Politics, Ethics, and Therapy for Homosexuality

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Imagine for a moment that you are an anxious person and that being anxious is against the law. You must try to hide your fears from others. Your own home may be a safe place to feel anxious, but a public display of apprehension can lead to arrest or at least to social ostracism. At work one day an associate looks at you suspiciously and says, "That's funny. For a crazy moment there I thought you were anxious." "Heck no," you exclaim a bit too loudly, "not me!" You begin to wonder if your fellow worker will report his suspicions to your boss. If he does, your boss may inform the police, or will at least change your job to one that requires less contact with customers, especially with those who have children.

There are many parallels between the way an anxious person is treated in this seemingly improbable fantasy and the current plight of homosexuals. In the United States alone it is estimated that at least four million people are predominantly homosexual. If each such individual has an average of two contacts per week, nearly a quarter of a billion homosexual acts are engaged in each year in this country. Millions of other people who are bisexual are involved in homosexual activity from time to time (Gebhard, 1972).

Sexual attraction among members of the same sex has been amply documented throughout recorded history in many different cultures. In many societies homosexual practices have been suppressed by harsh laws; indeed, in most states of contemporary America laws exist by which homosexuals can be arrested and imprisoned, although not all these statutes are rigidly enforced. Never have societal sanctions eliminated homosexuality, nor does it seem likely that they could. The widespread prevalence of homosexuality, even though such practices are often threatened by punishment, has led some workers to believe that this aspect of sexuality is, in some important way, part of human nature.

Recent years have seen a growing liberalization of laws regulating adult human sexual conduct. Several professional groups, including the American Psychological Association and the American Psychiatric Association, have moved away from an illness view of homosexuality. One of the earliest progressive statements was issued in 1974 by the Association for Advancement of Behavior Therapy while I was president of that group:

The AABT believes that homosexuality is in itself not a sign of behavioral pathology. The Association urges all mental health professionals to take the lead in removing the stigma of mental illness that has long been attributed to these patterns of emotion and behavior. While we recognize that this long-standing prejudice will not be easily changed, there is no justification for a delay in formally according these people the basic civil and human rights that other citizens enjoy.

As encouraging as these developments have been to those committed to removing the stigma of homosexuality, a less obvious but perhaps even more important political and ethical issue must be addressed—namely, the continuing availability of therapeutic regimens for altering sexual orientation from same-sexed to opposite-sexed partners. The following may illustrate this predicament:

API (Apocryphal Press International). The Governor recently signed into law a bill prohibiting discrimination in housing and job opportunities on the basis of membership in a Protestant Church. This new law is the result of efforts by militant Protestants, who have lobbied extensively during the past ten years for relief from institutionalized discrimination. In an unusual statement accompanying the signing of the bill, the Governor expressed the hope that this legislation would contribute to greater social acceptance of Protestantism as a legitimate, albeit unconventional, religion.
At the same time, the Governor authorized funding in the amount of two million dollars for the coming fiscal year to be used to set up within existing mental health centers special units devoted to research into the most effective and humane procedures for helping Protestants convert to Catholicism or Judaism. The Governor was quick to point out, however, that these efforts, and the therapy services that will accompany and derive from them, are not to be imposed on Protestants, rather are only to be made available to those who express the voluntary wish to change. "We are not in the business of forcing anything on these people. We want only to help," he said.

THE MYTH OF THERAPEUTIC NEUTRALITY

My basic premise is, to paraphrase Halleck (1971), that therapists never make ethically or politically neutral decisions.

Any type of psychiatric intervention, even when treating a voluntary patient, will have an impact upon the distribution of power within the various social systems in which the patient moves. The radical therapists are absolutely right when they insist that psychiatric neutrality is a myth [1971: 13].

The very naturalness of what therapists agree to do with particular kinds of cases tends to blind them to their prejudices and biases. Surely no ethical issues are worth discussing when one helps the severely disturbed child to stop banging his head against the wall. But this is an extreme case, and I suggest that most of what therapists deal with falls into that important gray area in which biases play a role in what is done. This seems to be particularly the case in the approach to those people who complain of being troubled by their homosexual behavior or feelings. I believe that any comprehensive perusal of the clinical and experimental literature in all therapies will confirm the assertion that most therapists by and large regard homosexual behavior and attitudes to be undesirable, sometimes pathological, and at any rate generally in need of change toward a heterosexual orientation.

SOME RELEVANT AND IRRELEVANT ISSUES SURROUNDING HOMOSEXUALITY

Allow me to mention briefly some exclusions that I hope will be obvious. I am not talking about homosexual behavior that is part of a psychotic pattern of existence. For example, the male who has the delusion that he is Marie Antoinette out to seduce every available twentieth-century man would be exhibiting a pattern of sexual behavior that is best viewed as part of an unfortunate psychotic aberration. I would similarly not want to conclude that heterosexuality is sick because there are male psychotics who chase female nurses and try to fornicate with them in hospital dayrooms.

There is something else implicit in what I will be saying, so let me make it explicit at this juncture. Though I will often be referring to "homosexuals," I am in agreement with investigators such as Kinsey, Pomeroy, and Martin (1948) and Churchill (1967), who urge that we construe sexual preference as a continuum on which people can be placed according to the relative frequencies of their homosexual-heterosexual fantasies, feelings, and behavior. Clearly the available survey data strongly indicate that a significant number of human beings lie between the extremes of exclusive homosexuality and exclusive heterosexuality.

In any discussion of homosexuals in therapy, the question of the normality of homosexual preference has often been raised. Many studies have failed to find differences in "mental health" between heterosexuals and homosexuals (see Evans, 1970; Gagnon and Simon, 1973). However, some point to Bieber et al.'s (1962) data and to a conceptual replication by Evans (1969) as evidence supporting a pathology view of homosexuality. There are a number of serious flaws in the Bieber study, not the least of which is the fact that the male homosexuals were all in therapy. However, there is also a major logical error in reasoning—namely, that one has demonstrated pathology of homosexuality by showing that male homosexuals have child-rearing experiences that are different from those of male heterosexuals. One cannot attach a pathogenic label to a pattern of child rearing unless one a priori labels the adult behavior pattern as pathological. For example, Bieber et al. found that what they called a "close-binding intimate mother" was present much more often in the life histories of the analytic male homosexual patients than among the heterosexual controls. My question is simple. What is wrong with such a mother unless you happen to find her in the background of people whose current behavior you judge beforehand to be pathological? Or, as Begelman (1975) has put it:

Studies finding differences between heterosexuals and homosexuals in developmental or familial patterns . . . or hormonal patterns . . . do not attest to the
Moreover, even when an emotional disorder is identified in a homosexual, it could be argued that the problem is due to the extreme duress under which the person has to live in a society that asserts that homosexuals are "queer" and that actively oppresses them.

There is another issue that is worth discussing. Many people point to brutality in homosexual relationships, prompting the conclusion that homosexuality could not possibly be normal. To such objections I would reply that homosexuals who engage in destructive activities and who suffer in poor relationships do not have a monopoly on stormy interpersonal functioning. Simply because there is so much marital discord in this country, one seldom hears people concluding that heterosexuality is inherently bad. What I am suggesting is that clinicians might perhaps pay more attention to the quality of human relationships, to the way people deal with each other rather than to the particular gender of the adult partners. If one follows this further, we might consider a shift in focus in therapy with homosexuals that pays little attention to the fact that the partners are the same sex and more attention to the kind of relationship a person might be in and how that relationship might be improved. Naturally, when therapeutic efforts are aimed in this direction, I believe one inevitably ends up having to deal with the tremendous legal and social oppression of these groups of people.

NO CURE WITHOUT A DISEASE

I believe that clinicians spend time developing and analyzing procedures only if they are concerned about a problem. It seems very much the case with homosexuality. And yet, consider the rhetoric that typically speaks of social labeling of behavior rather than viewing a given behavior as intrinsically normal or abnormal. Consider also the huge literature on helping homosexuals (at least males) change their sexual preference and the paucity of literature aimed at helping the labelers change their prejudicial biases and encouraging the homosexual to develop as a person without changing. How can therapists honestly speak of nonprejudice when they participate in therapy regimens that by their very existence—and regardless of their efficacy—would seem to condone the current societal prejudice and perhaps also impede social change?

This point has been enunciated independently by Begelman (1975) in a critique of behavior therapy, but his argument applies to any intervention:

[The efforts of behavior therapists to reorient homosexuals to heterosexuality] by their very existence constitute a significant causal element in reinforcing the social doctrine that homosexuality is bad. Indeed, the point of the activist protest is that behavior therapists contribute significantly to preventing the exercise of any real option in decision-making about sexual identity, by further strengthening the prejudice that homosexuality is a "problem behavior," since treatment may be offered for it. As a consequence of this therapeutic stance, as well as a wider system of social and attitudinal pressures, homosexuals tend to seek treatment for being homosexuals. Heterosexuals, on the other hand, can scarcely be expected to seek voluntary treatment for being "heterosexual," especially since all the social forces arrayed—including the unavailability of behavior therapy for heterosexuality—attest to the acknowledgement of the idea that whatever "problems" heterosexuals experience are not due to their sexual orientation. The upshot of this is that contrary to the disclaimer that behavioral therapy is "not a system of ethics" (Bandura, 1969, p. 87), the very act of providing therapeutic services for homosexual "problems" indicates otherwise [p. 180].

I further suggest that the availability of a technique encourages its use. For example, many behavior therapists who have good clinical success with systematic desensitization and who are also persuaded by the experimental literature that it is useful for reducing anxiety try to conceptualize client problems in terms of this technique. Thus, a depression might be viewed as a consequence of unnecessary sensitivities that themselves could be translated into an anxiety hierarchy. By the same token, I would suggest that the extensive clinical and experimental work in aversion therapy (for example, Feldman and MacCulloch, 1971), or "Playboy therapy" (see Davison, 1968), or heterosocial-heterosexual skills training channel the assessment and problem-solving activities of behavioral clinicians into working to change sexual orientation and to persuade homosexual clients that this is a worthwhile goal. Why else would they be spending so much time working on the techniques?
A PROPOSAL ON THERAPY WITH HOMOSEXUALS

Consistent with much of the thoughtful gay literature (see Silverstein, 1977), I suggest that therapists stop engaging in voluntary therapy programs aimed at altering the choice of adult partners to whom clients are attracted. As Silverstein (1972) put it at the 1972 Association for Advancement of Behavior Therapy convention in a discussion of male homosexuality:

To suggest that a person comes voluntarily to change his sexual orientation is to ignore the powerful environmental stress, oppression if you will, that has been telling him for years that he should change. To grow up in a family where the word "homosexual" was whispered, to play in a playground and hear the words "faggot" and "queer," to go to church and hear of "sin" and then to college and hear of "illness," and finally to the counseling center that promises to "cure," is hardly to create an environment of freedom and voluntary choice. The homosexual is expected to want to be changed and his application for treatment is implicitly praised as the first step toward "normal" behavior.

What brings them into the counseling center is guilt, shame, and the loneliness that comes from their secret. If you really wish to help them freely choose, I suggest you first desensitize them to their guilt. Allow them to dissolve the shame about their desires and actions and to feel comfortable with their sexuality. After that, let them choose, but not before. I don't know any more than you what would happen, but I think their choice would be more voluntary and free than it is at present [p. 4].

In other words, Silverstein suggests that therapists inquire into the determinants of the client asserting that he or she wants to change. He proposes that these determinants may be based on prejudice and ignorance and therefore should not be catered to or even strengthened by an establishment of therapists who offer their services to those clients who "express the wish to change."

But what would be the consequences of this? Does this not limit the choices available to the person troubled by his sexual orientation? Who is the behavior therapist or psychotherapist to decide for potential clients which options should be available in therapy? To my mind the most frank answer—but one that seems unpalatable to many—has been elaborated by Halleck (1971): Therapists already have made these decisions, perhaps not fully aware of their larger implications. By working so diligently on change techniques, is not the mental health establish-

ment affirming that the prejudices and laws against certain sexual acts are in fact well founded? What are therapists really saying to clients when, on the one hand, they assure them that they are not abnormal and, on the other hand, present them with an array of techniques, some of them painful, which are aimed at eliminating that set of feelings and behavior that have just been pronounced normal? What is the real range of "free choice" available to homosexually oriented people who are racked with guilt, self-hate, and embarrassment and who must endure the burden of societal prejudice and discrimination? What of the anxieties arising from this discrimination—how have therapists helped them with these problems?

London (1969) has suggested that an unappreciated danger in behavior control technology is our increasing ability to engineer what we have regarded as free will. Thus therapists seem to be capable of making people want what is available and what they feel clients should want. Moreover, just because therapists can assert that they are not doing something against the will of their clients does not free them from the responsibility of examining those factors that determine what is considered free expression of intent and desire on the part of our clients.

In a related vein—and this should be familiar not only to therapists but to those who have been clients themselves—Halleck (1971) says:

At first glance, a model of psychiatric practice based on the contention that people should just be helped to learn to do the things they want to do seems uncomplicated and desirable. But it is an unobtainable model. Unlike a technician, a psychiatrist cannot avoid communicating and at times imposing his own values upon his patients. The patient usually has considerable difficulty in finding the way in which he would wish to change his behavior, but as he talks to the psychiatrist his wants and needs become clearer. In the very process of defining his needs in the presence of a figure who is viewed as wise and authoritarian, the patient is profoundly influenced. He ends up wanting some of the things the psychiatrist thinks he should want [p. 19].

Though Halleck, as a psychiatrist, is addressing himself to a medical audience, his questions are obviously relevant to all the helping professions.

But is it not harsh and unfeeling to propose that therapists deny a particular client the possibility of losing himself or herself from his or her homosexual attraction and turning him or her onto the other half of the adult population? What about the homosexual client who could
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his or her sexual orientation questioned. It would be nice if a homosexual fearful of interpersonal relationships, or incompetent in them, could be helped without the therapist assuming that homosexuality lies at the root of the problem. It would be nice if a nonorgasmic or impotent homosexual could be helped as a heterosexual would be rather than guiding his or her wishes to change-of-orientation regimens. Implicit in this article is the hope that therapists will concentrate their efforts on such human problems rather than focusing on the most obvious "maladjustment"—loving members of one's own sex.

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