting and punitive society. They liken these responses to those of other persecuted or rejected minority groups.

Although this explanation is a *post hoc* interpretation of research, there is an important point here: few heterosexuals know the stress of living under persecution for their sexual feelings, and social hostility toward homosexuals is bound to be an influencing factor in any measure of emotional stability.

Gays and lesbians have higher rates of depression and substance abuse.

Maladaptiveness

A behavior pattern or characteristic is "adaptive" when it is constructive, helpful, healthy and contributes to the person moving in a valued direction. If you are in college and value academic success, good study skills and self-discipline are adaptive, while alcohol abuse or learning disabilities are maladaptive. Maladaptiveness refers to behavior or characteristics that sabotage rather than abet a person's moving in a positive, healthy direction.

Maladaptiveness can only be judged against some standard of "adaptiveness." We share many common judgments of what is adaptive, and by logical extension, what is maladaptive. It is maladaptive to kill yourself, to hallucinate or be psychotic, to be unable to hold a job and contribute constructively to society and so forth.

But any standard of adaptiveness can be challenged: Is success at work or high income or relational stability or even the absence of self-injurious behavior really an utterly reliable standard of adaptiveness? Lurking behind every definition of adaptiveness and its opposite is a hidden, implicit model of wholeness and health, a vision of what constitutes a "good life."

Summary

- Homosexuality is not formally recognized as a mental disorder in the DSM. However, some mental health professionals disagree: a few years following the removal of homosexuality from the DSM, the majority of psychiatrists in America viewed homosexuality as a pathology, and the majority of psychiatrists around the world continue to see same-sex attraction as signaling a mental illness.

- Research has shown that it is not the case that *all* homosexuals are *inherently* pathological. Sometimes these findings are misrepresented to suggest that homosexuals do not experience any greater distress than heterosexuals.

- Research supports a relationship between homosexuality and personal distress (e.g., rates of depression, substance abuse and suicidality), though not all homosexuals are distressed. Some view the distress as indicating something inherently wrong with homosexuality; others view homosexuals who are distressed as a reflection of societal prejudice.

- Research on maladaptiveness is inconclusive primarily because of the lack of agreement as to what constitutes maladaptiveness. The clear evidence of relational instability and promiscuity among male homosexuals must figure as problematic for Christians.

- Homosexuality violates societal norms; however, mental health organizations have taken the formal position that societal norms have to be changed toward accepting homosexuality as a normal sexual variant.

- Research on whether homosexuality is a pathological condition is not formally relevant to the moral debate in the church. Psychological abnormality and immorality are two different things, although sometimes they overlap. ■