"On Arriving at the American Psychiatric Association Decision on Homosexuality"

By Irving Bieber, M.D.

To keep the record straight against the threat of psychological revisionism, NARTH will from time to time, publish important historical articles documenting psychoanalytic and psychological studies on the subject of homosexuality.

The author of this article is the late Irving Bieber, M.D., the eminent scientist in whose honor NARTH has named the research library now forming. Dr. Bieber was one of the key participants in the historical debate which culminated in the decision to remove homosexuality from the psychiatric manual.

Dr. Bieber's article describes psychiatry's attempt to adopt a new "adaptational" perspective of normality. During this time, the profession was beginning to sever itself from established clinical theory—particularly psychoanalytic theories of unconscious motivation—claiming that if we do not readily see "distress and disability" in a particular psychological condition, then the condition is normal.

On first consideration, such a theory sounds plausible. However we see its startling consequences when we apply it to a condition such as pedophilia. Is the happy and otherwise well-functioning pedophile "normal"? As Dr. Bieber argues in this article, psychopathology can be ego-syntonic and not cause distress; and social effectiveness--that is, the ability to maintain positive social relations and perform work effectively--"may coexist with psychopathology, in some cases even of a psychotic order."

NARTH President Charles Socarides argued the same point in a review he wrote of gender researcher Robert Stoller's Pain And Passion: A Psychoanalyst Explores The World Of S & M. In that book, Dr. Stoller acknowledged the psychodynamic causes of sadomasochism, and then described practices, utensils, and bodily parts used in sadomasochistic performances. He offered a six-page listing of the various methods used to inflict pain and humiliation on willing victims, including the different hanging techniques used to achieve orgastic ecstasy. But then Stoller claimed sadomasochism was no more abnormal than "dislike of zucchini"--asserting that only our "deep prejudices" about perversion lead us to label it abnormal.

Indeed, as some prominent cultural observers have noted, the democratic drive toward ever-greater equality has turned Americans against any conclusion which entails values and consequences – resulting in a growing trend toward rejection of all evaluative conclusions as unkind and "undemocratic." Legal scholar Robert Bork sees this as a natural consequence of democracy untethered from its Judeo-Christian roots of self-restraint and responsibility, guided instead by unrestricted egalitarianism.

Reading the following account by the eminent Irving Bieber, the reader is reminded of the historic role played by Dr. Bieber and NARTH President Charles Socarides. Both influential and courageous men stood, we believe, for truth in a profession that has set itself adrift by rejecting its theoretical and philosophical roots.

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The article has been slightly abbreviated for inclusion in the Bulletin, and subtitles were added.

The deletion of the term *homosexuality* from the American Psychiatric Association's revised diagnostic and statistical manual was not simply arrived at after carefully considered judgment by a group of psychiatrists. It was the climax of a sociopolitical struggle involving what were deemed to be the rights of homosexuals.

It is my aim here to separate out the psychiatric and conceptual issues from the sociopolitical issues; to document my own theoretical and clinical position; and to describe the events that I participated in and observed—all of which I trust will bring into focus the elements that went into the American Psychiatric Association's decision of 1974.

The complexity of homosexuality as a category of human adaptation has stimulated argument and controversy among lawmakers, the clergy, and behavioral, social, and biological scientists. Is it a sin, a crime, a deviation? Is it a dislocation of sexual development or an illness? Is it a constitutional disorder, a genetic misprint, a habit? The question of whether homosexuality is or is not an illness played an important role in the APA decision.

Coming from another direction was the influence of the gay activist groups who believed that prejudice against homosexuals could be extinguished only if, as homosexuals, they are accepted as normal. They claimed that homosexuality is a preference, an orientation, a propensity; that it is neither a defect, a disturbance, a sickness, nor a malfunction of any sort. Therefore, homophile leaders and their followers consistently impugned the motives and ridiculed the work of those psychiatrists who asserted that homosexuality is other than normal. The long-term research that has engaged my attention for many years has demonstrated that homosexuality is other than a normal sexual adaptation.

What the Bieber, *et al* Research Revealed about Homosexuality

In 1962, the research team that I had led, consisting of nine practicing psychoanalysts and two psychoanalytically trained psychologists, published the findings of a nine-year study of male homosexuals.[1] The team psychiatrists and 77 respondents to a 500-item questionnaire were members of the Society of Medical Psychoanalysts, whose roster consisted of faculty and graduates of the Psychoanalytic Division of the Department of Psychiatry of New York Medical College.

The research sample consisted of 106 male homosexuals and a comparison group of 100 male heterosexuals, all in psychoanalytic treatment with members of the society. The data obtained were analyzed statistically in consultation with statistical experts,[2] and the clinical implications were carefully analyzed and evaluated.

When the volume first appeared, critics questioned the methodology on two major points: First, how reliable were data obtained from analysts, rather than directly from the patients, whose information concerned not only themselves but their families, whom the analysts had never seen? Second, could the findings obtained from a white, middle- and upper-class population be generalized to the homosexual population at large? I am now in a position to address those issues.

> Dr. Spitzer suggested that if the voyeurs, fetishists, and sexual sadists were to organize, they, too, might find their conditions normalized.

In the many years since our volume was published, I have interviewed more than 1,000 male homosexuals in psychoanalytically focused psychiatric interviews. I have also examined about 75 pairs of parents of patients. In all regards, the data were in accord with the findings reported in our volume. Most subjects of this large sample were interviewed at a city hospital, came from a lower socioeconomic strata, and belonged to one of three ethnic groups: black, Puerto Rican, or white, distributed about evenly.

Patient and Non-Patient Samples Had Similar Findings

In 1960, Westwood had published a study in England of 127 working-class male homosexuals, only 5 percent of whom had ever been in psychiatric treatment.[3] In those areas where our study tapped similar items, the findings were similar. A study of nonpatient homosexuals by Snortum and his coworkers, and another by Evans, each using our questionnaire, reported findings similar to ours, although there were differences in interpretation.[4] The consistency of findings on nonpatients coming from lower social classes supports the appropriateness of generalizing from a patient sample to the homosexual population at large.

Our study contained questions that tapped the following areas: interparental relationship; mother-son relationship; father-son relationship; siblings; the triangular family system; developmental aspects of the prehomosexual child; homosexuality in adolescence; sexual adaptation of the male homosexual; latent homosexuality; and the results of treatment. Space will permit only a brief review restricted to the relationship of mother and son, father and son, and aspects of the development and socialization of the child. Statistics describing the homosexual and heterosexual sample will be given to emphasize the differences between them, bearing in mind that psychological problems brought each group into therapy.

The items listed in Table 18.1 significantly differentiated the homosexual from the heterosexual sample at levels of confidence varying from 105 to .001. For about 80 percent of the mothers in the homosexual sample, a picture merged of a woman who was overly close to this particular son, spent a great deal of time with him, and preferred him to his siblings. More often than not, she openly preferred him to his father. The son became her confidant, and some mothers even confided to him the details of their sexual life with the father or lovers. Such a mother carried on a nongenital yet sexually oriented, romantic relationship with a son who replaced the father in this role.

The Close-Binding, Intimate Mother

Not only was there an exaggerated concern about the son's health and possible injury, but other salient findings revealed that these mothers interfered with the son's assertiveness, and they tended to dislocate his relationship with the father, with siblings, and with peers. We called this type of mother "close-binding-intimate" (CBI). Most mothers of homosexuals whom, at a later time, we were able to interview also conformed to this profile. But not every mother of a homosexual had these characteristics. In the study, six were found to be detached and uninterested; in a few cases, the sons had been boarded out to institutions and foster homes. We found that homosexuality can develop without the frequently occurring CBI mother-son bond.

Table 18.1 The Mother-Son Relationship

Questionnaire Findings	Level of Confidence
The patient was mother's favorite.	.050
The mother demanded to be the centre of patient's attention.	.001
Mother was dominating.	.050

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Mother was seductive.	.050
She spent a great deal of time with patient.	.001
She did not encourage masculine attitudes and activities.	.001
She discouraged masculine attitudes and activities.	.010
She encouraged feminine attitudes and activities.	.001
She was puritanical.	.050
She was considered to be sexually frigid by her son.	.001
She allied with her son against her husband.	.010
She openly preferred son to husband.	.010
She was more intimate with the patient than with his siblings.	.050
She interfered with heterosexual activities.	.010
The patient was the mother's confidant.	.050
The mother was the patient's confidant.	.050
The mother was unduly concerned with protecting the patient from physical injury.	.050
The mother's concern about health and injury caused her to interfere with or restrict his play, socializing, and other activities.	.001
The patient considered his mother to be overprotective.	.010
The patient was excessively dependent on his mother for advice in making decisions.	.010
The mother babied the patient.	.010
She administered frequent enemas.	.050
The patient could cope with the mother more easily than with the father.	.010

The Detached Father

The items listed in Table 18.2 distinguished the fathers of the homosexual sample from the fathers of the heterosexuals. The father-son relationship was almost the diametrical opposite of that between mother and son. The paternal portrait was one of a father who was either detached or covertly or overtly hostile. Detachment of a parent from a child is in itself an oblique manifestation of hostility, and perceptive children easily catch subtle attitudes toward them. But even where hostility may not be present, children are apt to interpret the detachment as a negative attitude of some sort.

Although we found that most mothers were CBI, there was also, as pointed out, variance in the mother-son pattern. Some mothers were not remarkable; some were detached; a few were hostile. The father-son relationship, however, revealed uniformly an absence of loving, warm, constructive paternal attitudes and behavior. In my long experience, I have not found a single case where, in the developing years, a father had a kind, affectionate, and constructive relationship with the son who becomes homosexual. **This has been an unvarying finding.**

Father is the Crucial Variable

It is my view, and I have so stated and written, that if a father has a kind, affectionate, and constructive relationship with his son, he will not produce a homosexual son, no matter what the mother is like. It turns out, contrary to popular thought and some psychoanalytic theories, that the crucial and determining relationship in the evolution of male homosexuality is usually not with the mother but instead with the father. When a homosexual is questioned about his childhood with his father, frequent answers are of this type: "He was not there"; "I don't remember"; "He played no part"; "He was not interested"; "He was hostile, mean"; "He hit me"; "I hated him"; and so on. The son leaves his childhood years with, on the one hand a profound fear and conscious or unconscious hatred of his father and on the other a deep yearning for his acceptance and affection. These elements of the father-son relationship dominate the psychopathology of the adult male homosexual.

Table 18.2 The Father-Son Relationship

Questionnaire Findings	Level of Confidence
The patient was not his father's favorite.	.001
Another sibling was the father's favorite.	.010
The patient was the child that the father least favored.	.010
The patient did not feel accepted by father.	.010
The father spent very little time with patient or was absent.	.001
The father did not encourage masculine activities.	.050
The patient consciously hated his father.	.001
He hated and feared his father.	.001
He did not respect his father.	.010
He did not accept his father.	.001
The father had less respect for the patient than for other sons.	.050
The patient did not side with his father in parental arguments.	.010
He did not cope with his father more easily than with his mother.	.010
He feared that his assertiveness would anger his father.	.010
He feared that his father would hurt him.	.050
He felt his father did not consider his needs.	.010
He did not feel currently respected by his father.	.010
He did not admire his father.	.001

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A Continuity of Poor Male Relationships

Table 18.3 lists the developmental aspects for which we found statistically significant differences between the heterosexuals and the homosexuals during their childhood years. We noted a continuity of traumatic experiences with males, starting with the father. Brothers were also usually feared and hated, and the prehomosexual child had difficulties with same-sex peer groups, until adolescence. The consistent history of unremitting fear of and hostility to other males throughout childhood has led me to conclude that male homosexuality is basically an adaptation to a disorder of a man's relationship with other men.

In childhood and beyond, affection and trust are felt toward the mother, perhaps women relatives, sometimes a sister, and not infrequently girl friends. At adolescence there tends to be a change, and social life improves. With the opening of this era there is an abatement of the combative play of preadolescent boys, making it easier for the homosexual teenager to come into contact with peer mates.

Table 18.3 Developmental Aspects

Questionnaire Findings	Level of Confidence
The patient was excessively fearful of physical injury.	.001
He avoided physical fights.	.001
Play activity before puberty was predominantly with girls.	.001
He was a lone wolf in childhood.	.001
He did not participate in competitive games.	.001
He did not play baseball.	.001
He was a clinging child.	.010
He was reluctant to start school.	.010

Fear of Heterosexual Relationships

The psychoanalyses of adult homosexuals reveal that they perceive other men in two ways: as aggressors who are feared and are identified with the father, with successful brothers, and with combative peers; and as nonaggressors and as homosexuals like themselves who are not feared. This division enables them to come into a relationship with men, men who need not be defended against. Relationships with women in adult life are more trustful and positive, as long as the possibility of sex and romance is excluded. The fear is that a heterosexual attempt will elicit a dangerous, even lethal attack by combative men. A frequently reported dream tells the story. The opening segment depicts the patient with an attractive young woman. Then there is a threat of attack or an actual attack by an aggressive male. In the third sequence, heterosexuality is abandoned, and the dreamer is involved in substitutive homosexual activity.

The cues that "turn on" a homosexual illuminate the operant psychopathology. Elsewhere I have delineated three categories,[5] but undoubtedly there are more. The first relates to the displacement of a heterosexual stimulus to a homosexual object; that is, a particular feature of a woman significant in the patient's life is perceived in a man. It becomes an arousing stimulus, although there is no awareness of it.

Arousal Cues

One patient became aware that he was attracted to men who had eyebrows like his mother's. Actually he was reacting to a heterosexual stimulus, a feature associated with a woman, his mother, but the incestuous aspect of the arousal had to be disguised by displacement to a male. Other physical features also serve as arousal cues, particularly eyes and skin texture. Some homosexuals are attracted only to men with very smooth skin or who are hairless, or men whose fat distribution suggests femininity or whose attitudes and behavior may suggest femininity. Thus, feminine traits are not infrequently sought for their ability to stimulate sexual arousal, although such motivations may be completely unconscious.

The second category includes the eroticizing of the feared stimulus. For example, a bisexual patient became aware that he was aroused by men who had hands like his father's. His father was a strong, burly workman with large, thick hands. He had often beaten the patient with his hands. Yet, as an adult, hands like the father's excited the patient sexually.

During an interview, an exclusively homosexual young man told me that he was attracted to hairy men. I obtained the following dream from him: In the opening scene he is in bed with a young woman. It is obviously a heterosexual setting. Next, there appears from under the bed a big, brawny, very hairy arm with knife in hand, threatening to kill him. Again, the dream sequence starts with a heterosexual segment; then there is a lethal attack by a man whose arm is covered with hair, the stimulus that is homosexually arousing.

Another common arousal phenomenon is the sight of a large penis. Only the very large penis is sexually exciting to certain homosexuals. It is the symbol of ultimate masculinity. The dynamics of the compulsive urge to possess this symbol of masculinity, which is also feared, is an attempt to neutralize fear through eroticizing the feared stimulus. Unconscious attitudes toward the large penis vary. One patient, the night after he had fellated a large penis, had a dream that he had blood on his teeth, a depiction of his wish to castrate the penis that had consciously excited him.

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The Wish to be Loved by Males

A third category consists of interpersonal reparative attempts. Many homosexuals become sexually excited when a man shows them warmth and acceptance. They are turned on by it even though the partner may not conform to the physical type who is usually arousing. This is a central element in the dynamics of homosexuality. As previously stated, the homosexual leaves his childhood relationship with his father and other males with profound fear and hatred but also with envy, admiration, and the wish to be accepted and loved by them. The homosexual response very often is based on a need to redeem masculine affection.

Results of Treatment

Of the 106 homosexuals who started psychoanalytic therapy, 29 were exclusively heterosexual at the time the volume was published. This represented 27 percent of the total sample. Fourteen of these 29 had been exclusively homosexual when they began treatment; 15 were bisexual. In 1965, in a follow-up study of the 29, I was able to reclaim data on 15 of the 29.[6] Of these 15 men, 12 had remained exclusively heterosexual; the other 3 were predominantly heterosexual, had married, but had occasional episodes of homosexuality when under severe stress.

Of the 12 who had remained consistently heterosexual, 7 had been among the 14 who had been exclusively homosexual when they started treatment. Thus, 7 men who started treatment exclusively homosexual had been exclusively heterosexual for at least six or seven years.

What is Normal?

Now to turn to the issue of normalcy: It has been the position of the gay activists that homosexuality is within the normal range of human sexual behavior. They claim that the only reason psychiatrists and others designate homosexuality as abnormal is because society does not look upon it as socially acceptable. They also claim that homophobic psychiatrists have used prejudicial social criteria to designate homosexuality as other than normal.

This, of course, is not the case. Any phenomenon that is statistically normal refers to the average, the mean, or near the average. Normalcy also refers to health as opposed to illness or pathology. The common cold is statistically normal because most people catch cold, but having a cold is not a normal condition. A cold is a viral infection, and there are demonstrable pathophysiological signs and symptoms that make the cold abnormal. In designating any behavior or condition as other than normal, psychiatrists use neither frequency distribution, nor standards of social acceptability as criteria.

Is Fear-Based Behavior "Normal"?

Behavior is psychologically abnormal when it is based on irrational or unrealistic fears. In the case of homosexuality, as I have emphasized, the fears are of hostile responses by other men, should heterosexual, romantic wishes be fulfilled. Such fears may have been realistic during early life when other males were in fact hostile, as in cases where a father was specifically hostile when observing the son's closeness with the mother. But in adult life, the fear of injury from other men for heterosexual activity is not rational. Homosexuality first develops as a consequence of such fear and is maintained in adult life, usually unconsciously, by the continuity of fear.

The A.P.A. Decision

The questions that were raised at the outset in committees—that is, Is homosexuality a mental disease? Are homosexuals as well adjusted as heterosexuals? — only obfuscated the basic issue. The term "mental disease" in the *DSM-II* applied only to *psychotic illness*, and no psychiatrist with expertise in the subject has ever considered homosexuality, in that sense, as a mental disease.

Not All Psychiatric Disorders Result in Work or Social Impairment

Factors such as excellent occupational performance and good social adjustment were cited as evidence of the normalcy of homosexuals; such factors do not, however, exclude the presence of psychopathology. Although psychopathological disorders frequently impair occupational and social adjustment, the converse is not necessarily so. Men with potency problems, or women who are sexually frigid, may function well at their jobs and in their social circles, yet, excluding the infrequent occurrence of physical illness, these conditions are viewed as symptomatic of sexual psychopathology.

A number of important events and circumstances preceded the voting by the Board of Trustees of the APA in December, 1973, and the vote of the general membership in 1974. On September 18, 1967, the United States Department of Health, Education and Welfare of the National Institute of Mental Health issued a press release announcing the formation of a task force to encourage research on homosexuality.

Task Force Includes Only Psychiatrists Who See Homosexuality as Normal

The study that I had conducted in 1962 was by then widely known. In 1964 the APA had bestowed upon my group the Hofheimer Research Award, Honorable Mention, yet neither I nor any member of the research team was invited to join the task force. Other colleagues who had published important contributions were also overlooked: Lionel Ovesey, Charles Socarides, and Lawrence Hatterer.[7] Common to our work was the conclusion that homosexuality was not a normal sexual variant.

Not a single psychiatrist who held the view that homosexuality was anything other than an adaptation within the range of normal sexual organization was invited to participate. Evelyn Hooker had written two papers based on a

study of the adjustment of homosexual men, members of a homosexual association known as the Mattachine Society.[8] She found that their adjustment was in the normal range, in some ways even superior to that of heterosexuals.

The only other member of the task force who had written on the subject was Judd Marmor,[9] a well-known psychiatrist, psychoanalyst, and a former president of the APA. In his view, homosexuality is a normal variant but has been considered pathological because many psychiatrists had not freed themselves from the long-standing prejudices against homosexuality.

The task force issued its final report on October 10, 1969. First, they recommended the establishment of a center for the study of sexual behavior to include research, training, education, prevention and, treatment. A second category encompassed considerations of social policy in regard to legal and societal prejudices, emphasizing the adverse effects of social discrimination. "Homosexuality presents a major problem for our society largely because of the amount of injustice and suffering entailed in it not only for homosexuals but also for those concerned about them."

The Gay Movement Gains Power

The political, intellectual, emotional and psychiatric thrust of this movement is well demonstrated by the writings of Franklin E. Kameny, a leading spokesman.[10] In a statement describing the forces that gave rise to the gay liberation movement, he wrote:

> Gay liberation as a formal entity had its birth in a riot by homosexuals in late June, 1969, at a bar called the Stone Wall on Christopher Street in Greenwich Village, New York City...
>
> The message was we have been shoved around for some three thousand years. We are fed up with it and we are starting to shove back. If we don't get our rights and the decent treatment as full human beings which we deserve and get them now, there's going to be a lot more shoving back.

Riots at Scientific Meetings

The gay activists thus explicitly targeted psychiatry as its main enemy. Among their major activities was the disruption of psychiatric meetings. My first direct contact with the Gay Activist Alliance occurred during the 1970 annual meetings of the APA in San Francisco. I was a member of a panel on "Transsexuals and Homosexuals." As we were preparing to start, a number of gays dressed in fantastic garb entered the meeting hall, distributed literature, behaved as if they intended to disrupt the meeting, and, in fact, did. We finally got under way when arrangements were made for gay representatives to remain and be given the opportunity to speak.

My next direct contact with disruptive tactics occurred in 1972 at the APA annual meeting in Dallas. I was to present a paper entitled "Homosexuals Dynamics in Psychiatric Crisis."[xi] When I learned from an informed source that the gay activists intended to disrupt the meeting, I conferred with several colleagues who were in charge of arrangements. They worked out an agreement with the gays to deliver their remarks following my presentation. Frank Kameny was their major speaker.

The gay activists had from the beginning of their social protest action blamed the psychiatrists for perpetuating discriminatory practices against homosexuals, and although homosexuality was listed in the *Diagnostic and Statistical Manual* with the limitations previously described, the homosexual community nevertheless considered its inclusion to be damaging. Many psychiatrists shared the gay point of view, especially the younger colleagues.

Socarides and I decided to constitute an *ad hoc* committee for those APA members who believed that the term homosexuality should not be removed from the diagnostic manual. We cochaired this meeting and composed a letter stating our position and sent it to all members of the Board of Trustees of the APA in April 1973. Our major points were that our studies indicated that homosexuality was not a normal variant and did belong in the statistical and diagnostic nomenclature.

Will Prevention of Homosexuality Be Prohibited?

Moreover, deletion threatened the prophylactic treatment of children who, in preadolescence, constitute a population at risk for becoming homosexual. Such children, particularly boys, are easily identified, not only by psychiatrists but by teachers and peer-mates. If treated, many may not become homosexual. The question remained: What will the APA position be on the prophylactic treatment of this population of preadolescent boys? We requested the trustees of the APA to constitute a task force whose views would include the ones we represented, unlike the homogeneous group that had been appointed by the national Institute of Mental Health.

In the fall of 1970, the New York District Branch of the APA appointed Socarides as chairman of a task force to investigate the problem of sexual deviation. I became a member of this group, along with ten other psychoanalysts who represented a broad spectrum of theoretical orientations.

After working together for about two years, the task force submitted a detailed report of its findings and conclusions. We unanimously agreed that homosexuality was not a normal sexual variant, but was a manifestation of psychopathology; that it was experientially, not organically derived; and that a significant number of homosexuals could shift to exclusive heterosexuality if they had a psychoanalytic type of psychotherapy.

Task Force Findings Ignored

The council of the New York district Branch refused to accept our report on the ground that the issue of homosexual normalcy or pathology was controversial and that the society could not take a stand on controversial scientific issues. Yet this same council did indeed take a stand on a controversial issue when it directed its delegate to the assembly at the district branches to vote to remove homosexuality from *DSM-II*. Further, they took this stand without consultation with the general membership of our district branch.

In the fall of 1972, I was appointed chairman of this task force, but shortly thereafter we were instructed by the council to disband, on the ground that since they had submitted our report on homosexuality there was no reason for our committee to continue its work, even though we had been appointed as a task force to study the broader topic of sexual deviation.

Shortly thereafter, Robert Spitzer, a leading member of the Nomenclature Committee, invited me to participate on a panel of which he was chairman, scheduled for the 1973 APA meetings in Honolulu. The subject again was whether homosexuality should remain in *DSM-II*. My fellow panelists were Ronald Gold, a representative of the Gay Activist Alliance; Richard Green; Judd Marmor; Charles Socarides; and Robert Stoller. There was an audience of about 2,000, and it was evident from the mood and response that the majority supported the Gay Alliance position.

Should Psychiatry Remove Diagnoses to Eliminate Prejudice?

The first issue was clear: Was homosexuality a normal sexual variant, or an expression of psychopathology? The second issue was sociopolitical. Did the inclusion of homosexuality in *DSM-II* significantly contribute to the continued prejudice against homosexuals, and, if so, was the solution one of removing the term from the manual, even if homosexuality was deemed to be pathological? Instead of keeping to the issue, clarity was lost by introducing the concept of mental illness and by discussing a new set of criteria for diagnosing psychiatric conditions.

Spitzer was appointed chairman of a subcommittee of the Committee on Nomenclature and Statistics to investigate the broad problem of homosexuality and to determine whether or not it belonged in the diagnostic manual. He introduced two criteria for determining which psychiatric conditions should be listed in *DSM-II*. The condition must

(1) regularly cause distress, or
(2) interfere with social effectiveness.

Pathology is Not Always Accompanied By Adjustment Problems

In a position paper published in *Psychiatric News*, I stated that psychopathology can be ego-syntonic and not cause distress; that social effectiveness-—that is, the ability to maintain positive social relations and perform work effectively—may coexist with psychopathology, in some cases even of a psychotic order.

In a dialogue with Spitzer, reported in the *New York Times* December 23, 1973, I pointed out that there were several conditions in the *DSM-II* that did not fulfill his criteria: voyeurism, fetishism, sexual sadism, and masochism. He replied that these conditions should perhaps also be removed from the *DSM-II*, and that if the group so affected were to organize as did the gay activists, they, too, might find that their conditions would be removed as a diagnostic entity from *DSM-II*.

On December 14, 1973, the Board of Trustees of the APA was to meet in Washington, D.C., to vote on whether or not to remove the term from the manual. Socarides and I agreed that our viewpoint should be represented, and we decided to go to Washington. Robert McDevett, a fellow psychiatrist, joined us there, and we each addressed the committee, offering our considered opinions as to why the term should not be deleted.

I stated that apart from scientific error, if they voted for removal, their decision would be interpreted by the gay community and the public as an APA declaration that homosexuality is normal. My major concern was and continues to be the effects of their decision on prophylaxis and the treatment of children and adolescents who show clear-cut signs of developing homosexuality.

Research, Not Power Politics, Should Settle the Question

I emphasized that scientific issues must be settled by research, not by vote, and that a task force of colleagues holding varying opinions should be constituted to study the problem further. The Executive Council, with two absentions, voted unanimously to remove the term *homosexuality* from the *DSM-II*.

Now that a vote had been used to settle a scientific issue, it was Socarides' thought that the entire membership should therefore have a voice and that a petition for referendum should be initiated. The required 200 signatures were soon obtained, and Socarides and I became cochairman of an *ad hoc* committee for the referendum.

Before the vote, two letters were circulated to the entire APA membership. One was signed by the president-elect of the APA; the other letter was written by a group calling themselves the Committee of Concerned Psychiatrists. Each of the letters asked the membership to support the

Board of Trustees and vote against the referendum. Ballots were returned by 9,644 members, roughly 37 percent of the membership; 5,834 backed the board and 3,810 voted against the decision we supported. We later learned that there was an overrepresentation of younger colleagues who supported the board, though it probably did not affect the outcome.

Gay Task Force Conducts Direct-Mail Campaign

Shortly after the referendum was completed and action was taken to remove the term *homosexuality* from the *DSM-II*, the following circumstances came to light: the letter that had been sent to the entire membership under the signature of the two officers and three candidates for office had been written by a gay-activist group and had been financially supported and distributed by them. The failure to identify gay sponsorship prompted demands that the APA investigate this seeming impropriety. It was the *National Gay Task Force* who had written the letter, solicited the signatures, purchased a membership list from the APA for $360, and mailed the letter to 17,900 psychiatrists, urging them to vote in the referendum and to uphold the APA trustee's decision to eliminate the term *homosexuality* from the list of mental disorders.

A number of APA members questioned the propriety of sending a letter to the membership before the vote on the referendum without noting that the letter had been financed by the National Gay Task Force. The ethics committee of the APA investigated the matter and came to the conclusion that although the actions had been unwise, there had been no impropriety.

After the Decision: Disruption Continues

On April 6, 1976, more than two years after homosexuality had been removed from the *DSM-II*, a meeting that was to be devoted to a discussion of male homosexuality was scheduled to be held at the New York Academy of medicine under the auspices of the Columbia Psychoanalytic Society. The three main speakers were to be Socarides, Ovesey, and myself. The meeting was completely disrupted by the gay activists, and the papers were not given. Thus, several years after winning their position, the gays were still breaking up psychiatric meetings.

Despite Vote, Many Psychiatrists Still See Pathology in Homosexuality

The November 1977 issue of *Medical Aspects of Human Sexuality*, a magazine widely circulated among physicians in the United States, published the results of an analysis of the first 2,500 replies to a questionnaire it had sent out to 10,000 psychiatrists. The questions and answers follow:

Q: *Is homosexuality usually a pathological adaptation (as opposed to a normal variation)?*
A: Yes, 69 percent; no, 18 percent; uncertain, 13 percent.

Q: *Can homosexuals become heterosexual via therapy?*
A: In most cases, 3 percent; fairly often, 37 percent; almost Never, 58 percent.

Q: *Are homosexual men generally less happy than others?*
A: Yes, 72 percent; no, 26 percent.

Q: *Are homosexual men generally less capable than heterosexual men in mature loving relationships?*
A: Yes, 60 percent; no, 39 percent.

Q: *Are lesbian women less capable than heterosexuals of mature loving relationships?*
A: Yes, 55 percent; no, 43 percent.

Q: *Are homosexuals' problems in living a result of personal conflicts more than of social stigmatization?*
A: Yes, 70 percent; no, 28 percent.

Q: *Can bisexuals have successful heterosexual marriages?*
A: Usually, 21 percent; occasionally, 65 percent; almost Never, 12 percent.

Q: *Are homosexuals generally more creative than heterosexals?*
A: Yes, 22 percent; no, 74 percent.

Q: *Are homosexuals generally a greater risk than heterosexuals to hold position of great responsibility?*
A: Yes, 42 percent; no, 54 percent.

Summary

The factors that seemingly determined the decision of the APA to delete *homosexuality* from *DSM-II* may be summarized as follows:

(1) The gay activists had a profound influence on psychiatric thinking.

(2) A sincere belief was held by liberal-minded and compassionate psychiatrists that listing homosexuality as a psychiatric disorder supported and reinforced prejudice against homosexuals. Removal of the term from the diagnostic manual was viewed as a humane, progressive act.

(3) There was an acceptance of an altered concept of psychiatric conditions. Only those disorders that caused a patient to suffer or that resulted in adjustment problems were thought to be appropriate for inclusion in the *Diagnostic and Statistical Manual*.

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The First Scientific Matter to be Settled by Membership Vote

The way the APA decision was arrived at was unique, in that never before had a scientific controversy been settled by vote of the members of a large professional society. There was no precedent for this procedure in the APA, and probably not in any other scientific organization.

The initial decision of the board of trustees was also arrived at by a vote—unanimous, with two absentions—and had the subsequent referendum not taken place, the board's pronouncement would likely have stood without protest. Yet their decision by no means reflected broad agreement among the membership. A substantial minority, 29.5 percent, voted **against** deleting *homosexuality* from *DSM-II*.

In the final analysis, scientific controversies are settled in time, when the overwhelming weight of evidence makes the continuation of controversy irrelevant. Long before convincing evidence is in, however, there usually tends to be a polarization of opinion, with one side attaining decision-making power and influence. It seems obvious enough that scientific differences should be settled by scientific methods, not by vote nor by power politics, but given a choice between a small group decision and a democratic vote, I do not regret that the APA had a mechanism that permitted the membership to have a voice in the outcome.

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