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A Discussion of "Homosexuality: The Ethical Challenge"

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Davison's (1976) thesis is simple. He assumes that homosexuality is a normal sexual mode in the wide spectrum of human sexuality and that the psychological problems noted among homosexuals directly derive from societal prejudices. He suggests, therefore, that it is unethical for clinicians to cooperate with homosexuals who wish to change their sexual direction.

The central argument on which his assumptions are based is by now well worn. It comes down to whether homosexuality is, in fact, normal or is the consequence of and an expression of psychopathology. If, as Davison thinks, homosexuality is normal, then patients who seek a change in sexual orientation should be dissuaded. If, as I think, homosexuality is pathological, the failure to develop prophylactic programs or provide therapeutic services for people who wish to become heterosexual would be a grave error. I am not inclined to use the term "unethical." It is a scare word, an accusation really, that implies dubious therapeutic intentions.

As to the assumption that homosexuality is normal: Over the many years of my work with many colleagues on this subject, we have found no supporting evidence, Hooker's much quoted studies notwithstanding (Hooker, 1957, 1958). I shall not offer a critique of her studies; others have already done so (Socarides et al., 1973). I shall, instead, refer to my own work.

Although the major findings of the homosexuality study by Bieber et al. (1962) are now well-known, the data are often inaccurately reported or the emphases misplaced. In most cases, the mother was indeed overly close, inappropriately intimate with her son, intrusive, overprotective, and demasculinizing, but the most striking of our findings was the consistency of a seriously disturbed father–son relationship. In not one homosexual case could the father's attitude be described as affectionate or even reasonably constructive. Mostly, the fathers were reported as detached, and/or openly hostile or "never there." Children perceive detachment as hostility, which in fact it is. One is not unremittingly detached from a love object. These sons emerged from the paternal influence hating and fearing their father on the one hand and deeply yearning for paternal affection on the other.

A major conclusion of our 1962 study was that male homosexuality would not evolve given a loving, constructively related father despite a neurotic mother–son relationship. There is no reason now to change this conclusion. If one were to choose any single criterion on which to base a prognosis for change, it is the degree of pathology of the father–son relationship. Where some positive elements exist, there is comparatively less existing pathology and the prognosis for change is more encouraging.

Since 1962, I have examined about 850 male homosexuals in psychiatric consultation. The large majority were seen in the walk-in clinic of Metropolitan Hospital in New York City. The sample included men from various ethnic and socioeconomic groups. I also examined about 50 pairs of parents whose sons were homosexual. This sizable sample of parents and sons confirmed our research findings. In not a single case was there a good father–son relationship. In general, the parents' relationship with each other was also poor. Mothers tended to be complainingly dissatisfied with their husbands and openly preferred their son to their spouse.

In referring to Bieber et al. (1962) Davison (1976) mentions only the mother–son relationship and asks, "What's wrong with

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such a [close-binding intimate] mother unless you happen to find her in the background of people whose current behavior you judge beforehand to be pathological?" (p. 158) As a behaviorist, Davison may be disinterested or perhaps naive about the effects of life history and family influences. As a psychoanalyst I find plenty wrong with a close-binding, possessive, overintimate mother as we described her. But that is not my point. Davison says nothing about the father and the ubiquity of disturbed relationships notable between them and their sons who become homosexual. I have noticed that writers who avoid mentioning fathers and developmental history usually advance the view that homosexuality is normal sexual behavior.

Bieber et al. (1962) compared 106 male homosexual analysands with 100 male heterosexual analysands clinically and statistically on about 500 items that tapped parent–child relationships, interparental relationships, sibling and peer relationships, sexual development, adult sexual functioning, and treatment results. A very brief description of the interparental and parent–child relationships and the other areas are as follows:

The patients' relationship with siblings, particularly with brothers, was, in most instances, hostile. Usually the brothers initiated the hostility because of their rivalrous reaction to the patients' preferential status with their mother. The relationships that patients had with sisters were significantly better.

Childhood and preadolescent relationships with same-sex peer groups were, for the most, unhappy, painful experiences. During boyhood, they were isolated from same-sex peer groups. Other boys soon discerned unusual fears of physical injury, timidity, and a reluctance to participate in rough and tumble games, and they made the prehomosexual boy the butt of their hostility, verbal and physical, thus isolating him further and leaving him to play with the gentler girls or with boys who had similar problems.

The developmental history of the patients revealed a continuity of traumatic experiences with other males starting with the father, and later including brothers and other boys. The fear of aggressive males warps a sense of masculinity and has a dislocating effect on heterosexual development. Later, heterosexual relationships are avoided as a consequence of early established fears of attack by men perceived as aggressive and dangerous. Homosexuality evolves as a substitutive adaptation permitting sexual gratification with minimal anxiety since it is perceived as safer. Most homosexual acts, however, are psychologically well-concealed heterosexual acts. In frequently occurring psychodynamic themes, the homosexual partner psychologically represents a woman or, if a man perceives his partner as masculine, there is an identification with him in the sexual act while he himself acts out the role of a woman. According to classical psychoanalytic theory, a homosexual phase normally precedes heterosexual development and remains latent. This view does not accord with my observations. Before a homosexual adaptation evolves, children go through a heterosexual phase of development, a phase that becomes disturbed and derailed by anxiety.

In sum, we found homosexuality to be the outcome of adverse experiences with both parents. The homosexual direction is reinforced by disturbed sibling and same-sex peer group relationships. Adverse life experiences establish fears and sexual inhibitions during heterosexual development. Homosexuality develops as a complex substitutive adaptation thus preserving sexual gratification. It also serves defensive and reparative functions. Psychodynamically, it is a way of defending against attack by aggressive males, assuaging feelings of paternal rejection and restoring a defective sense of masculinity. In every case I have examined, studied, or treated, homosexuality was the consequence of serious disturbances during childhood development. It never represented a normal segment in the spectrum of sexual organization.

Psychiatrists who consider homosexuality to be a pathological adaptation have frequently been criticized in homophile publications for generalizing from a clinical sample to the universal population of homosexuals. But psychiatrists who think homosexuality is normal are never criticized for generalizing the inference of normalcy to nonpatient homosexuals who are said to be no more or less disturbed than the average individual.

Several studies on nonpatient homosexuals have been reported. Bieber et al. (1962) described interviews with 50 nonpatient homosexuals who had been apprehended by the military police for homosexual behavior during World War II. The data gathered compares with the data reported in our homosexuality study.

Westwood (1961) published a study of 127 male homosexuals of whom only 5% had ever been treated. His was a British sample mainly of a lower socioeconomic group. Where his inquiry tapped the same areas we studied, the findings were similar.

Using the questionnaire of our study, Evans (1969) and Snortum et al. (1969) independently examined a group of nonpatient homosexuals. Their findings were essentially the same as ours, although their conclusions differed.

Finally, clinicians who work in this area tend to obtain rich stores of anecdotal material from patients about their homosexual nonpatient lovers and friends. Such information is consistent with clinical data.

Prophylactic measures can interrupt the development of a homosexual pattern during childhood and preadolescence. Among boys, the population at risk is easily identified. Any intelligent, observant school teacher knows which boys in the class are developing in a homosexual direction. Where there is reason to believe that a child has such tendencies, the child and parents deserve psychiatric examination. If problems are found to exist, the youngster and both parents should be treated.

Treatment for the adult and late adolescent homosexual presents a different problem. Adaptive sexual potentials have become a reality. Sexual preferences and practices are now personal, private matters insofar as consenting partners are involved. Treatment for homosexuals, as for heterosexuals, should be voluntary. Heterosexual motivation cannot be forced. But many homosexuals do wish they were or could become heterosexual if only their anxieties and inhibitions about it could be minimized or extinguished. The fear of impotence and actual impotence in attempts at intercourse with women are common. Recurrent depression is a frequent symptom. It follows resurgent heterosexual yearnings and a conscious or subliminal awareness of an inability to fulfill such desires. Significant manic–depressivelike episodes may occur when homosexuals approach middle age, a time when a last, losing attempt may be made to reinstate heterosexuality.

The wish to be heterosexual is based not merely on pressures to conform to social norms. The most profound positive emotional attachment in the lives of most homosexuals are women—the mother and sisters, sometimes an aunt. For most, the basic feeling toward the mother is of deep love and tenderness. When a homosexual's mother dies, the usual reaction is one of grief and a profound sense of loss. The reaction to the death of the father may vary from bitter sadness to a more frequent, relative detachment. The strong positive feelings for women engender heterosexual longings that represent a normal continuity of the past relationships primarily with the mother and secondarily with sisters.

Davison (1976) states that the wish to have a family and children constitutes a rare motivation to change. I have not found this to be so, nor have numerous colleagues. In my experience, many homosexuals love children, enjoy being with them, and ardently wish to have children of their own. Some do marry, have children, and become devoted fathers. Very rarely do homosexual fathers produce homosexual sons.

Although societal prejudices contribute to the suffering of homosexuals, feelings of inferiority are engendered within the family, not by society at large. Social prejudice merely reinforces what is already there. An impaired sense of masculinity, as has been emphasized, is induced by parents, the designers of a homosexual pattern in a child. In my view, if social pressures were entirely absent, homosexuals would still wish to change. When the facts about therapeutic efficacy become known to them, many young homosexuals seek treatment. In Bieber et al. (1962), including a 5 year follow-up, one third became exclusively heterosexual. Others report even better results (T. B. Bieber, 1971; Hatterer, 1970).

We have no accurate statistics about the incidence and prevalence of male homosexuality. The most probable "guesstimates," us-

ing World War II statistics, is that somewhere between 1% and 2% of the male adolescent and adult population are predominantly homosexual and another 2%–3% are bisexual. The large majority of boys enter adolescence without a homosexual pattern, and if it is absent, subsequent vicissitudes cannot activate homosexuality. This large population is not concerned with homosexuality; however, a borderline group of about 10% come to adolescence with a homosexual potential. Adolescent experiences determine whether or not such boys become homosexual. This group is particularly vulnerable to homophile propaganda and misinformation. The notion that homosexuality is normal and should not be treated only reinforces denial and resistance. Substantial numbers in the borderline group can benefit by psychotherapy, although they are likely to be led away from it by the position propounded by Davison.

Homosexuals often enter psychiatric treatment for reasons other than a desire to shift to heterosexuality. They may achieve significant therapeutic goals without necessarily changing their sexual orientation. A change in sexual orientation is not decided by the therapist; it may not even be the primary criterion for improvement. The goal is to resolve as much of a patient's psychopathology as can be accomplished. When irrational beliefs and idea systems that distort interpersonal relationships are clarified and corrected, significant changes in various areas of personality and behavior occur. Davison has concluded from a point of view opposite to my own that therapists should not extinguish homosexual behavior but should address themselves to improving the quality of interpersonal relationships. He seems to have discovered for himself the major work of analytic therapy. This is precisely the difference between psychoanalysis and behavioral therapy (I. Bieber, 1973).

Prejudice against homosexuality has existed in western culture for millenia. Religious teachings fostered myths and superstitions that homosexuality was immoral, evil, and sinful; legal authority that it was criminal; medical authority that it was a degenerative disease. Freud was a pioneer in the study of homosexuality as a psychological problem. He thought it was the result of an arrest in sexual development, and he built rather elaborate theories to explain it. Since Freud, contributions from psychoanalysis and psychiatry have further clarified the phenomenon. Changes in irrational mass attitudes may be brought about by presenting the public with the realities of the condition. But promulgating a new myth that homosexuality is a normal variant of sexuality does not alter societal prejudice. Few believe it or can be made to believe it. And the only ones the new mythology hurts are the homosexuals themselves. It robs them of options and undermines the determination needed for a reconstructive, therapeutic experience.

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