

## THE REMOVAL OF HOMOSEXUALITY FROM THE PSYCHIATRIC MANUAL

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*Discusses the American Psychiatric Association's well-known removal of homosexuality from its list of mental disorders. Argues that this was done because of political pressures, the overall influence of the sexual revolution, and problematic humanitarian motives. Asserts that now homosexuals who seek treatment for their condition are often denied help by psychologists and psychiatrists.*

*All three great pioneers of psychiatry—Freud, Jung and Adler—saw homosexuality as disordered. Yet today, homosexuality is not to be found in the psychiatric manual of mental disorders.*

*Were these three great pioneers just reflecting the ignorance and prejudice of their times? Is this radical shift due to our modern-day enlightened, sophisticated attitude? Has there been any new research to account for this shift of opinion?*

*Submits that no new psychological or sociological research justifies this shift. Research did not settle the question. Research simply stopped, and it is politics that has silenced the professional dialogue. Now, the only studies on homosexuality are from an advocacy perspective.*

*Militant gay advocates working in a small but forceful network have caused apathy and confusion within our society. They insist that acceptance of the homosexual as a person cannot occur without endorsement of the homosexual condition. Intellectual circles too—who are self-conscious about sounding intolerant—proclaim homosexuality as normal, yet it is still not so for the average person for whom it “just doesn't seem right.”*

### History of Diagnosis

In 1952, the original *Diagnostic and Statistical Manual of Mental Disorders (DSM)* listed homosexuality among the sociopathic personality disturbances.

In 1968, *DSM II* removed homosexuality from the sociopathic list, categorizing it with other sexual deviations.

Then in 1973, the *DSM III* showed the most striking change of all: homosexuality was considered a problem only when it was dissatisfying to the person. When the condition was compatible (“ego-syntonic”)—and the person was comfortable with his homosexual thoughts, feelings and behavior—homosexuality was not considered pathological.

This is, I believe, a false distinction. The problem lies not in the person’s attitude toward his homosexuality, but in the homosexuality itself. I believe that while homosexuality may be compatible with the conscious ego, it can never be compatible on the deepest levels of self. Homosexuality, as we will show, is symptomatic failure to integrate self-identity. Symptoms will always emerge to indicate its incompatibility with a man’s true nature.

The *DSM III* was further revised, and now homosexuality is not referred to at all: no reference is made to it by name within the diagnostic manual.

Actually, there is an oblique reference in the catch-all category of “Other Sexual Disorders Not Otherwise Specified.” Here they describe “Persistent and Marked Distress About One’s Sexual Orientation.” Reference to homosexual orientation is avoided as if “persistent and marked distress” could also apply to heterosexuality.

Yet in the history of psychiatry, has a heterosexual ever sought treatment for distress about his heterosexuality and wished to become homosexual? When I put that question in correspondence to the chairman of the *DSM* Nomenclature Committee, Robert L. Spitzer, he replied: “the answer, as you suspected, is no.” Why does the profession no longer consider homosexuality a problem?

### Political Factors

In his scholarly analysis of the American Psychiatric Association’s reversal of the diagnostic classification of homosexuality, Ronald Bayer (1981) states: “the result was not a conclusion based upon an approximation of the scientific truth as dictated by reason, but was instead an action demanded by the ideological temper of the times” (p. 3-4).

The combined effects of the sexual revolution and the “rights” movements—civil rights, minority rights, feminist rights—have resulted in an intimidating effect upon psychology. Some writers have even questioned whether “straights” are capable of doing research on homosexuality (Suppe, 1982). Because there is a fear of offending any vocal minority or of being considered judgmental, there has been little critique of the quality of gay life.

Although recent behavioral inventories of homosexual men have revealed more anonymous sex than previously imagined, it is like the case of the Emperor's new clothes: everyone sees the problem, but no one dares acknowledge the obvious.

The removal of homosexuality from the *DSM* had the effect of discouraging treatment and research. The bulk of early psychodynamic research and theory beginning with Freud indicated that homosexuality is not a natural, inborn condition. Yet the literature came to an abrupt stop when it became "common knowledge" that homosexuality was in fact not a problem. This discouraged clinicians from communicating with each other, and from making presentations at professional meetings.

The silence among researchers was not brought about by new scientific evidence showing homosexuality to be a normal and healthy variant of human sexuality; rather it became fashionable not to discuss homosexuality as a problem any longer.

Other pro-gay researchers fear any inquiry into psychological causes would amount to a concession of pathology; after all, there has been no similar investigation of the causes of heterosexuality (Stein and Cohen, 1986). They have encouraged only the search for a genetic or endocrine basis for homosexuality, in the belief that such a discovery would once and for all resolve the issue of homosexuality's normality.

We too consider it possible that there could be some predisposing genetic factors; but in this regard we see a parallel with alcoholism. Although there is now greater recognition of some biological predisposition to alcoholism, we continue to acknowledge it as problematic, we continue to treat it, and we still find the most successful treatments to be psychological, social and spiritual supportive therapy.

### **Humanitarian Motives**

Beyond political pressures, there were two other reasons why the psychiatric profession removed homosexuality from its diagnostic manual.

The first reason is that psychiatry hoped to eliminate social discrimination by removing the stigma of "sick" attributed to homosexual people (Bayer, 1981; Barnhouse, 1977). Most psychotherapists are personally committed to removing emotional distress and diminishing the destructive effects of socially-imposed guilt. There was a leap of assumption that continued diagnosis of homosexuality would perpetuate society's prejudice and the homosexual person's social suffering.

The second reason is that the psychological profession has failed to identify, with certainty, the psychodynamic causes of homosexuality, and

consequently to devise a consistently successful treatment for it. Historically, the cure rate in the treatment of homosexuality has been modest. In those few studies that do claim success, the percentage of clients converted to heterosexuality runs from 15-30%, and there is question whether the “cure” was maintained on long-term follow up. Such results have culminated in an acceptance of the condition.

However, while the humanitarian intent must not go unappreciated, failure by the profession to find a consistently successful cure should not be the criterion for determining normalcy. We are resorting to the logic “if we can’t fix it, it ain’t broke.”

The psychological profession is responsible for diagnosis—for identifying what is “disease” or “loss of ease” within the person. It is not for the profession to erase diagnosis for lack of a ready cure.

### **The New Problem of Reverse Discrimination**

While the intention has been to end discrimination, one result has been discrimination for a different group of people—those men whose social and moral values and sense of self cannot incorporate their homosexuality.

In its new outspokenness, the gay movement portrays a false scenario wherein the so-called “victim-patient” is invariably preyed upon by the “victimizing mental-health professional” who trades on such a man’s homophobia. Forgotten is the homosexual who, out of a different vision of personal wholeness, legitimately seeks growth and change through the help of a professional. Unfortunately, these men have been labeled victims of psychological and religious oppression rather than the courageous men they are, committed to an authentic vision.

Failure by the psychiatric profession to recognize homosexuality as an unwanted condition for some, serves to discourage members of the mental health profession from offering treatment. Most harmfully, the client himself is disheartened, since the very profession to which he turns for help tells him that it is not a problem and he must accept it.

It is extremely demoralizing for a client to persist in attempting to overcome homosexuality when the psychological profession—which would administer treatment—insists he does not have a problem.

Some people define the whole person by his unwanted sexual behavior, basing upon the simplistic phenomenological premise: “You are what you do.” In contrast, my clients experience their homosexual orientation and behavior as at odds with who they really are. For these men, their values, ethics, and traditions carry more weight in defining their personal identity than their sexual feelings.

Our approach views sexual behavior as just one aspect of a man's identity: an identity which may continually deepen, grow, even change—through his relationship with others and with his Creator.

Is it possible to address the needs of the dissatisfied homosexual and still propose a model of psychological disorder which will not offend those who do not wish to change? The only answer is to “agree to disagree”—by allowing the debate to continue rather than, through pressure and intimidation, putting an end to the discussion.

### **The Failure of the Mental Health Profession**

Today, influenced by the popular assumption that homosexuality is in no way amenable to change, psychotherapists proceed to bring about “cure” by encouraging the client to accept his homosexuality. The most effective treatment is considered to be desensitization to feelings of guilt. This is done not because therapists necessarily advocate the gay lifestyle, but because they see no successful treatment.

Renowned behavioral psychologist Joseph Wolpe was faced with a Catholic client who felt guilty about his homosexuality. Wolpe had to decide which behavior to extinguish—the homosexuality or the religious guilt. Rather than the homosexuality, he chose to extinguish the guilt. This case is an example of the power of the therapist and a decision made all too often by the psychological profession.\*

Today psychology claims to work from a “value-free” philosophy. However, decisions such as this—to eliminate religious guilt—are in fact being made from another value hierarchy of the therapist's choosing.

Leahey (1987) describes how psychology was first understood to be the practical application of philosophy. This philosophy was based in morality and religious principles, emphasizing man's need to be attuned to his spiritual nature.

By the end of the 19th century, the newer scientific, rationalistic approach arose in opposition to this tradition. Psychology sought to break all ties with its philosophical roots and to be the objective, empirical and “value-free” science of human nature. The myth was, Leahey says, that we had at last found a philosophically-neutral psychology.

\*Two interesting notes on this case: First, Wolpe said he made his decision based upon a belief that homosexuality was biologically determined. Second, the client later discovered heterosexual attraction on his own and was married, and Wolpe determined him to be cured of homosexuality.

In the 1960's, the humanistic movement then influenced this psychology in the direction of a new (but disguised) version of moral authority. Its new reliance was on the gauge of "feelings" to assess morality (Leahey, 1987).

This popular movement of the sixties and seventies criticized what psychology had been and preached emotional openness, spontaneity and being true to oneself. Growth was no longer seen as a product of intelligence and problem solving, but rather was viewed solely in emotional terms. "Feeling good about yourself" became the litmus test of good behavior, a sort of bastardized moral sense" (Leahey, 1987).

Humanistic psychology rejected much of the rationalism of the psychoanalytic tradition. It introduced instead the soft sentiment of full acceptance of the person, as he is, without expectations. Following the influence of Carl Rogers' client-centered philosophy, therapists were expected to remain neutral, non-directive and not to contaminate the therapy through any sort of value system.

However, in reality, effective treatment takes its direction from a shared value system between client and therapist. Neither psychology nor any other science can address the question of "what is" without some perspective on "what ought to be."

Because of his day-to-day involvement in the human drama, the clinical psychologist is particularly enmeshed in philosophical issues. He must help people who are struggling for answers, and those answers are not to be found solely in behavioral data. Neither will they emerge in a value-free and non-directive client-therapist interaction. Rather, they unfold through the active interplay between client and therapist within the context of their shared world view.

The "non-gay homosexual" is my name for the homosexual struggler who holds the conviction that all men are essentially heterosexual. For such a man, growth is promoted by an anchoring scheme of values and ideals supported by conventional society, perhaps his religious tradition, and—most essentially—a psychotherapist who shares his perspective of the homosexual condition. Indeed it would be demeaning not to provide a treatment for those who value and freely desire growth out of homosexuality.

### "Cure" vs. "Change"

In his final work, *Psychoanalysis: Terminable and Interminable*, Freud concluded that analysis is essentially a lifetime process. This is true in the treatment of homosexuality, which—like many other therapeutic issues such as alcoholism, unhealthy eating habits, or deeply engrained self-esteem problems—requires an ongoing growth process.

Yet while there are no shortcuts to personal growth, how long it takes to reach a goal is not as important as the choice of direction. A sense of progress toward a committed value is what is most important. The non-gay homosexual is on the road to unifying his sexuality with his masculine identity. When he can look back over the past months and see a realization of some of the goals he has committed to, he gains hope.

To some, this approach may sound reactionary and anti-gay, anti-sexual, anti-freedom. Rather, for those men who seek an alternative to the gay lifestyle, this is progressive treatment. Indeed, many men have found these ideas to reflect a truth they sense within themselves. This approach acknowledges the value of gender difference, the worth of family and traditional social values, and the importance of the prevention of gender confusion in children.

