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The Medicalization of “Homosexuality”

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CHAPTER ONE

INTRODUCTION

Recent research indicates that prejudice and misconceptions concerning homosexuality persist in contemporary medical practice (Kalbflesch 1996, Kelly et al. 1987, Kitts 2010, Makadon et al. 2008, Schatz & O'Hanlan 1994, White et al. 1997). My own experiences as an employee in five health centers are consistent with this research. This research on prejudice and my own experiences as a lesbian working in healthcare delivery caused me to ask the following questions: What are the historical roots of medical analysis and treatment of homosexuality? Who are the major figures in this history? What are the salient themes and perspectives promulgated by these figures? How do these themes and perspectives persist and influence contemporary medical practice?

Academic textbooks and histories of human sexuality were used to identify important figures and themes (Beach 1965, Fausto-Sterling 2000, Khachadurian 1985, Marshall & Suggs 1971, Terry 1999). My discussion in chapter two begins with *Researches on the Riddle of Man-Manly Love*, published in 1864 because that is the first explicit analysis of homosexuality (Terry 1999). In an attempt to shed light on "homosexuality," many of the authors discussed in chapter two ascribe to physical and behavioral stereotypes to "homosexuals." Furthermore, medicalizing "homosexuality" gives the impression that "homosexuals" are a homogenous group.

In chapter two I analyze the views of the following authors: Karl Heinrich Ulrichs, Richard Krafft-Ebing, Havelock Ellis, Magnus Hirschfeld,

Otto Weininger, Auguste Forel, and Edward Carpenter. The major process for these authors was identifying the cause of “homosexuality,” diagnosing it, and treating it. Medicalizing “homosexuality,” marginalizing, and stereotyping “homosexuals” are major themes in the works of these authors. We will see that some authors medicalize “homosexuality” and thus pathologize it. The authors dichotomize between heterosexuals and “homosexuals.” Furthermore, their use of extreme stereotypes such as butch lesbians and feminine gay men implies that these are discrete categories and implicitly excludes all of the “homosexuals” who do not fit the stereotypes. I will analyze the progressiveness¹ of the texts for the time period. I will also examine the problematic assumptions the authors make.

Chapter three discusses the works of Sigmund Freud, C. Stanford Read, Wilhelm Stekel, T.A. Ross, George Henry, and Edward Streker. These authors focus on developmental theories which emerged from the psychoanalytic school of thought. In these theories, the most famous of which is Freudian psychoanalysis, childhood and family relationships were seen as primary determinants of sexuality.

Chapter four reviews contemporary biomedical views and research. In general, this research avoids the moral judgments that characterize most of the research in the 19th and early 20th centuries. This research is biological rather than medical and thus does not necessarily imply pathology. The genetic

¹ I use “progressive” to mean having positive social consequences for gay and lesbian individuals. This usually refers to taking the issue of “homosexuality” out of moral ground and instead positioning it as a subject for scientific investigation aimed at clearing up misconceptions.

theory of “homosexuality” and the theory that “homosexuality” is a choice are compared. Chapter four also reviews bias and misconceptions, whose historical roots we will have examined, that appear in contemporary clinical practice.

In chapter four, I discuss how historical misconceptions persist in contemporary clinical practice in the form of ignorance and homophobia. I then review empirical studies that identified significant misconceptions and homophobia in clinical practice. My own informal observations as a health care worker are consistent with this research. I observed the treatment of gay and lesbian individuals at three Syracuse hospitals (one Catholic and two secular), one secular health center in Fayetteville, and one LGBTQ² health center in Boston. From my experiences at these health centers, I received a very strong impression that there was a significant difference in the treatment of gay and lesbian individuals.

The four health centers that cater to the general public created an atmosphere where it was awkward and unpleasant for lesbian and gay individuals to discuss their sexuality because they were assumed to be heterosexual. In comparison, the LGBTQ health center created an atmosphere of open communication and trust between the clinician and patient. The differences between these types of settings will be discussed in greater detail in chapter four.

In conducting this project, I want to stimulate discussion about these issues. I review the issues of the medicalization of “homosexuality” so as to

² Lesbian, Gay, Bisexual, Transgender, Queer

illuminate the historical bases for the problematic distinctions that I observed in dealing with patients at different hospitals/health centers. By examining the underlying assumptions scientists and medical professionals had about “homosexuals,” we can better understand where the homophobia in the medical system came from. In addition, providing this kind of history and promoting education on the subject can beget an understanding of the struggles of gay and lesbian populations both historically and today. Furthermore, it can lead to improved clinician/patient relationships.

CHAPTER TWO

INTRODUCTION

This chapter examines the role of medicine and sociology in creating a “homosexual” body. The work of the sociologists and physicians from 1864 until 1908 focuses on three areas of concern: causation, diagnosis, and treatment. Although many of the authors attempt to be objective and express progressive ideas for the time period, they often make problematic assumptions about “homosexuals” that have negative consequences. First, the study of causation assumes that “homosexuality” is located in the body and sexuality is a stable feature. This marginalizes groups who feel there is more fluidity to their sexual orientation. Second, diagnosing “homosexuality” reinforces the discourse of difference—the idea that “homosexuals” are inherently different from “normal” people in set ways³. This sometimes involves comparisons to the opposite sex. Furthermore, diagnosis implies medicine which implies pathology. Third, attempting to treat “homosexuality” as a medical entity pathologizes it, reinforces gender stereotypes, and supports the belief that heterosexuality is superior.

BACKGROUND

“HOMOSEXUALS” ON SEXUAL CONTINUA

Karl-Heinrich Ulrichs is one of the first major authors to write in-depth about “homosexuals.” Perhaps because Ulrichs was gay himself, his

³ I use this term in the rest of the paper to discuss how “homosexuals” were differentiated from heterosexuals and how this was stigmatizing for “homosexuals.”

theory about Urnings (“homosexual” males) is progressive for his time; he is considered the first known gay advocate (StoneWall Society 2000). In *Researches on the Riddle of Man-Manly Love* (originally published in 1864), Ulrichs argues that the human species is broken into many subcategories. Furthermore, each has its own respective role and dynamic with the other groups. He categorizes people based on the congruence of their body, character, and desire. Ulrichs work primarily explores two subcategories of humans: Urnings, whom he defines as male-bodied persons with female desires and character, and Dionings, who he describes as male-bodied persons with male desires.

Ulrichs differentiates Urnings from “normal” men who express traditionally masculine character and desires, and instead equates Urnings with women who demonstrate traditionally feminine character traits and the desires. Ulrichs’ theories about Urnings and Dionings served an important function for his society. By differentiating Urnings and Dionings from “normal” men, his theories created an identity for those seeking to set themselves apart from those who society deemed “abnormal” by broadening and more precisely defining the gap between the “normal” men and “abnormal” men. Therefore, Ulrichs contribution to medical science in his day lay largely in defining the characteristics of homosexuals as a means by which to identify them.

In *The Intermediate Sex: A Study of Some Transitional Types of Men and Women* (originally published in 1908), Edward Carpenter extends Ulrichs work by attempting to observe and record evidence that would allow for the determination of the nature of Urnings. Carpenter believes that Urnings demonstrate a different kind of soul manifested in a male or female body. Thus, his work investigates the duality of nature—those conditions arising from the soul versus those conditions created by the body—and he seeks to define the gradations of soul-material with respect to sex (Carpenter 1999). His theory is progressive because it presents “homosexuality” in a positive light. However, the idea that the body and soul are in gendered opposition is problematic.

Carpenter posits that individuals fall on a continuum, with males with masculine souls at one pole and females with feminine souls at the opposite pole. Thus, homosexuals fall in an intermediate place, arising when the physical body is somehow misaligned with the soul. Carpenter’s book (1999) focuses on these intermediate states, and the characteristics of homosexuals who fall there.

Like Carpenter, Weininger, in *Sex and Character* (first published in 1903), regards “homosexuality” as one of the varying degrees along the spectrum of males and females, with the masculine males falling at one end and the female virgin falling at the other end (Weininger 2005). Therefore, Weininger’s image of the “homosexual” has elements of both Ulrichs and

Carpenter's works, viewing "homosexuality" as a variation that lies somewhere in the middle of a natural continuum. In this respect, Carpenter's work on "homosexuality" is progressive for the period; nevertheless, he regards and promotes heterosexual relations as the ideal form of sexual expression.

Weininger argues that sexual "inversion" constitutes a special case of the natural laws that determine sexuality and his first published in the. Weininger believes that everyone is born bisexual at birth but society then pushes individuals toward unisexuality over time. In spite of this societal push toward unisexuality, Weininger believes that bisexuality cannot be totally extinguished and that every individual displays roughly equal amounts of masculine and feminine traits (Weininger 2005). Because it postulates that everyone has the potential to be bisexual or "homosexual", Weininger's theory can be considered progressive.

Havelock Ellis, in *Studies in the Psychology of Sex Volume II: Sexual Inversion* (originally published in 1897), has a similar opinion to Weininger regarding bisexuality. Ellis considers everyone as constitutionally bisexual, but their theories differ in the way that an individual becomes heterosexual or "homosexual" (Terry 1999). Ellis gives his theory of the causes of "homosexuality" and where "homosexuality" fits on the sexual continuum. Ellis places individuals on the continuum of sexual differentiation with male

and female heterosexuals at either end (Terry 1999). Like Weininger's, Ellis's theory is progressive because it supposes a predisposition toward bisexuality.

In 1948, Kinsey postulates a sexuality continuum on a seven point scale. Someone who is exclusively heterosexual would score a 0 and someone who is exclusively "homosexual" would score a 6. Most humans fit in somewhere between the two poles. Even recently, the reliability of a continuum for sexuality has been hotly contested in the literature (McConaghy 1987).

THE IMAGES OF "HOMOSEXUALS"

Carpenter strikes a delicate balancing act in identifying the characteristics of "homosexuals". Although he believes that "homosexuals" can be good or bad people like anyone else, he also argues that they are widely misunderstood. Carpenter observes that a large number of "homosexuals" are very accomplished and contribute positively to society, but he also states that at their worst, "homosexual" men are sentimental, at their best they are emotional. Carpenter explains:

The great probability is that, as in any other class of human beings, there will be among these too, good and bad, high and low, worthy and unworthy—some perhaps exhibiting through their double temperament a rare and beautiful flower of humanity, others a perverse and tangled ruin (1999:10-11).

Like Ulrichs but even more expansively, Carpenter views “homosexuality” as a natural variation. Overall, *The Intermediate Sex* portrays “homosexuality” in a positive light. However, by categorizing and characterizing Urnings, Carpenter unintentionally gives medical scientists the ability to diagnose “homosexuals”.

The medicalization of “homosexuality” creates great pressure on individuals to seek treatment and be “cured” of their disease. Medicalization is strengthened when diagnosis on the basis of observable symptoms is possible. Ellis’s work also serves to create a new image of “homosexuals,” first by describing and categorizing them as “inverts,” and then by ascribing characteristics to them. This new image has both positive and negative effects. The categorization of “homosexuals” as inverts gives individuals a way to define themselves and to identify with a group, which is a positive effect. However, by ascribing characteristics to inverts (although he rejects the notion that inversion resulted from tainted heredity), Ellis makes “homosexuals” subject to scrutiny and medical diagnosis. For example, symptoms of sexual inversion include sexual precocity and excessive masturbation, horror of the opposite sex, sexual opposition, preference for “normal” people (heterosexuals), and some physical abnormalities.

Krafft-Ebing, in *Psychopathia Sexualis* (originally published in 1886), firmly believes in the treatment of “homosexuals”. He divides them into two groups based on the nature of the person. These two groups are treated

similarly. Krafft-Ebing regards the first category of “homosexuals” as sickly and perverted individuals because their “homosexuality” is ingrained. The second group that Krafft-Ebing describes is immoral and perverted individuals who uncharacteristically act in ways that can be construed as “homosexual,” but they do not carry the inherent “homosexuality” of the invert. Krafft-Ebing believes that both groups of “homosexuals” should be treated medically rather than with punishment or jail (Terry 1999). Many of Krafft-Ebing’s patients exhibited other paraphilias in addition to “homosexuality,” which distorts his view on “homosexual” individuals. The view of “homosexuality” as immoral persists today.

As late as 1999, out of one hundred second-year medical students in an introductory lecture on human sexuality, one quarter believed that “homosexuality” is immoral and dangerous to the institution of the family and expressed discomfort and aversion in interacting with “homosexuals.” Nine percent believed it was a mental disorder (Klamen et al. 1999). Therefore, it is apparent that the idea of “homosexuality” as immoral postulated by many authorities carries over into the present time.

BASIC THEORIES ON “HOMOSEXUALITY”

Ulrichs’ theories contribute to the identification and marginalization of the “homosexual” as abnormal because he characterizes them. In addition, he utilizes gender stereotypes to do so. Nevertheless, Ulrichs actively argues the inherent nature of homosexual desires and he defends the political and social

rights of the Urnings and Dionings subcategories. He is regarded as a pioneer in initiating the quest for scientific answers about the nature of “homosexuality” and its origins. Ulrichs believes that “homosexuality” is “a riddle” of nature that could be “solved” by science (1994).

For his time, Ulrichs’ theories are progressive, as he counters the prevailing societal notion that “homosexuality” is a willful and malicious decision to sin. He supports his theory with evidence that “homosexuality” has long existed and persisted in every known society. By arguing that Urnings were acting naturally in accordance with their nature, he attempts to establish “homosexuality” as a biological truth and an inherent drive, the satisfaction of which is a natural end to a natural desire. As such, Ulrichs states that it was wrong for society to judge individuals who were only expressing their natural and immutable desires.

Interestingly, Ulrichs only affirms the “naturalness” of “homosexuality” for certain Urnings--those whose “homosexual” desire began at puberty, who had consistently had sex with Dionings since that time, and those who are of a “feminine” disposition. By identifying only certain “homosexuals” as “natural,” his theories distinguish and marginalize those “homosexuals” who do not meet the criteria of a natural Urnings.

Ellis is different from Ulrichs in his theory of “homosexual” origins. He argues people are constitutionally bisexual, and that differentiation from constitutional bisexuality occurs naturally in most people, leading to a

heterosexual sexual identification in most cases (Terry 1999). Ellis seeks to determine, in a scientific manner, why some individuals differentiate to heterosexuality while others do not. By focusing on the scientific inquiry of the biological underpinnings of “homosexuality” and its diagnosis (which implies pathology), Ellis seeks to remove morality from the discourse of “homosexuality,” which generally led the moral condemnation of the “homosexual”. For this reason, Ellis’ work is progressive. However, it was later used by the Eugenics movement as evidence that “homosexuals” can be identified, and thus eliminated through selective breeding.

Unlike Ellis, Krafft-Ebing posits that “homosexuality” is hereditary and passed onto future generations with ever increasing frequency. Like eccentricity, stupidity, and artistic ability, “homosexuality” can be inherited. Furthermore, Krafft-Ebing regards “homosexuality” as a mental illness.

In contrast to Krafft-Ebing’s characterization of “homosexuality” as a mental illness, Hirschfeld does not regard “homosexuality” as a mental illness in and of itself, but he speculates that the primary disorders related to “homosexuality” are caused by the stigma imposed upon the “homosexual” by an intolerant society.

CAUSES OF HOMOSEXUALITY

All researchers examined in this chapter attempt to ascribe physical causes to the “homosexual” phenomenon. Although their rationales appear

simplistic to the contemporary reader, they reflect some of the leading scientific thought of their day.

KARL HEINRICH ULRICHS: "HOMOSEXUALITY" AS A NORMAL, PHYSIOLOGICAL STATE

Ulrichs believes that "homosexuality" is a normal, physiological state. He describes "homosexuals" as psychical hermaphrodites who possess characteristics of both sexes. Ulrichs proposes that "homosexuality" is the product of two germs: the sex organs and the sex drive. When one germ acts in opposition to the other germ, the result is an individual with the body of one sex and the desire of the other sex (Ulrichs 1994).

According to Ulrichs, every person has both a female and a male germ, but one germ's effects are expressed while the other germ's effects are repressed. Under Ulrichs' theory, Urnings are individuals who are male-bodied but who express female desires caused by the expression of both male and female germs. Urnings' female germ develops into female sexual desire independently of its male germ which dictates male sex organs. Urnings are a particular subgroup of humans who differ from men and women in the incongruity between their body and their desire. The negative implication is that feminine and masculine elements oppose each other and are at war in a single body.

Ulrichs believes that "homosexuality" is a result of differentiation in the embryonic stage, therefore, it is not caused by sexual precocity,

suggestion, or masturbation because it is present at birth. Furthermore, people cannot be willed one way or the other. He defends the “inextinguishability of Uranian love by force or will” (1994:88). Urnings act as they were born to act and they love as they were meant to love. Therefore, there is no validity to the theory of suggestion. This conclusion effectively defends Urnings because they cannot be viewed as corrupting forces. In this way, his theory presents “homosexuality” in a positive light.

In this way, Ulrichs is a progressive advocate. However, the reasoning is problematic. Dionings cannot be converted because they do not really love men, are not feminine, and can't really use their genitals with men (Ulrichs 1994). This creates an imbalance in “homosexual” relations; Urnings are submissive and Dionings are dominant and indifferent. Despite the fact that Ulrichs does not use the word “suggestion”, it is apparent from his theory on Urning and Dioning relationships that he believes that although Dionings engage in “homosexual” acts, they are different from Urnings because they do not have female desire.

OTTO WEININGER: “HOMOSEXUALITY” AS A UNIVERSAL PREDISPOSITION

Weininger is clearer than Ulrichs on the issue of “homosexuality” as an inherited condition; he does not believe that “homosexuality” is inherited but instead posits that a predisposition for “homosexuality” is present in varying amounts in every human being. He cites the frequency of sensual

childhood friendships as proof for his position. Every cell of an organism has a sexual nature—arthenoplasm is the male plasm and thelyplasm is the female plasm-- and the degree of the sexual nature of each cell can vary. (Weininger 2005). Cells must be complimentary in their sexual nature in order to make a definitive male or a definitive female. The secretions of the gonads then solidify the sex and sexuality. To Weininger, sex and sexuality are closely intertwined so that the male essence and female essence determine whether individuals push themselves towards heterosexuality or “homosexuality.” Thus, a woman who is attracted to women is half man and a man who is attracted to men is half woman (Weininger 2005). This idea is problematic because Weininger sees females and femininity as inferior.

MAGNUS HIRSCHFELD: “HOMOSEXUALITY” AS A VARIATION OF NORMAL SEXUALITY

Magnus Hirschfeld is another 20th century scholar who subscribes to the belief of “homosexuality” as a form of variation. Hirschfeld’s theory is similar to Weininger’s in that it attributes sexual desires to what we now call hormones. At the time, he only knew that sexual feelings were due to chemical secretions by glands in the body. Stekel cites Hirschfeld and lays out his eight main points. First, “homosexuality” is inborn. Second, it is caused by the “homosexual” constitution of the brain. Third, it is caused by a mix of male and female hereditary plasm. Fourth, ambisexuality results in an instable nervous system. Fifth, there is a close relationship between the specific and

nervous constitutions. Sixth, a “homosexual” constitution is necessary for external causes to be effective. Seventh, “homosexual” desire manifests itself in 99% of innate “homosexuals” because of the commonness of external causes. Eighth, “homosexuality” is not morbid, degenerate, criminal, or a sign of hereditary taint; it is a natural variation (Stekel 2011). He thinks that “homosexuals” are harmless and rare variants of the human species (Terry 1999). This is a morally neutral theory that presents “homosexuals” in a positive light.

AUGUSTE FOREL: “HOMOSEXUALITY” AS AN UNFORTUNATE INTERSECTION OF BAD HEREDITY AND A CORRUPT SOCIETY

Auguste Forel, in *The Sexual Question* (originally published in 1905), argues that “homosexuality” is not a case of perverted will. It is “the unfortunate and destructive result of bad hereditary disposition developed under the influence of the bad habits of a corrupt society” (Forel 1924:218). This is progressive because it aims to take “homosexuality” out of moral ground and explores it with science instead. This can aid in identity formation as well as create alternatives to the “it’s a choice” argument.

Auguste Forel looks at the brain as the cause of “homosexual” desire. He comments, “The brain is the true domain of nearly all sexual anomalies” (1924:208). The brain’s hereditary character throws light on “homosexuality.” Despite the fact that he finds “homosexuals” “repulsive”, he intends to demystify “homosexuality” with medicine. This is potentially helpful to the

gay community because it aims to enlighten people on the nature of “homosexuality.” On the other hand, Forel harshly criticizes the work of the two prominent gay activists of the period—Ulrichs and Hirschfeld.

Forel strongly rejects Ulrichs’ and Hirschfeld’s support of “homosexuality.” He adamantly disagrees with Ulrichs on the subject of normality. Forel claims “homosexuality” cannot be normal because the sexual desire is not aimed at procreation. This was also the Church’s position, which prohibited even masturbation. He writes condescendingly that Ulrichs is a misguided invert. In addition, he argues that Hirschfeld has no foundation for his assumption that “homosexuality” is not hereditary. Forel believes the brain is the locus of the trait. Because “homosexuality” is inherited, he argues that there are characteristics that accompany it.

Ulrichs believes that Urning desire is not inherited like diseases, but instead results from differentiation in the embryonic state. He also states that Urning individuals run in families, particularly with respect to male siblings—even in those cases where brothers are raised apart. His work does not give further explanation of how these two facts coexist.

HAVELOCK ELLIS: “HOMOSEXUALITY” AS AN INVERSION OF THE NORMAL SEX DRIVE AND AS INDIRECTLY LINKED TO ILLNESS

Ellis is a complex character in the “homosexuality” debate because his wife is a lesbian. Thus, inversion is not a foreign, distant concept, but a very

real phenomenon. Ellis believes that heredity plays a role in inversion and that some mental illnesses can be associated with it. He does not believe in a strong correlation with bad health or a correlation with insanity, masturbation, or suggestion.

Ellis examines the role of heredity in sexual inversion using the information of sixty-two patients. Thirty-nine percent of these patients had some inversion in their families—either brother(s), sister(s), cousin(s), or uncle(s). Other authors, such as Hirschfeld, Krafft-Ebing, and Moll, agree that heredity plays a role, although they give different numbers (Ellis 2007). In addition to heredity, the study of cases of “homosexuality” involves a history of general and mental health.

Ellis does not make a clear association between the health of the individual and “homosexuality.” In two-thirds of his eighty cases the patient is in good health. The other third is delicate with a tendency towards consumption and neurasthenia (twenty-two cases), morbid (four cases), or institutionalized (one case). Ellis claims that his sample does not represent the sample of “homosexuals” the doctors see because those individuals are generally on the edge of a nervous breakdown. Therefore, they appear more mentally unstable. This is an objective and positive observation that takes away some of the stigma associated with being an invert because it rejects the idea that all inverts are insane or unstable.

Ellis asserts that a considerable proportion of inverts make important intellectual contributions to society. Despite this claim, Ellis remarks that a significant proportion of his patients is neurotic and has a nervous temperament. There is little relationship between “homosexuality” and insanity, but hysterical symptoms and paranoid delusional ideas are common. One matter to consider is whether or not the paranoid, delusional ideas are really a reaction to the stigma imposed upon “homosexuals” by an unforgiving society. In cases one of chapter five, Ellis notes a family history of mental illness. In case two, he documents some insanity in the family. Case three contains neurotic history on both sides of the family (Ellis 2007). Ellis associates mental illness in the history of the family or presence in the individual as being relevant in his study of “homosexuality.” This is a dangerous connection because it implies that “homosexuality” and mental illness are linked. Which one he thinks causes the other or whether or not they are co-morbidities is unclear.

In his assessment of the mental health of inverts, Ellis rejects the association of insanity and “homosexuality,” but promotes the linkage of some mental problems with it, including eccentricity in the family. He references Nacke’s observation that “homosexual” actions occur in every form of psychosis and during periods of heightened excitement (Ellis 2007). This creates a tie between mental illness and inversion. If mental illness can cause “homosexual” tendencies, then it follows that “homosexuality is

treatable. The correlation between mental illness and “homosexuality” is dangerous because it implies pathology and the possibility of a cure.

THE TROUBLESOME ISSUE OF MASTURBATION AND SUGGESTION

Two other problematic causal theories are masturbation and suggestion. The theory of suggestion involves the seduction of an individual by a “homosexual” into “homosexual” relations and possibly identification. Many authorities during this period debate the role suggestion plays in causing and/or exacerbating “homosexuality” in individuals. The authors in this Capstone Project take differential views on the role of masturbation in “homosexual” inclination. Krafft-Ebing believes that masturbation can cause “homosexuality.” Ellis and Forel agree that masturbation cannot cause “homosexuality” because “homosexuality” is inborn. Ellis and Weininger agree that suggestion (seduction) cannot cause “homosexuality”, but can trigger it in those who are already predisposed.

Krafft-Ebing differs from Ulrichs and Ellis in their positions on masturbation. Krafft-Ebing believes that masturbation can cause “homosexuality.” In contrast, Ulrichs and Ellis deny the causal nature of masturbation, although Ellis believes early and excessive masturbation can be a favoring condition. This is explored further in the “Treatment” section of this chapter. Masturbation and suggestion are topics of immense debate during this early period of medical scholarship on “homosexuality.”

Ellis agrees with Krafft-Ebing that excessive masturbation at a young age can solidify emotions at a premature stage and precocious sex can produce “a feeble sexual energy” that is a factor in “homosexual” relations (1897: 164). However, Ellis refutes Krafft-Ebing’s idea that masturbation causes inversion. He admits that many “normal” women masturbate. Excessive masturbation and sexual precocity merely exacerbate inversion.

Ellis reviews the opinions on the topic of leading contemporary scholars. Moll, Nacke, and Hirschfeld do not think masturbation causes “homosexuality” (Ellis 2007). Ellis says that it is possible that inverteds masturbate more than “normal” people because it is the lesser of two evils. Five of seven inverted women in his study masturbate, but they insist it is not related. Ellis comments that it is not rare among “fairly normal women” (1897:167). However, early and frequent masturbation is a favoring condition for “homosexuality.” He believes this is especially true in women. Overall, Ellis argues that with masturbation there is a break between the physical and psychic aspects of sex, so a person of the same sex can “step in and take the place rightfully belonging to a person of the opposite sex” (2007:168). Thus, masturbation brings about a weakness or an opening for a person of the same sex to exploit. This is a loaded statement, because it implies that heterosexuality is the “right” way of having relations.

Auguste Forel disagrees with Krafft-Ebing and agrees with Ellis on the subject of masturbation. He says that one cannot juxtapose congenital and

acquired “homosexuality” because seduction (suggestion) can bring out “homosexuality” in a person with only the slightest tendency towards it. He argues that many cases are too complicated to be reduced to one or the other, such as the circumstance above. He claims that the term “acquired vice” has been abused, because congenital causes are rarely, if ever, present without acquired causes, and vice versa.

Ellis also concludes that suggestion is not a significant causal factor. No one can be persuaded to change in either direction (Ellis 2007). He claims that children regard adult sex organs as a mystery that can either result in attraction or horror. Thus, there is an inner truth that is waiting to manifest itself, and suggestion merely reveals one’s nature. Ellis says, “The seed of suggestion can only develop when it falls on suitable soil” (2007:165). In cases one and three of “Sexual Inversion,” the patients claim suggestion at puberty. Ellis remarks that suggestion led to inversion because the patients were predisposed to “homosexuality.” Predisposition does not necessarily mean that one is indulging in inverted ideas or fantasies from birth. Latency of “homosexual” instinct is possible until puberty. After that, the inverted instinct manifests itself. Ellis’ image of the invert is a predisposed individual whose affinity for individuals of the same sex manifests itself with or without suggestion by a “homosexual.”

As a result of the biological underpinning of his theory, Weininger does not believe that suggestion and experience trigger “homosexuality,” but

instead relies largely on the biological causation of “homosexuality.” He claims that opportunity to commit “homosexual” acts can only actualize what is already present in the body. Other physicians writing between 1864 and 1908, for example Krafft-Ebing (1886) advises avoiding places where “homosexuals” congregate because they can trigger “homosexuality.” Other researchers, for example, Ulrichs and Ellis, support Weininger’s view by also rejecting suggestion and experience as the cause of “homosexuality.”

Contrary to the modern, popular belief that “homosexuality” is biological, a 1993 study suggested that a change from heterosexuality to “homosexuality” by means of seduction by another male occurred in three cases. The author suggests that it is more important to ask the question “what do I like” as opposed to “who am I” when it comes to sexuality. This implies fluidity to sexuality which allows for seduction (Meijer 1993). Thus, this is a recurring theme in modern times.

DIAGNOSIS: THE BODY AS A LEGIBLE TEXT

Many authorities writing from 1864 until 1908 use a reversed method of diagnosis—first they examine the “homosexual” patient and then they identify characteristics that may be causes of his/her “homosexuality.” This diagnosis method appears backward-- creating questions regarding the “homosexual” diagnoses because it fails to precisely distinguish between observations that may be coincidental, correlated, or true causes. Are the identified characteristics found together by chance, or are they demonstrably

correlated? Is the diagnosis a result of suppositions regarding relatedness of certain observations, or is it a valid scientific conclusion regarding causality?

Scientists and physicians between 1864 and 1908 examine and vividly describe “homosexuals,” thus they view the body as a legible text that could be read for signs of “homosexuality.” The description of the “homosexual” serves several purposes, but the primary purpose is to create a bright line between those individuals who are deemed “normal” and those who are not.

Krafft-Ebing believes that the diagnosis of “homosexuality” can be “read” from the body. Terry says, “Among homosexuals, Krafft-Ebing claimed to find skull dimensions, postures, gestures, and mannerisms that set them apart from normal people, and he concluded that homosexual degeneration originated in the brain and nervous system” (1999: 46). His work *Psychopathia Sexualis* demonstrates his belief that “homosexuality” is a pathology-- unnatural, immoral, and only causes unhappiness and dissatisfaction for the “homosexual.” Krafft-Ebing’s goal is to alleviate gay and lesbian suffering through treatment. In this respect, *Psychopathia Sexualis* (2010) is progressive because its goal is to ease “homosexuals’” moral, social, and mental/emotional burdens. In addition, it views “homosexuality” as a physical condition rather than the result of hopeless moral degeneration. However, his ideas about “homosexuality” created an unflattering characterization of those experienced “contrary sexual feelings” (2010).

Krafft-Ebing describes the symptoms, traits and experiences of individuals with contrary sexual feelings. There are eight themes to Krafft-Ebing's case studies. First, masturbation is common among "homosexuals" and it aggravates their "condition". Second, seduction (suggestion) takes place and solidifies "homosexuality." Third, the "homosexual" patient is often depressed or has neurasthenia. Fourth, there is a lack of real love in "homosexual" relationships; the "homosexual" relationship is based solely on sex. Fifth, the patient is often anemic. Sixth, the patient often models heterosexual behavior through attempts at heterosexual sex with prostitutes or, in some cases, the patient prostitutes himself. Seventh, the patient is desperate and considers suicide, usually due to criminal charges or blackmail. Eighth, the patient experiences considerable gains from treatment. Krafft-Ebing's characterizations of "homosexuality" evoke a negative image of "homosexual" males as overly sexual, weak willed, prone to immoral behavior, and emotionally and physically unstable. Yet, he concludes that their condition is treatable. Through his description and diagnoses of "homosexuality," Krafft-Ebing underscores the gap between "normal" people and "homosexuals."

Like Krafft-Ebing, Otto Weininger also believes that the human body is a legible text that may be read for signs and signals of "homosexuality." Weininger differentiates "homosexuals" from "normal" men and women through his descriptions of "homosexuals." The appearance of both sexes in one body demonstrates itself in physical form and in behavioral traits.

Weininger claims that “the sexual invert always shows an anatomical approximation to the opposite sex” (2005:41). Thus, “homosexual” women would have some masculine physical characteristics and the “homosexual” man would have some feminine physical characteristics. With respect to behavior and character, Weininger describes “homosexual” men as vain, proud, well-dressed and manicured, and desperate for attention (2005). He does not list any of women’s positive attributes when comparing women to male “homosexuals.”

Weininger makes grand assumptions about the nature of “homosexual” men and its similarity to the nature of heterosexual women. This connection creates an awkward association between the two groups, as he ascribes to them a common set of negative characteristics without distinguishing any of the positive characteristics that might distinguish them from each other. Therefore, “homosexual” men demonstrate all the negative qualities that women demonstrate but none of their positive qualities. In fact, he argues that “a woman attracted to another woman is half man,” and because of the male presence, she is superior to other women (2005:58). Conversely, his apparent bias towards men makes him condescending towards male “homosexuals” whom he views as “half woman.”

THE DISCOURSE OF DIFFERENCE I: DIFFERENT AND INFERIOR?

Weininger and Forel are two authorities on “homosexuality” who present “homosexuality” as inferior. Weininger views “homosexuality” as a

bad mix of the sexes. Forel seems to unintentionally create negative connotations with the category of “homosexual” by reinforcing negative, oppositional gender stereotypes.

Weininger effectively separates “homosexual” men and women from heterosexual men and women. Although he sees “homosexual” women as superior to heterosexual women in intellect, he strongly disparages “homosexuality.” “Homosexuals” are an undesirable mix of the two sexes. Weininger’s separation of “homosexuals” and heterosexuals on the basis of their behavior further divides the groups and amplifies “homosexuality” as a state of “otherness”. Hereafter, the institutionalization by sociological authorities, scientists, doctors, and physicians of the idea that “homosexuals” are inherently different from their heterosexual counterparts is referred to as “the discourse of difference”.

Forel’s characteristics of male and female “homosexuals” oppose one another, and he expects the characteristics of “normal” males and females to oppose each other, as well. Enforcing this code of the opposition of the sexes is very limiting and reinforces stereotypes. It stigmatizes “homosexuals” who manifest the “homosexual” stereotypes because they are assumed to be flaunting their “homosexuality.” Second, it stigmatizes “homosexuals” who do not fit the stereotype because they may not be recognized within their group. The assumption of complete gender opposition places “homosexuals” outside the realm of “normal” society.

According to Forel, male inverts supposedly act like women, and female inverts like men. Male inverts are passive, submissive, they like to read novels, dress themselves in finery, and engage in female activities and engage in the society of women. They practice their skills in coquetry, and experience and act on extreme passions. They differ from women in their sexual precocity and sexual appetite, but are similar in their love letters, vows of eternal affection, ceremonies of love, and jealousy.

Forel argues that “homosexual” men want “normal” men like women do, but they settle for each other. On the other hand, female inverts do not have to settle. They find it easy to seduce “normal” women because of the ambiguity of their friendships. This only becomes pathological if the “normal” woman engages in the behavior for an extended period of time. Thus, there is a divide between “homosexual” acts in women and “homosexuality.” It creates an inborn discourse of “homosexuality” that differs from behavior.

On the other hand, female inverts act like men in dress, activities, hair, and sexual drive. They are similar to male inverts in their affinity for ceremonies and jealousy. Both male and female inverts choose occupations where their desire may be tolerated or concealed. For example, they may pursue careers in Catholic institutions, asylums, and prisons. Forel believes “homosexuality” is a form of neurosis. He claims that “homosexual” love is pathological, psychotic, or neurotic; it is abnormal and often caused by a large sexual appetite. He admits that some inverts are well behaved despite what

has been published about the “cynics and debauchees” (1922:245). He contributes to the discourse of difference in assuming that “homosexuals” have set characteristics and behaviors.

THE DISCOURSE OF DIFFERENCE II: CHARACTERIZING THE “HOMOSEXUAL”

Ulrichs and Carpenter unintentionally subscribe to the discourse of difference in characterizing Urnings as beings apart from “normal” men. Ulrichs believes that Urnings are a completely different subcategory of humans and defends the presence of sexual antagonism in one body (thus, reinforcing gender stereotypes). Carpenter discusses the variation within the category of Urning, but then proceeds to stereotype them according to gendered assumptions about behavior.

Ulrichs also subscribes to the discourse of difference, claiming that Urnings are akin to a different subspecies of humans. He states that Urning desire is inborn, and therefore it cannot be pathological. It lies latent until puberty, when the desire for Dionings (male bodied persons with male character and desire) manifests itself. From this point forward, Urnings show a consistent sexual attraction to Dionings and revulsion of women’s touch. Therefore, Ulrichs defends the naturalness of Urning desire, but through this defense, he inadvertently marginalizes any individuals who do not demonstrate his prescribed notion of Urning sexual behavior.

Carpenter's theories also express the notion of sexual antagonism in relationships that was common in this period. For example, he stereotypes "homosexual" women by describing butch-femme pairs as the female "homosexual" norm. Carpenter also argues that "homosexuality" is inborn. He says that even if "homosexuals" marry, they still can't help their attraction to the same sex. Unlike Krafft-Ebing, Carpenter claims that "homosexuals" can have stable loving relationships that can result in life-long attachments.

Carpenter consistently references variation between individuals in groups. Therefore, by recognizing not only differences between groups of individuals but variations in personality and character of individuals within each group, Carpenter is progressive and moves the study of "homosexuality" beyond granular descriptions that create fixed buckets of individuals into a more nuanced view of the "homosexual" as an individual.

Carpenter states that although many "homosexuals" are healthy and productive members of their sex, their mental tendencies are reversed, with "homosexual" men being "intuitive, instinctive, and artistic" (like women) and female "homosexuals" being "logical, scientific and precise" (like men) (1999: 27). This characterization of "homosexuality" illustrates the discourse of difference.

Carpenter describes the most "extreme" forms of male "homosexuals" in the following manner:

“distinctively effeminate type, sentimental, lackadaisical, mincing in gait and manners, something of a chatterbox, skilful at the needle and in woman’s work, sometimes taking pleasure in dressing in woman’s clothes; his figure not infrequently betraying a tendency towards the feminine...his affection, too, is often feminine in character, clinging, dependent and jealous, as of one desiring to be loved almost more than to love” (1999:29)

The extreme homogenic woman is almost the opposite. She is:

[an] aggressive person, of strong passions, masculine manners and movements, practical in the conduct of life, sensuous rather than sentimental in love, often untidy, and outré in attire; her figure muscular, her voice rather low in pitch; her dwelling-room decorated with sporting-scenes, pistols, etc...while her love (generally to rather soft and feminine specimens of her own sex) is often a sort of furor, similar to the ordinary masculine love, and at times almost uncontrollable (Carpenter 1999:30).

Carpenter’s desire—at once to describe “homosexuals” as normal but then to focus attention on the extreme creates confusion. It is confusing for “homosexuals” who express certain “negative” traits but do not consider themselves extreme, and it creates confusion for society as a whole. Is “homosexuality” normal or is it abnormal?

Despite his examination and detailed description of extreme “homosexual” characteristics, Carpenter reaffirms that most “homosexuals”

are like other people. Yet his characterization of “homosexuals” creates a contradictory view, as he clearly seeks to describe them as being different from heterosexuals in set ways that easily leads to continued identification and marginalization of “homosexuals.”

THE DISCOURSE OF DIFFERENCE III: GENDERED BEHAVIOR

Ulrich's theory of the congenital nature of Urning love also fuels the discourse of difference which led to the identification of “homosexuals” as being different and inferior to others. Urnings are unlike any other group, which renders them vulnerable to stereotyping and diagnosis. According to Ulrichs, “The inheritance of man-manly love is such that the individual who is affected, the Urning, is not a complete man but rather should be called a ‘would- be man’ (Quasi- Mann), or ‘half-man’” (1994:36). The Urning's mood is feminine; he may “play the man” but it is like acting because on the inside, he is a feminine being (1994:58). The feminine part of Urnings breaks through whenever it can, so they appear feminine. They are not feminized, but virilized (1994). In many Urnings there is girlish face coloring, delicate hands, a delight in the falsetto, the inability to whistle, and a girlish way of dressing. Yet, Ulrichs also says that the only feminine found in the physical sphere is the “effects of the overlapping of female sexual power of the psyche into the sphere of the body” (1994:386). This situation is rare, however, and he expresses some ambivalence on this point.

Ulrichs also describes Urnings as gentle and having an inclination during childhood for feminine toys, games, and friends. Ulrichs says that the Urning “even handles the ball with a girl’s soft, weak motion” (1994: 59). They must express their natural individuality. They have an emotional and lifelong love of their mothers, but they desire men to fill a different space (Ulrichs 1994). This space is one that they do not occupy themselves because they have female desire. Ulrichs makes assumptions about Urnings living female gender stereotypes.

Ellis expands the differentiation of “homosexual” men from heterosexual men into other areas, such as sexual virility and artistic ability. Ellis associates inverts with the arts, a feminine interest. Although Ellis says, “No class of occupation furnishes a safeguard against inversion”, he explores the assumption that “homosexuals” are inclined towards art, music, and literature (2007:174). Ellis feels that there is no pure science for “homosexuals.” The majority (56%) show artistic aptitude. Male “homosexuals” are inclined towards music, which demonstrates their emotional instability. They are skilled in literature. Ellis claims that they never work hard or succeed in useful areas. They are fond of praise and want it for doing little (Ellis 2007). Ellis’ view is depreciatory because it supposes that male “homosexuals” act like women and often live negative stereotypes about the female nature.

The view that “homosexuals” embody the characteristics of the opposite sex persists today: “Gay men are seen as possessing traits and interests that have been traditionally associated with straight women, and lesbians are seen as being similar to straight men” (Cohen et al. 2009, Kite & Deaux 1987, Taylor 1983). This means that “many heterosexuals have come to view homosexuality as the violation of traditional gender-role stereotypes” (Cohen et al. 2009). This can produce homophobia.

THE DISCOURSE OF DIFFERENCE IV: PHYSICAL DISCREPANCIES

Ellis states that although inverts, in general, do not differ physically from “normal” women and men, some inverts do evince physical differences. In some cases, female patients experience menstrual problems, masculine handwriting, and a young appearance, while male patients may have large penises or small, flabby testes. He also documents that in male inverts there are sometimes breasts, rounded arms, hips, feminine handwriting, inability to whistle, young appearance, menstrual phenomenon, oligotrichosis (less than the usual amount of hair), and high voice. Ellis sees these as indications of inversion, but he does not support the use of these differences as the bases of diagnosis. This is a disinterested view because it does not assume that all “homosexuals” exhibit the bodily characteristics of the other sex. However, he does loosely associate inversion with sexual debility.

Ellis also suspects that more than the reported six or seven male patients are sexually weak, which makes “homosexual” relations easy because

there is “no definite act to be accomplished” (1897:164). Hyperesthesia, or “irritable weakness”, is frequent among inverts and stimulates strength (1897:164). Ellis doubts that is the full extent of its effects, however, and cites the frequency of seminal emissions as a weakness. This examination of artistic ability, physical characteristics, and sexual virility make “homosexuality” into a case study of both physical and mental qualities. Thus, “homosexuality” can affect or be affected by physical, mental, and emotional characteristics; it becomes a broader issue. For example, “homosexuality” in men causes female emotions and behaviors.

Ellis claims that irritability of the sexual centers results in affection, self-sacrifice, and extravagance of devotion in men, which, likens them to women of excessive temperament.

Gender stereotypes persist in medicine and affect diagnosis and primary care. In a sample of 1,913 patients in New South Wales Australia, Redman et al. (1991) found that males and females showed equal levels of psychiatric symptoms when assessed by a standard instrument; however, in actual practice, most male doctors diagnosed more female than male patients as having psychiatric symptoms. Overwhelmingly, male doctors ascribed a higher proportion of false positives to women. A second study of male and female interns yielded similar findings, but only male interns diagnosed a higher percentage of female "normals" as having mental problems. The authors proposed that female interns are more feminist in their sex-role

attitudes than the male interns and are, therefore, less likely to harbor and be influenced by sexist stereotypes. A study of diagnoses made by primary-care physicians in Wisconsin yielded similar results (Cleary et al. 1990).

Ellis states that even invert friendships are “feminine, unstable, and liable to betrayal” (2007:171). The association of women with negative qualities is evident. In addition, Ellis also associates “homosexual” men and women with instability. He argues that permanent relationships between two inverts are uncommon (2007). Many authorities during this period agree that relationships between inverts are sporadic and temporary. For instance, Ulrichs argues that Urnings’ true desire is for Dionings, not other Urnings (1994).

“HOMOSEXUAL” DESIRE AND DESIRABILITY OF “HOMOSEXUALITY”

According to Ulrichs, nature intended Dionings for women and Urnings. Urnings desire young men. Ulrichs is insistent that they do not desire boys, but neither does he mention older men. Ulrichs stages a play in which the dynamics between Urnings and Dionings are severely off balance, with Urnings pining after the Dionings, who will never fully return their love. Ulrichs says that “character, masculine power, and masculine courage is charming to us” (1994:68). Unfortunately, Dionings do not return the sentiment. They are neutral or indifferent to the indulgence with an Urning and do not feel the magnetic pull. Ulrichs contends, “we never taste the

mutual love which we truly yearn for” (1994:84). This is because there is a “certain natural horror for the Urning embrace” (1994:115). Thus, the Urning and the Dioning are not seen as equals in the relationship. The Dioning always has the power (and it seems desire) to reject the Urning, who loves him deeply. This puts Urnings at a grave disadvantage.

The desire of the Urning for the Dioning is not the same as the desire of the Dioning for the Urning. The Urning feels true love for the Dioning, and a magnetic current in their embrace. Urnings want to complement their feminine spirit. Thus, Urnings do not often attract other Urnings.

Although Ulrichs thinks it is rare and less fulfilling, Urnings can love Urnings if they are of different subtypes. Mannlings (masculine Urnings) and Weiblings (feminine Urnings) can be in relationships with each other because they still complement; the Weibling desires to be penetrated and the Mannling desires to penetrate his beloved (Ulrichs 1994). No love exists for the Mannling; it is only about sex and it never lasts. Ellis also comments on the nature of these relationships, saying “it is extremely rare to observe a permanent liaison between two pronounced inverts” (2007:171). On the other hand, Weininger notes that “homosexuals” tend to date and associate with each other (2005). This view persists today.

In 1971 Donald Marshall and Robert Saugus published *Human Sexual Behavior* as part of a series published by the Kinsey Institute. In their epilogue they warn that homosexuals, driven by rejection may isolate from overall

society in groups where their behavior is mutually reinforced and intensified. This can result in an ever increasing alienation from mainstream society and lead to such extremes as the recently proposed development of "gay communities" where homosexuals "may seek to impose their deviant way of life on an existing society." Because such behavior deviates from that of mainstream society, it disrupts other social relations; homosexual "rings" develop in which homosexuals are recruited, favored, and advanced-- at the expense of heterosexuals. Marshall and Suggs conclude that, just as homosexual personal ads appear with those of the voyeur, the sadist, the masochist, and the fetishist, it is difficult to interpret such behavioral manifestations such as transvestite beauty contests as anything "more exalted than sociopathic manifestations of personality disturbances *complicated by membership in a pervasive subculture*" [emphasis original] " (p. 234).

Ellis argues that relationships between "homosexuals" are undesirable to both individuals and rarely work. In addition, he believes there is a natural antagonism by heterosexuals for inverts because of their attractiveness. This creates a terrible reality for the invert because he will lack genuine satisfaction because she/he is attracted to "normal" people (2007). "Homosexuals" have to settle for other inverts who do not have the same male (in the case of male inverts) essence. H.C. (one of Ellis' correspondents) rejects this assumption and says that inverts are not women, so they do not want the typical male. They want someone who can give them "passionate friendship in return" (2007:171). Inverts are attracted to youths (Ellis reasons that having this

tendency makes some inverts more “normal” than those who do not have this tendency because youths more closely resemble women), men in uniform, and those with extreme physical development but lacking intellect. They are like women in a position of irresponsibility combined with the freedom to be promiscuous (Ellis 2007).

Ellis’ connection of male inverts with women is typical for the period (Carpenter 2010, Ulrichs 1994, Weininger 2005), but is problematic because it associates inverts with lower class citizens (on the basis of their gender), and women with even lower class citizens (on the basis of their sexual orientation). This association makes “homosexual” men into a different sort of being who is, at least partially, inferior because of his female qualities.

In inverts, there is an absence of parallel excitement (in heterosexual relations) and unfamiliarity or neurotic hypersensitiveness (1897). Yet, Ellis believes that there is some sexual opposition in inverted relationships. There is not always an active and passive member, but in some way, opposites attract. This could take the form of race or color (Ellis 2007). This affinity for the same sex and fear of the opposite sex can sometimes be demonstrated in dreams.

Erotic dreams are valuable in diagnosis because people are often more willing to admit to their dreams rather than the act. He does not place too much stock in the dreams of “normal people” because there may sometimes be a “homosexual” element, but the dreams of inverts always seem to be

significant. In many of the men in his study, women are frightening, imposing figures. Thus, Ellis, like Krafft-Ebing and others, uses a reverse method of diagnosis—first identifying the “homosexual” patient and then identifying and ascribing great meaning to observations of his/her behavior and character.

TREATMENT OF THE “HOMOSEXUAL”

HYPNOSIS

Krafft-Ebing lays out his treatment plan and results for the “homosexual” condition. The aim of his treatment plan is to lessen the social, moral, and mental burdens “homosexuals” face. This is progressive for his time, although his goal to reduce “homosexual” inclinations implies pathology. He says, “It is thought that all must be left to Nature, in the meantime, Nature rises in her power, and leads the helpless, unprotected, and innocent into dangerous bypaths” (2010:252). His primary goal with congenital cases involves the prevention of such cases. Avoidance of masturbation gives this protection. There are three levels of treatment for “homosexuality.” In the early stages, the first two are sufficient. First, prevent onanism and other bad influences. Second, cure the neurosis caused by the unhygienic conditions of the *vita sexualis*. Third, psychologically treat patient to encourage heterosexual desire (Krafft-Ebing 2010:253). All of these protocols assume that the “damages” of “homosexuality” can be mitigated.

Krafft-Ebing uses hypnosis as one of the primary means of treating “homosexual” patients. He puts them into a trance and then has them repeat what he says. His message to patients in a trance is three-fold. First, I can not, will not, and must not masturbate. Second, I hate loving my own sex. Third, I will be healthy again and marry a woman and make her happy (Krafft-Ebing 2010). Krafft-Ebing reports much success with hypnosis, success meaning the patient is free of “homosexual” urges, is able to fight “homosexual” urges that arise, lacks sexual inclinations of any kind, and/or is able to avoid masturbating.

HETEROSEXUAL SEX AS TREATMENT

Weininger reports limited success with hypnosis. He believes that the goal of treatment is to ensure heterosexual copulation. He argues that heterosexual relations are the ideal. His treatment is simple: masculine “homosexual” women and feminine “homosexual” men should have sex. He says, “She, in fact, is almost the only woman who attracts the sexual invert, and the only woman who is attracted to him” (Weininger 2005:45). In his mind, the closer they come to heterosexual intercourse, the better. His method reduces “homosexual” desire to sex. To him, heterosexual sex is the only acceptable kind.

Although Forel is condescending towards inverts and their relationships, he does not advise them to marry as a remedy. Forel links two unfortunate social consequences with “homosexuality.” First, once the

“homosexual” realizes his behavior is “wrong”, he listens to his ignorant friends and doctors and marries or goes to a brothel. Forel thinks that the former is the most problematic result because it will result in an abandoned wife, “homosexual” children, if any are born, and orgies in the family household. Second, people will attempt to blackmail “homosexuals.” If blackmail occurs, victims are forced to pay, emigrate, or kill themselves. Forel’s rejection of these behaviors might imply acceptance of the “homosexual” lifestyle, but it also implies that "homosexuality" is pathological, or at the very least, will lead to pathological behavior.

CONTEMPORARY TREATMENT

Donald Marshall and Robert Suggs compare homosexuality to other "paraphilias" and criminal sexual acts, such as child abuse, rape, and the atrocities of the Manson family (1971:233). They assure the reader that the homosexual needs tolerance and understanding which "should be extended to any ill person." But such deviant individuals still need "medicopsychiatric treatment, *just as the socio-cultural climate that produced the symptom in the individual is in need of treatment*" [emphasis original] (1971:236). Finally, they conclude:

Social approval of active homosexuality is tantamount to declaring that society has no interest in, or obligation to make well, the socio-psychologically deviant so as to prevent a disturbing behavior pattern from spreading in its midst-- or that the society is not concerned with its own survival! (Marshall & Suggs 1971:236)

The preceding statement would be neither surprising nor shocking were it written by religious zealots. However, this volume was published by Basic Books as part of a series of the Kinsey Institute. Both of the authors are anthropologists and held important teaching and government positions.

During the last 50 years, the psychiatric approach to "homosexuality" exemplified the sentiment expressed in the preceding paragraph: "homosexuality" is an illness that must be treated. In the 1960s psychiatrists experimented with behavioral reorientation therapy. In the 1970s and 80s, psychotherapists tried to induce "heterosexual shifts" (Schwanberg 1986), in which they promoted "changes in sexual behaviors, sexual arousal, dating activities, and achievement of coitus" (Henry 1977:1173). In assessing the effectiveness of the therapy, sometimes physiological indices are used, such as penile erection, heart rate, pulse volume, and electrodermal response. Other times behavioral techniques are used, such as self monitoring and the charting of sexual fantasies, urges, and behaviors. The effectiveness of these therapies is unclear because most of the studies do not include control groups (Henry 1977).

IS "HOMOSEXUALITY" SUPERIOR?

Ulrichs asks the question of whether or not Dionian (heterosexual) love is superior. He seems to think it is because Uranian love involves an "unsuitable sexual organ for that particular end"; he degrades anal sex because he feels it is not a union of the sexual organs and substitution is necessary

(1994:141). In addition, Uranian love leads to rejection by the Dionian. Furthermore, Urnings are uncomfortable in their own bodies. Although Dionian love seems more complete, Uranian and Dionian love are equal in the joy with physical contact, sense of thrill, sexual gratification, and medicinal properties. He also says of Urning love, “indeed, I think that, in some aspects, it even outdoes Dionian love” because it is selfless, tender, and inspires great works (1994:155). Therefore, despite his reservations, Ulrichs can be considered an advocate for other Urnings.

THE RIGHTS OF THE “HOMOSEXUAL”

Ulrichs demands equal rights for Urnings. He argues from scientific and moral grounds. He admits that the lack of procreative potential of Urning sex is a possible counter argument, but he appeals to men and women to ask God, and not Urnings, why they exist. He contends that Uranian love is morally acceptable when within the bonds of love or out of sympathy for the suffering of the Urning and/or out of consideration for the threat of illness to the Urning (1994). This reasoning is problematic because it portrays the Urning as helpless and needy. It differentiates them from heterosexual men and women because Urnings require sacrifice of men to be happy and healthy. Urnings ask men to do things they (seem to) not want to do. This puts them in a vulnerable and pitiable position that reduces their agency.

Ulrichs argues that others must renounce the assumption that all male-bodied persons have love for women. He admits that everyone is biased with

regards to issues of “homosexuality,” but he asks men to free their sense of reason from their prejudice. Urnings have their own standards of sexual conduct; they cannot be held to others’ standards because they are different. Men and women are not qualified to judge Urning love, character, or bodies. As with many arguments concerning “homosexuality” there are problematic underlying assumptions.

Carpenter believes it is society’s duty to try to understand “homosexuals” because of how numerous they are and because they should be helped to understand themselves. In addition, Carpenter argues that “homosexuals” are not libertines; they represent part of the evolution of the race (Carpenter 1999). This indicates that they are a benign, or even progressive, variation of the human species. Carpenter uses the word “race” to refer to Urnings, which both separates them from “normal” people and unites them within their group and in the framework of the diversity of human beings.

Hirschfeld also takes the stance that society should aim to understand and help “homosexuals.” He suggests adaptation therapy for “homosexuals” to help them accept their innate desires. He criticizes science’s mind-body dualism for its neglect of studies which focus on social influences on health and wellness of individuals and organizes the Scientific-Humanitarian Committee in 1896—the first “homosexual” rights organization. He believes

that only enlightened professionals can work to alleviate suffering in society (Terry 1999).

CONCLUSION

19th century researchers who support physical underpinnings for “homosexuality” encounter both internal and external conflicts. Their work is both descriptive and prescriptive—and it attempts to create a better understanding of “homosexuality” as a naturally occurring phenomenon. In this way, these researchers are progressive in their thinking and they attempt to move the dialogue on “homosexuality” from one of moral condemnation to one of scientific inquiry and understanding. Their efforts, however, are bound by the times in which they worked, and despite their well-meaning attempts to shed light on “homosexuality,” prejudice frequently crept into their work. Furthermore, their work was misused by others as a means to identify and marginalize “homosexuals.” In this respect, this era characterizes the common plight of “homosexual” research across time. “Homosexuals” are simply not objectively studied nor well understood. The 19th century authors sought to characterize “homosexuality”, but succumbed to the pitfalls of stereotyping. 20th century authors sought to understand “homosexual” origins but attributed “homosexuality” to incomplete maturation or maladjustment of the individual.

CHAPTER THREE

INTRODUCTION

As “homosexual” scholarship moves into the 1900s there is a perceptible shift in the interests of the researchers. Earlier studies focused on locating “homosexuality” in the body, whereas later studies locate “homosexuality” in experiences, memory, and the unconscious. While the sources examined between 1864 and 1908 searched for a cause, those written between 1908 and 1946 seek to find the root in the “homosexual’s” past that kept him from achieving “normal” (heterosexual) desire. What was once a quest for the recognition of “homosexual” persons is now a detailed study of how their relationships with themselves and others shape their desires, emotions, and behavior. Medicalization is demonstrably nuanced in both of the periods studied; it can be progressive and facilitate the formation of self-identified communities but at the same time rely on problematic implicit assumptions.

The theories on “homosexuality” from 1908 until 1950 portray “homosexuality” in different ways; some of the theories presented in this chapter portray “homosexuality” as pathological; other theories demonstrate that “homosexuality” is on the natural psychosocial path, but represents an earlier stage.

In order to discuss the process of solidification of “homosexual” desire, psycho-analysts have to first establish definitions with which to relate their works. During this time period, psycho-analysts set out to define what

desire and heterosexuality are, what the developmental process is, and how relationships with the self, family, and others and society contribute to “homosexuality.”

BACKGROUND

THE FREUDIAN SCHOOL VIEW OF “HOMOSEXUALITY”

Freud insists repeatedly in *Three Essays on the Theory of Sexuality* (originally published in 1909) that not enough is known about the brain or about “homosexuality” to explain it satisfactorily. This is a very progressive view point because the physicians writing between 1864 and 1908 all believed that they had uncovered the truth about “homosexuality.” This is not to say Freud does not have his own theory, however. He believes that “all human beings are capable of making a homosexual object-choice and have in fact made one in their unconscious” (Freud 2000:11). This period from 1908 until 1946 demonstrates an appreciation for the role of the unconscious in predicting later mental and emotional characteristics.

It is difficult to determine the role of the unconscious without performing retrospective diagnosis, described in the last chapter as assessing a “homosexual” patient’s background to identify the root of their “homosexuality.” For most of the patients surveyed by these psycho-analysts, it is known or assumed that the patient is “homosexual.” Therefore, the task at hand is determining the cause of it; psycho-analysts seek the cause in the

patient's background and attribute their "homosexual" inclinations to unconscious feelings associated with their uncovered memories. This mirrors Foucault's idea that sex becomes the secret inner truth of a person. Under the right guidance and persuasion, one may find the cause of their "homosexual" inclinations.

Like Weininger of the previous era, Freud explores the idea of innate bisexuality to explain both heterosexuality and "homosexuality." The veracity of this statement is less important than the implications, which are that every person has the potential to be both "homosexual" and heterosexual, and that the final determination of sexual orientation occurs through a developmental process. Although implying that "homosexuality" is an immature stage is judgmental, suggesting that every person has the potential for both orientations absolves the patient.

Wilhem Stekel, in *Homosexual Neurosis* (originally published in 1908) is similar to Freud in stressing unconscious feelings and desires. He argues that even the self-aware know little of themselves and one cannot accept her/his own candid statement as the entire truth. Stekel intends to discover the "homosexual" inner truth and retrospectively determine the signs of it. His viewpoint, on the other hand, is very difficult to compare to Freud's in the tone. Stekel associates "homosexuality" with many mental and emotional deviations from the norm, and thereby makes dangerous linkages to neuroses.

C. Stanford Read in “Homosexuality” (originally published in 1921) is heartened by a renewed interest in Freud’s theories as demonstrating a move from strictly descriptive psychiatry to a look at mental disease from “a more psycho-biological” point of view. The study of homosexuality through psychoanalysis is the first attempt to study the connection of homosexuality and certain mental abnormalities using a “more satisfactory and scientific pathological basis” (Read 1998:60). In this way, Read is similar to Stekel because they both associate “homosexuality” with pathology. Edward Stecker similarly connects “homosexuality” with pathology, but places all of the blame on the perverse psychology of the mom.

Edward Strecker in *Their Mothers’ Sons: The Psychiatrist Examines an American Problem* (originally published in 1946) takes a psychological approach to the study of “homosexuality.” He argues that many cases of “homosexuality” are biological, but many are also due to the immaturity of the mom. He uses the term “mom” to refer to the immature, selfish parent whereas a “mother” is a thoughtful and mature parent. To Strecker, “homosexuality” results in the creation of a mom surrogate, where the “homosexual” can’t have a mature, loving relationship but instead is drawn to dysfunctional relationships because of the controlling mom. Thus, he focuses on the way that the home environment can create “homosexuality.” This defines “homosexuality” as a mental and/or emotional issue. It is the result of bad parenting on the mom’s part.

Stekel takes a similar position on “homosexuality.” He emphasizes the role of the childhood environment in contributing to “homosexuality.” He states that for “homosexuals,” the heterosexual pathway is blocked psychically but it is not absent. The word “blockage” implies an obstruction to the routine or normal route. This view is problematic because it implies that something has gotten in the way of normal progress. Stekel believes that symptoms of the blockage are anxiety, disgust, and scorn. He ascribes these characteristics to “homosexual” individuals: fear, suspicion, sadism, narcissism, incest, and jealousy.

THE ROLE OF ENVIRONMENT IN THE CREATION OF THE “HOMOSEXUAL”

In the previous period (1864 to 1908), Hirschfeld concluded that “homosexuality” is a natural variation. Stekel argues that Hirschfeld’s conclusions are faulty, at best. Stekel contends that it is impossible for “homosexuality” to be congenital. Instead, he argues that it is the result of environmental factors. This conclusion creates an interesting but thorny analysis of which environments create “homosexuality” and the traits that accompany “homosexuality.”

T.A. Ross in “A Case of Homosexual Inversion” (originally published in 1927) presents a case of a forty-seven year old male who describes himself as feminine and has desire and arousal toward men. Through therapy, he reveals that when he was fifteen and staying at someone’s home, he had a

brief heterosexual encounter which was interrupted by his host, the girl's mother, who was furious. He went home the next day. He was therefore "diverted so completely from the heterosexual path" (Ross 1998:69). Similar to Stekel's "blockage", this diversion from the intended path implies a detour to an undesirable destination—"homosexuality."

Ross' patient lived as a "homosexual" until the age of forty. He was ashamed of his attraction and attempted suicide. Once Ross shared the insight regarding why he chose homosexuality, these considerations appeared to the patient to be reasonable: "Thereafter his normal heterosexuality unfolded itself with inconvenient rapidity" (Ross 1998:69). The method of presenting material in a case study form is common for this time period. George Henry also uses this form to discuss "homosexuality" in his book *Sex Variants* (originally published in 1941).

T.A. Ross states that the "practical physician" must consider both heredity and environment, and they should not say that nothing can be done, but they also should not promise to transform a person "...who has departed so far from ordinary development" into "a perfectly normal heterosexual person" (Ross 1998:68). This viewpoint is very enlightened because previous physicians believed that a cure was possible. Ross examines alternatives to a cure, such as alleviation of pain and suffering on the part of the patient.

One more recent article suggests that "homosexuality" is not a disease: It is rather a manifestation of poor personality integration and from the etiological standpoint should be considered in a similar category to excessive masturbation and chronic alcoholism. Homosexuality becomes desirable or necessary as an outlet for libidinous drives in certain individuals, largely

because of a combination of adverse psychogenic and environmental forces (Jonas 1963:626).

Therefore, the belief that “homosexuality” is the result of psychosocial factors remains. Furthermore, the idea that “homosexuality” is pathological persists though the 1960s.

“HOMOSEXUALITY” AS A VARIATION

The Committee of Sex Variants was formed in the spring of 1935, and later commissioned George Henry to do a study of eighty male and female sex variants in order to “get a clearer appreciation of the sex variant as a member of society and of the many factors which contribute to his maladjustment” (Henry 1998:vi).

Psychiatric and clinical evaluations were made of each participant of the study. Some participants permitted nude photos to be taken, and some male participants submitted to hormone therapy. Psychiatric evaluations, which included family background and personal history, were detailed and extensive. Physical examinations were summarized in brief fashion, but each included a notation of any finding related to masculinity or femininity.

Henry concludes that prejudice and misinformation have persisted with what is commonly termed sexual perversion. The percentage of people who manifest this behavior is too high to permit the subject to be neglected, and the medical profession is tasked with helping the public understand sexual problems (1998:ix). Henry states that there is a general agreement that the treatment of sex variants is a medical and social concern and not one to be given to the penal system.

PERSPECTIVES ON HOMOSEXUALITY

PSYCHICAL HERMAPHRODITISM AND BISEXUALITY

Henry describes how to predict “homosexuality”: “artistic tastes, gentle manners, or other special characteristics on the part of a man or unusual self-assurance and aggressiveness on the part of a woman suggest sex variant tendencies” (1959:1027). Other clues include: position in the family, choice of friends, occupation, recreational activities, body form, posture and gestures, dress, attitudes about sex, and manner of dealing with sexual matters (Henry 1959:1027). This marginalizes both the inverts that these characteristics do not apply to because they are not recognized within their own group, and the inverts that they do apply to because it stereotypes them and oversimplifies the complexity of an individual.

Freud contends that the idea of psychical hermaphroditism assumes that the invert is comparable to a person of the opposite sex. Freud argues that there are some inverts who retain all the characteristics of masculinity. He also argues that what these inverts look for is someone who combines qualities of both sexes. He uses cross-dressing prostitutes and the Grecian love of boys as support for his argument because these examples demonstrate the desire for sexual antagonism in relationships. He claims that the sexual object is a reflection of one’s bisexuality. He contends that the situation is less ambiguous for women because masculine women pursue feminine women, but admits that further information could yield greater variety.

Freud counters Ulrichs and Krafft-Ebing in his discussion of bisexuality. He argues that we do not know enough about the brain to say that an invert has a feminine brain in a masculine body (Ulrichs). In addition, we do not know whether or not there are areas of the brain reserved for the functions of sex, so it is impossible to say that there is a bisexual brain until puberty (Krafft-Ebing).

Henry says, “The sex variant is not an uncommon person and he is found in all classes of society” (1959:Xii). Moreover, there is little scientific basis for precise classification of humans as males and females. Masculinity and femininity are quantitative and qualitative variations. These variations are registered in structural, physiological and psychological attributes which are peculiar to each individual. Regardless of sex, a person gives expression to masculine or feminine traits in accordance with his innate tendencies to maleness and femaleness and in proportion to the opportunities for expression of these tendencies” xii). Furthermore, sex variants are “...those who express affection and passion in a manner unfamiliar to the majority...” (1959: xi)

Henry says that some sex variants make valuable contributions to society. For instance, female sex variants are responsible for women’s equality. Giving credit to female inverts is complimentary but problematic because it assumes, in part, that only women with some masculine characteristics enact change in society and desire equal rights. Another problem with Henry’s beliefs is his argument that society must classify sex

variants in order to protect itself, especially children. It reinforces the belief that sex variants corrupt youths. It is unclear as to whether or not Henry is lumping together pedophiles with sex variants. This is a dangerous connection; it raises suspicion about the pathology of "homosexual" behavior.

CATEGORIZING "HOMOSEXUALS"

Freud differentiates among three types of inverts: absolute inverts (those whose desire has been inverted from a very early age and who feel at one with their oddity), amphigenic inverts (psychosexual hermaphrodites whose sex object may be of the same or opposite sex), and contingent inverts (those who are inverts under certain external circumstances. For example, when normal sexual objects are unavailable). Freud argues that these are a connected series.

Read differentiates between the active and passive homosexual. The actual homosexual is "developmentally abnormal and often has distinct feminine characteristics," while the passive type is one who has acquired the condition during the process of mental growth, which is a form of neurosis (1998:60).

"HOMOSEXUAL" DESIRE—INNATE, DEGENERATE, OR ACQUIRED?

Freud breaks desire into two components in order to shed light on sexuality. He defines the sexual object as the person for whom sexual attraction is intended. He defines the sexual aim as the intended act. Freud

argues that there is no single sexual aim for inverts. Both deviations in the sexual object and deviations in the sexual aim can occur with inversion.

Freud believes that there are two suppositions: that inversion is a form of degeneracy and that it is innate. He is dissatisfied with both options. He claims that the theory of degeneracy is only relevant where there are several severe deviations from the norm identified together or where one cannot effectively function. It cannot be degeneracy because one sees inversion in people who have no other serious problems and in those who are unimpaired and efficiently make contributions to society. Furthermore, it cannot be a form of degeneracy because of the broader picture: inversion was frequent in antiquity and it is widespread among savages. The latter is relevant because the use of the word degeneracy is limited to “high” civilization. Freud says:

The perversions are neither bestial nor degenerate in the emotional sense of the word. They are a development of germs all of which are contained in the undifferentiated sexual pre-disposition of the child, and which, by being *sublimated*—are destined to prove the energy for a great number of our cultural achievements. When, therefore, any one has become a gross and manifest pervert, it would be more correct to say that he has *remained* one, for he exhibits a certain stage of *inhibited development* (1963: 42) (emphasis original).

Thus, Freud did not see “homosexuality” as a form of degeneracy, but instead as a case of arrested development. In addition, some psychologists would even

cite that there are instances where “homosexual” feelings are useful, such as in the military or to maintain a sense of fraternity. “Homosexual” feelings can create group solidarity (Terry 1999). There is a great diversity of opinions on the causes and value of “homosexuality.”

The second hypothesis is that inversion is innate. This would apply to the absolute invert, but the presence of the other two kinds makes this theory doubtful. Furthermore, to say it is innate means taking these absolute inverts’ word that they have never had any heterosexual instinct or desire because otherwise they would fit into one of the other categories (amphigenic or contingent inverts).

The acquired theory counters the idea of congenital inversion. The theory of acquisition is based on three observations. First, there was a sexual impression which left a permanent consequence (inversion) in many inverts. Second, in many inverts there are external influences such as war, prisons, the perceived dangers of heterosexuality, etc. Third, some inversion can be removed by hypnosis, making it difficult to believe that it is innate.

From the discussion of bisexuality, Freud realizes two things: there is a bisexual disposition involved in inversion beyond anatomical structure and one has to deal with disturbances that affect the sexual instinct as it is developing. Therefore, Read, like Freud, believes that the homosexual component has “its germ in all mankind, and finds its outlet normally in a

sublimated form in friendships and companionship” (1998:61). For example, Freud says:

A romantic and sentimental friendship with one of her school-friends, accompanied by vows, kisses, promises of eternal correspondence, and all the sensibility of jealousy, is the common precursor of a girl’s first serious passion for a man. Thenceforward, in favourable circumstances, the homosexual current of feeling often runs completely dry (1963: 53).

Freud contends that the final sexual attitude is decided after puberty and is the result of constitutional and accidental factors (sexual frustration or lack of a strong father, for example).

THE INFERIORITY OF “HOMOSEXUALITY”

According to Freud, perverse acts are those that extend beyond the regions used for sexual union or those that linger over activities that should be passed over quickly on the way to copulation. Freud concedes that abnormal sexual identities and expressions exist, but insists that the divergence of pleasure-seeking from concentration on the genitals, intercourse, and love and monogamy is what defines behaviors as abnormal.

Freud believes that sexual drives are aimed towards pleasure. Activities other than sex, such as kissing and touching, and the stimulation of various erogenous areas of the body elicit pleasure. Behaviors only become

abnormal when they are exclusively driven towards pleasure or consumed by one act or sensation. Freud assumes that homosexuality is the result of wrongful fixation. Reducing “homosexuality” to sex has unintended negative consequences, such as reducing “homosexuals” to their sexual behavior and denying their personal ties to their desire.

Freud argues that “homosexuality” is a phase that all people experience but most surpass. This suggests that Freud sets the pinnacle of pleasure and sexual drive at heterosexual intercourse. Physicians during this period exalt heterosexual pair-bonding by diagnosing and treating “homosexuals.”

“HOMOSEXUAL” DEVELOPMENT

Read contends that individuals who get prematurely fixated or arrested during the evolution of their sexual dispositions are exposed to the danger of “a flood of libido” that finds no other outlet will, through a failed social life, strong outburst of sexual needs, or disappointment in the opposite sex, regress to the former means of gratification (homosexuality). Thus, Read argues that “homosexuals” have fallen back into “homosexuality.” Strecker, Freud, and Henry dispute that there is a regression. Instead, they argue that the “homosexual’s” emotional growth has been stunted.

Strecker believes that the critical period is up until ten years old. If the mother has not “weaned” the child, the “silver cord” (like an adult umbilical cord) remains intact. Characteristic of the mom is “the emotional satisfaction,

almost repletion, she derives from keeping her children paddling about in a kind of psychological amniotic fluid rather than letting them swim away with the bold and decisive strokes of maturity from the emotional maternal womb” (1946:31). Thus, “homosexuality” and other kinds of immaturity are compared with being a dependent and almost parasitic fetus. Furthermore, he makes it clear that he assumes “homosexuals” to be dramatically emotionally underdeveloped. Freud also had this idea of being arrested at a less developed stage.

Freud contends that those who do not graduate to the fourth stage of psychosexual development (the genital phase) are also considered psychologically underdeveloped. Freud develops a theory that one passes through four psychosocial phases in life—oral, anal, phallic, and genital. Moving into the last stage marks the beginning of adulthood. As one begins to rely on others for sexual stimulation, one becomes a social being, oriented to others and immersed in society (1999). Freud positions homosexuals as being in a juvenile psychosexual state, and therefore they must have stopped short of the fourth stage. Either that or never advanced beyond the Oedipal or Electra complex (1999). The idea of latent “homosexuality” means that every person might have some “homosexual” tendencies.

Henry argues that the sex variant remains at the immature level of sexual adjustment because of constitution (structural, physiological, and/or

psychological) deficiencies, the influence of the family and their patterns of sexual adjustment, or the lack of opportunities for psychosexual development.

RELATIONSHIPS

SELF

According to Stekel, the illusion of persecution is common among “homosexuals.” This reinforces an image of “homosexuals” as individuals who present themselves too confidently but suffer from paranoia and an inferiority complex. Stekel believes that “homosexuals” experience a lot of self-hatred that transforms into hatred of other people or groups. For instance, one patient’s hatred of children apparently showed her hatred of her child self. Many patients’ fear of the opposite sex represents a fear of self. It is true that some “homosexuals” are/were insecure about their sexual orientation, but the image of the paranoid, self-hating “homosexual” is detrimental and only presents the reader with one type. Furthermore, it is possible that “homosexuals” are paranoid because society stigmatizes them. Stekel does not take this into account.

Stekel presents other one-sided images of “homosexuals.” According to his case studies, “homosexual” individuals fear and/or hate the opposite sex. Often, this is because they are jealous of them. Thus, Stekel’s “homosexual” is not only incestuous, narcissistic and paranoid, but also jealous, afraid, and sadistic towards the opposite sex. Stekel believes that

jealousy shows a repressed “homosexual” instinct. This is often tied to incest. For example, Stekel often reveals to the patient her/his jealousy of a mother or father’s lover and how it shows repressed “homosexual” desire. Fear of the opposite sex also shows “homosexual” instinct. Stekel argues that this fear is really the fear of one’s own aggressiveness or impotence. He says that all sadistic women are “homosexual” and there is a strong sadistic element in “homosexual” individuals. After a sexual encounter, fear is the fear of violence and one’s disgust, which are the disgust of self. This projected fear acts as a safeguard against feeling the extent of one’s own ethical failure.

Stekel uses moral and psychological arguments to frame his analysis of “homosexuality.” Claiming that “homosexuality” is a moral issue is regressive for this time period since medicalization of “homosexuality” has been underway since the 1860s. It returns the “issue” to a moral front where it cannot be defended. Despite its many flaws, medicalization creates opportunities for medical scientists and the gay community to defend what they see as inborn. Furthermore, Stekel defends the environmental causation of “homosexuality.”

FAMILY

Henry states that until 1903, homosexuality was not included in medical inquiry. There was little understanding of the “endless variety and complexity of human problems” (1998:ix) Therefore, just as the study of general pathology is needed in medical education, so is the study of sexual

maladjustment in order to understand the emotional and sexual problems of the homosexual patient ranging from conflicts in masculinity and femininity; sexual experimentation and frustration; and abnormal attachment and hostility between parent and child (1998:x). Henry believes that dominance/submission and masculinity/femininity patterns in the family determine these qualities in the sex variant. Family patterns repeat themselves in the offspring. Thus, childhood and adolescent relationships must be thoroughly examined.

Henry believes that sexual education should begin at infancy and parents are primarily responsible for this. A child should be continuously monitored and gradually exposed. He argues that male children are more vulnerable to distortions of views on sex.

Stekel believes that the childhood environment can be critical in shaping a child's sexuality. Relationships with the father and mother carry a great significance and can be tied to "homosexuality." Stekel emphasizes the father's role in particular. According to him, boys or girls raised in an all female environment are likely to become "homosexual." A mother's warning about heterosexual sex can result in "latter day obedience" that causes "homosexuality" (1922:49). In addition, love of men in other men can be a substitution for love of the father. But men and women can also be "homosexual" to be unlike their mothers or fathers. From Stekel's case studies, it seems as though any family dynamic can signify "homosexual" desire. This is problematic because it makes his arguments unfalsifiable.

Furthermore, he claims that family dynamics can also indicate a desire for incestuous relations, which he ties to “homosexuality.”

Strecker argues that in the case of a “sissy” or “mother’s boy”, there is often a mom behind him. The surrogates she may push on him are that he will never find anyone as pretty or worthy of his attention as his mom and that sexual intercourse is a horrible act in which the man is a beast (1946). The mom may ruin heterosexual sex by exposing too much or imparting negative attitudes. Mom is the “pretty addlepate” (1946:130). Perhaps she wanted a child of the other sex, and so she raises a boy to wear girls’ clothing and think of himself as a woman, or she raises a masculine girl. She effectively poisons her children’s minds with her selfishness. Strecker says that a boy never “weaned” has been “so badly cheated that it would have been better if he had never been born” (1946:25). He remains a child in many ways.

Strecker differentiates mom from mother—a mom is overbearing and won’t let her children grow up and move on. This kind of parenting fosters mentally and emotionally underdeveloped children. Strecker includes “homosexuality” in this category. He urges moms to change their ways for the good of the nation. This nationalist agenda taints the study and makes “homosexuality” seem like a preventable plague upon the nation. Strecker mainly focuses on the causes of “homosexuality” in terms of the mother’s influence.

Like Freud, Strecker believes that the mom is the love object for boys. The boy feels guilt about thinking about her sexually and so finds other mom surrogates (girls and women) and may turn to “homosexuality” as the lesser of two evils (Strecker 1946). Therefore, “homosexuality” is seen to be the result of bad mothering, or rather mom-ing. It is preventable and unfortunate.

Stekel also closely links “homosexuality” with incestuous desire. Stekel believes that “homosexual” men love boys when they resemble a cherished sister and they love old men when they resemble their father. Additionally, he argues that love (of any kind) of the family is narcissistic because family members are mirror images of each other. According to Stekel, narcissism is a part of the “homosexual” neurosis too. A “homosexual” commits a “revolt against natural law and order” because he is too unique for the world and he spites god. Despite this grandiose feeling, the “homosexual” is neurotic.

SOCIETY/OTHERS

Henry believes that sex variants are the by-product of civilization. Read states, “By the majority of individuals, and even of medical men, homosexuality has simply been regarded as a disgusting perversion which merits no further interest or investigation.” This disgust and revolt stems is explained by Freud as a reaction of the normal mind to its homosexual component of sex instinct which results in the condemnation of homosexuality in others. This notion is confirmed—countries with great tolerance of

homosexuality also have less sexual repression (1959:59-60). Henry agrees and is against violent homophobia and believes it to be the result of one's own fear of being a sex variant.

CONCLUSION

Many psycho-analysts during the period between 1908 and 1946 seek to ease "homosexual" suffering through their research and therapy. Furthermore, Freud, Read, Ross, and Henry make the divide between heterosexuals and "homosexuals" less pronounced. Freud argues that, "psycho-analytic research is most decidedly opposed to any attempt at separating off homosexuals from the rest of mankind as a group of a special character" (2000:11). The discourse of difference is strong in other authors' works, however, such as Stekel and Strecker. They intentionally created a divide between the "normals" and "abnormals". All of the authors play a part in the marginalization of "homosexuals"; they differentiate them from "normal" people and characterize them in set ways. Medicalization is an extremely nuanced process whereby steps forwards and backwards are made almost simultaneously. Currently, medical perspectives on "homosexuality" have shifted from a problem of psychology to one of biology.

CHAPTER FOUR

SECTION I: BIOLOGICAL BASIS FOR “HOMOSEXUALITY”

INTRODUCTION

Dean Hamer, a renowned geneticist, believes that science will reduce discrimination based on sexual orientation. Karla Mantilla argues that the biological argument makes heterosexuality seem stable and limits the questions we can ask about why people choose certain sexual behaviors and identifications. This section will explore both sides of a longstanding debate as to whether “homosexuality” is inborn or socially constructed and/or a choice. This will be done by first surveying Dean Hamer’s genetic research on sexuality and associated studies and then exploring the view of “homosexuality” as a choice. The intent of this section is to present diverse sides of the debate with their associated strengths, weaknesses and underlying assumptions.

CURRENT DEBATES ON “HOMOSEXUALITY”

THEORIES OF BIOLOGICAL INFLUENCE ON “HOMOSEXUALITY”

Contemporary scientists that emphasize biogenetic determinants of homosexuality are qualitatively more sophisticated than their 19th-century counterparts. Modern geneticists, for example, accept that most traits cannot be determined by one gene--especially a “high level” aspect of personality such as sexual orientation (LeVay & Hamer 1994:46). Despite the sophistication of current research, however, people commonly believe that we will soon identify the gene that makes people gay: "finding the gay gene"

makes headlines. In reality, geneticists such as Dean Hamer are attempting to identify DNA markers that have an influence (in addition to other factors) on a person's sexual orientation. Sexual orientation is a trait like eye color. Genetic determinants are important, but they are polygenic, complex, and may interact with environmental factors to determine phenotypes.

Researchers like Dean Hamer and Simon LeVay hope that scientific evidence will reduce discrimination by changing the way people view "homosexuality"; they want to counter prejudice with science. In this respect they resemble the more progressive 19th-century scholars of "homosexuality" we examined earlier. Modern researchers view the discourse of biological determinism positively because it refutes the right-wing assumption that "homosexuality" is a free choice and that people who make this choice commit a sin.

Critics of biological determinism often opt for more agency in determining their sexual orientation. Some believe that experience shapes one's sexuality and people choose their identities and the behavior they exhibit. Hamer wants to genetically define "homosexuality". In an interview with TruthWinsOut.org, he claims that genes are "the single most important factor in determining whether someone is gay or straight or somewhere in-between" (interview with Frank R. Aqueno. October 10, 1993). He contends that there are probably environmental factors that influence one's sexual orientation, but no one knows what those factors are. Most likely, those

unknown factors interact with many different genes to produce “homosexual” individuals.

This section of the project will cover a number of the major studies conducted by Hamer and his colleagues regarding the role of biology in sexual orientation. LeVay and Hamer recapitulate much of the research surrounding biology and “homosexuality” (1994). This includes Gorski’s rat studies (1991) and Bailey and Pillard’s twin studies (1991), all of which attribute “homosexuality” to different sources in the body. Dean Hamer et al. (1993) discuss neuroanatomical studies. There are three regions of the brain under scrutiny: the third interstitial nucleus of the anterior hypothalamus, the anterior commissure, and the suprachiasmatic nucleus. Gorski’s research assigns “homosexuality” to the medial preoptic area in the front of the hypothalamus, where sexual behavior is controlled. Gorski’s research is weakened by his methodology. Fausto-Sterling discusses the arbitrariness of the way in which tissue is sliced for analysis (2000). This indicates that scientists can use tissue slicing as a way to manipulate the results and support their hypotheses. Furthermore, impairment studies in monkeys show differing sexual behavior but no difference in the size of the region (Fausto-Sterling 2000).

The reasoning behind the supposed difference in size of the structure is that the surge of testosterone by the testes around the time of birth stabilizes the neurons, causing fewer to die. The INAH3 region in the medial preoptic

are of the hypothalamus is supposedly three times larger in men. This surge of testosterone does not occur in females and so they have a smaller medial preoptic area (Fausto-Sterling 2000). LeVay argues that this area in Gay men's brains is two to three times smaller (1991). This indicates a kind of feminization of the gay man's brain, contributing to the association of gay men with women. This study is weakly supported because it only used gay men who died of AIDS. Of the heterosexual group, six out of sixteen died of AIDS. The inconsistency, as well as the presence of disease, may have confounded the results. Furthermore, the mode of transmission of AIDS is not a poor index of sexual orientation. The sample size was small—19 gay men and 16 straight men, hardly enough to support generalizations (LeVay 1991).

LeVay and Hamer (1994) discuss Gorski's study of the anterior commissure (1991), which argues that the bundle of fibers in gay males is equal in size to heterosexual women, even when controlled for brain size. They propose three theories on why these structural differences occur (LeVay & Hamer 1994). First, the brain structure is pre-established and helps determine sexual orientation. This is the theory they support. Second, men's sexual orientation changes the structure. The third theory suggests there is a confound that disguises the lack of a correlation between sexual orientation and brain structure. They also review twin and family tree studies regarding the heritability of "homosexuality" in men.

The family tree articles feature the idea that "homosexuality" in men can be traced to genetics handed down on the maternal side. There were no

correlations on the paternal side. They find that the overall heritability of sex orientation in males is 53% and 52% in women, although this is less true for male-female sibling pairs. Hamer et al. (1993) argues that twenty-two of thirty-three gay brothers share all of the Xq28 markers while heterosexual brothers gave a level of haplotype sharing of 22%. The researchers found no significant percentage of haplotype sharing in females. In conclusion, the researchers stress the need for more studies on Xq28 linkage (Hamer et al. 1993, Mustanski et al. 2005).

Rice et al. (1999) completed a similar study and were unable to replicate the findings. The authors discuss their findings and how the methodology differs between their and Hamer's studies (Hamer 1991, Hamer et al. 1993, LeVay & Hamer 1994). Rice et al. state that combined with the other independent study (Sanders 1998), the two studies deviate significantly from Hamer's results. Furthermore, Rice et al. maintain that family history studies are unreliable, the experiment lacks controls, and the reason for the extreme selective process is not given. Hamer criticizes Rice et al. for the sample size that was studied on the DNA level and the lack of qualitative measures of "homosexuality". Despite the reported significance of the male results in Hamer et al.'s study (1993), the researchers make several mistakes that jeopardize the validity of their results.

In addition to these technical issues, there are theoretical problems with Hamer's work. For instance, the research fails to take social environment into account. Historical and social changes influence and complicate ideas

about sexual orientation. Self-identification patterns have changed and this influences how they define “homosexuality” and thus may confound sample selection. Furthermore, the research fails to address sexual fluidity and the possibility of choice in sexual orientation.

THE THEORY OF CHOICE

Since the publication of the first articles on the supposed “gay gene” there has been a lot of resistance from a variety of groups, including feminists, queer scholars, gay and lesbian publications, and other scientists. The biological determinism suggested by the publications can elicit frustration, disbelief, fear, consent, and many other emotions in these groups. Many critics of biological determinism advocate for the choice discourse whereby “homosexual” individuals choose nonnormative identities based on a variety of factors. The opposition to the “born that way” discourse is complicated because some individuals experience their sexual orientation as inborn. Karla Mantilla explains this disruption of assumed origin by saying, “First, no one can deny someone’s experience, but people’s interpretation of their experience is what is truly in debate” (1999:3). She argues that the choice interpretation of experience makes the most sense given the fluidity of sexuality and the limited ability of biology to explain sexual object choice.

In an interview with Ruth Hubbard, author of Exploding The Gene Myth: How Genetic Information Is Produced and Manipulated by Scientists, Physicians, Employers, Insurance Companies, Educators, and Law Enforcers,

she talks about what choosing “homosexuality” and bisexuality means. She says:

Well I think it has to do with the sum total of your experience from the moment you were born or maybe earlier. What your parents expected of you. What society expected of you...the parameters within which you lived. What you have to adjust to with your friends. If I think of my own sexual development...I mean it was channeled by expectations...by my own expectations...my own seeing what went on in the world around me...plus the whole range of options that I saw...not just in the sexual realm...the areas in which I decided I wanted to run counter to the stream...the areas in which I decided I wasn't going to fight my battles...I mean there's just so much that goes on in the way one grows up...There are decision points all along the way and we make choices at those times but they are all very contingent, and every choice is a choice among options. And it really depends on what the options that are out there are. I don't think about men as much as I think about women...and I can think of so many women who in an earlier generation just wouldn't ever have had even the choice to think about....being lesbian much less to be lesbian....(1997:13).

Her explanation of choice contains political connotations. The reference to where one chooses to go against the grain of social standards exhibits this political stance. Furthermore, she suggests that the options we have play a significant role in what we choose. For instance, “homosexuality” is broadly recognized as a sexual orientation, even if it is seen as undesirable, and that gives individuals a choice in what behavior and identities they engage with.

The choices that are available are more pronounced now than in the 18th and 19th centuries, but it is possible that the reasons for these kinds of relationships are the same. Susan Rosenbluth in her 1997 article “Is Sexual Orientation a Choice?” says:

Empirical studies comparing lesbian, gay male, and heterosexual couples typically report three major findings. The first is that homosexual couples, unlike heterosexual couples, do not generally engage in traditional gender-role divisions of tasks and behaviors. The stereotype of one partner assuming a traditionally masculine role while the other assumes a traditionally feminine role is not characteristic of lesbian or gay male couples... Second, compared to other types of couples, lesbian couples have been described as more emotionally nurturant... Finally, the literature suggests that lesbian couples are characterized by uniquely high levels of relationship equality (596-597).

These assumed differences in relationships between gay and straight groups dominate the literature. Peplau et al. cite studies that presuppose that gay men are only interested in sex without the threat of commitment and that lesbians are looking for intimacy. These generalizations rely on the stability and reality of sexual orientation that Peplau questions.

Constructionists such as Peplau argue that sexual orientation is somewhat arbitrary because it is historically assigned. She argues that sexual behavior demonstrates “the ways in which individuals navigate scripts over time” (1999:92). Sexual orientation cannot be defined solely by behavior because it also includes the influence of politics.

CONCLUSION

The difference between choice and biological determinism is clear. What is not explored in either side of the debate is the question of diagnosis. Both sides seek to diagnose “homosexuality”, either by claiming it is a relatively conscious decision or it is an immutable genetic predisposition. The question that neither side explores is why diagnosing people’s sexual orientations is important. Both sides seem to be limited by their obsession

with identifying individuals and categorizing them with labels. The possibilities of sexualities are limited by the discourse that deems sexuality to be one's essence. Our discourse surrounding sexuality reduces us to one-dimensional beings. Exploring the ways in which we can explode or confound the categories would be a more interesting study than how we can "out" people.

SECTION II: CLINICAL PERSPECTIVES ON "HOMOSEXUALITY"

INTRODUCTION

A 2001 national survey reports a liberalization of attitudes on "homosexuality since 1990. Until then, there is an increase in the belief that "homosexuality" is immoral. After 1990, however, attitudes become more liberal and the morality of "homosexuality" and the "homosexual's" rights to civil liberties become more separate; there is a decrease in the willingness to restrict "homosexuals'" civil liberties (Loftus 2001). In one study of 193 female and 173 male heterosexual college students, the data supports the author's hypothesis that heterosexuals would have a more negative view of "homosexuality" if it was attributed to controllable causes (Whitley 1988). Therefore, the biological argument for "homosexuality" is socially and politically advantageous for gay individuals. Despite the liberalization of attitudes and a shift toward viewing "homosexuality" as biological, institutionalized homophobia persists in the medical setting, as evidenced by the history and by the present gaps in health care.

HOMOPHOBIA IN THE MEDICAL SETTING

“Homosexuality” is classified as a “sociopathic personality disturbance” in the first DSM published in 1952 (Bayer 1981). The removal of “homosexuality” from the DSM in 1973 is prompted by radical political movements, religious and legal positions becoming more liberal about sex that occurs between consenting adults, and research published by cultural anthropologists, psychologists, and sociologists. Psychological illness came to be seen as a social malfunctioning or patient discomfort as opposed to pathological cause of disease (Bayer 1981). This definition excludes most cases of “homosexuality.” Nevertheless, gaps in health care and homophobia in the medical setting still exist.

A study done in Jackson, Mississippi showed that medical students were less likely to interact with “homosexual” patients than heterosexual ones, and found them to be less honest, likable, assertive, attractive, smart, and appropriate than their heterosexual patients (Kelly et al. 1987). These studies effectively show the homophobia and misinformation present in U.S. medical school students in recent times.

In a study of 711 physicians and medical students, researchers found that 67% of participants reported knowing of prejudice against gay persons directed towards patients, 52% actually saw colleagues provide substandard care or denying care to patients on the basis of sexual orientation, and 88% heard colleagues make discriminatory remarks about LGB patients (Schatz & O’Hanlan 1994).

In a study of 184 physicians at Upstate University, adolescents presenting issues about sexual orientation were only asked to follow-up by 30% of physicians, 10% of physicians said it was unlikely that they would schedule a follow-up, and 47% responded that it was not applicable (Kitts 2010). Furthermore, 23% of physicians responded that same-sex relationships were always or almost always wrong and 9% reported that they were wrong sometimes (Kitts 2010). Most of the physicians selected that discussing sexual orientation while taking a sexual history was not applicable. Nineteen physicians provided their own reasons, including “I usually let the patient bring it up if he/she feels it is worth discussing,” “I assume heterosexuality unless they give some behavioral or historical cue to the contrary,” “Other history makes orientation obvious,” “Usually it is obvious when discussing STDs and birth control,” and “I don’t understand sexual orientation” (Kitts 2010:737). This ignorance about sexual orientation creates gaps in health care for gay and lesbian populations.

“Providers who are uncomfortable working with LGBT patients or fail to recognize the sexual orientation of a patient will manage patients incompletely, perhaps incorrectly. They will fail to obtain pertinent information or to recognize important elements of evaluation and treatment” (Kalbflesch 1996). This is important because the manner in which patients are dealt with has a direct impact on their treatment. In environments where LGBTQ patients are viewed with a lack of understanding, these individuals have a basis to fear that they will be discriminated against if they disclose

their sexual orientation. This has the compounding effect of limiting significant disclosures that can have an impact on a patient's health.

Moreover, patients are likely to avoid health care altogether if they view clinical settings as hostile or insensitive to their needs.

Ignorance is one critical component to health disparities. "The primary care of lesbian, gay, and bisexual (LGB) people is compromised by gaps in clinical care and practice systems. These gaps include documented deficiencies in the LGB-specific knowledge and skills of health care professionals" (McNair & Hegarty 2010). Therefore, disparities in health care for gay men and lesbians are increased by a lack of knowledge and consideration of sexual orientation.

The LG population is at increased risk for weight issues, smoking, substance abuse, depression and suicide ideation, and violence against them (Makadon et al. 2008). Another opinion is that "most of the health concerns of LGBT people are the same as those of the general population" (Kalbfliesch 1996). Regardless, fear, discrimination, and stigma cause many LG individuals to avoid medical care. Clinicians may be hesitant to provide LG individuals with care because they are not sure what language to use, are uncomfortable getting a detailed sexual history, or are inexperienced in LG health care issues. Between 13 and 90% of lesbian and gay patients in the study did not disclose their sexual orientation to their primary clinician because of previous bad experiences or fear. From 20 to 75% of lesbians and gay men in the study reported negative responses from a health care provider

after they revealed their sexual orientation (White et al. 1997). Thus, it is clear why some LG individuals feel uncomfortable revealing their sexual orientation.

In a study that included 2,269 returned surveys, statistically significantly more women than men reported that their clinician usually or always presumed that they were heterosexual (Neville & Henrickson 2006). More women than men had disclosed their sexual identity to their clinician (Neville & Henrickson 2006). “Such ‘heteronormativity,’ and even outright homophobia in healthcare environments, can present major barriers to LGB people’s ability to access health care” (Neville & Henrickson 2006).

When I informally observed clinician/patient appointments at the health clinic in Fayetteville and then at the LGBTQ health center in Boston, I became aware of the subtle but significant differences in how the medical professionals dealt with taking the sexual history. At the health clinic the clinician would ask if the patient was sexually active, then if the patient was using protection, and finally the clinician would push the use of birth control. Lesbian patients were forced to out themselves in an awkward manner to avoid the chiding of the clinician for not using birth control. This has happened to me every time I have gone to the doctor’s office as well. Furthermore, the clinicians were visibly uncomfortable when the lesbian and gay patients did discuss their sexual history.

Conversely, at the LGBTQ health center, the sexual history is conducted in a more open manner. For example, the clinician would ask if the

patient was sexually active with men, women, both, or other. It was an open environment where patients who had had bad experiences at other health centers were put at ease. Patients were never assumed to be a specific sexual orientation and were always given the opportunity to openly discuss their sexual history and concerns. The opportunities to disclose one's sexual orientation within healthcare settings are minimal (White & Dull 1997), but clearly, it is important that one feels comfortable discussing one's sexual orientation and sexual matters in order to receive optimal care.

The LGBTQ health center focuses on outreach to the targeted population and being in touch with the needs of the community. For example, when I worked there, I cofacilitated an outreach activity for bisexual individuals and shadowed a doctor treating an illegal immigrant for an STD. They provide free tobacco cessation educational sessions and a walk-in substance abuse clinic because LGBT individuals have a higher incidence of tobacco and substance use (Makadon et al. 2008). I watched as they provided the highest quality of health care to individuals who could not pay, people who had been stigmatized by society, and illegal immigrants.

CONCLUSION

Until 1973, "mental health providers and clinicians generally viewed homosexuality as a disease state: abnormal, dysfunctional, perhaps immoral or criminal" (Kalbflesch 1996). Even today, at the 82 U.S. medical schools surveyed by Wallick et al., the mean average time spent on "homosexuality" was only 3 hours and 26 minutes (1992). Other than these three and a half

hours, lessons in medical schools assume that patients are heterosexual--with the exception of the discussion of AIDS (Wallick et al. 1992). This association between homosexuality and AIDS is highly prejudicial. The authors write, "To enhance sensitivity and comfort with gay and lesbian issues and to counter stereotypic responses, the authors propose that the topic of homosexuality be wholly integrated throughout the curriculum" (Wallick et al. 1992).

There is a critical need for a focus on gay and lesbian health care, because current practice tends to be stigmatizing and even hostile. The lack of adequate care is the result of multiple factors:

Among the many factors that contribute to disparities in LGBT health, several deserve emphasis: negative societal attitudes that persist even within the medical community, lack of appropriate education for health professionals, and communication shortfalls during clinical encounters (Makadon 2008).

It is vital that medical professionals create a safe environment where patients feel comfortable volunteering information about their sexuality. Recent research thus indicates that the historical discrimination against gay men and lesbians by medical professionals persists today.

CHAPTER FIVE

CONCLUSION

Although great strides have been made since the removal of “homosexuality” from the DSM in 1973, homophobia and the belief that “homosexuality” is pathological persist. “Homosexuality” is used more frequently than “gay” or “lesbian” in the relevant texts published between 1864 and 1984: “The term that designated an illness classification continued to be used after demedicalization” (Schwanberg 1986:66). Gay persons are first and foremost recognized in the literature as “homosexuals” rather than individuals, despite the great diversity within the LGB population (Bell 1975).

Chapter two discusses the basic theories of “homosexuality”, including presumed causes, in the early period of medicalization of “homosexuality.” Many of those authors strictly differentiate “homosexuals” from heterosexuals and provide stereotypical descriptions with which to diagnose them. Diagnosing “homosexuality” implies pathology and the possibility of a cure, and indeed, various “treatments” were proposed. Some of these authors are progressive for the time period because they seek out scientific answers to the “homosexual” question in order to dispel misconceptions and avoid the moral condemnation characteristic of religious views. However, they also dichotomize between “homosexuals” and heterosexuals, marginalize “homosexuals,” and base their characterizations of “homosexuals” on extreme gender stereotypes.

Chapter three examines psychoanalytic texts that are based primarily on Freudian theories. It discusses perspectives on “homosexuality”, including

psychical hermaphroditism and bisexuality, the categorization of different types of homosexuals, and views on “homosexual” desire. The analysis of childhood development and of the “homosexual’s” family relationships are major themes in these texts. On the one hand, many of these authors are progressive because they remove some of the stigma of being “homosexual” by arguing that everyone is, at one time, inclined to “homosexual” urges. On the other hand, these authors view "homosexuality" as a mistake in development and blame it on dysfunctional family dynamics.

Chapter four reviews contemporary research on possible biogenetic determinants of sexual orientation. Research shows that this type of research can benefit lesbian and gay individuals politically and socially because it negates, or at least reduces the probability, that homosexuality represents a moral choice (Whitley 1988). However, some biogenetic studies have problematic methods. In addition, they deprive gay and lesbian individuals of agency and autonomy. In direct contrast to these biological theories is the theory of choice. This theory is problematic in its total disregard for the available scientific evidence and because it implies that "homosexuals" could be heterosexual if they would only stop being immoral. On the positive side, the notion of choice grants lesbian and gay individuals agency for their sexual orientation.

Chapter four also discusses contemporary research on homophobia in clinical settings. The research supports my observations that homophobia persists in contemporary health care delivery and can appear in different

forms: On one end of the continuum, unintentional but nevertheless ignorant and inconsiderate practices; on the other end, outright aversion and rejection. This research indicates that, in order to improve clinician/patient relationships and clinical practices generally, health care providers need a fair and objective education concerning “homosexuality” and specific issues associated with LG communities. If this population is to receive adequate health care, critical shifts in thinking must occur. The final remnants of the moral condemnation of “homosexuality” must be rejected and alternative forms of sexuality must be accepted.

As we have seen, prejudice in medicine results in suboptimal care. Medicalization has had some negative consequences. Stereotypes from the 19th century supported old ideas about gender and the associated masculinity with lesbians and femininity with gay men. These stereotypes have resulted in the rejection of masculine lesbians and feminine gay men by mainstream society, but also made feminine lesbians and masculine gay men invisible to the LGBTQ community. Furthermore, the practices of the authors studied marginalized these groups by separating them so drastically from heterosexuals. The ideas and practices of the 20th century have promulgated the idea that “homosexuality” is a baser form of sexuality tied to dysfunctional family dynamics. These ideas have carried over into modern times, as evidenced by the ignorance, misunderstanding, and prejudice still practiced in medicine. These ideas have also created an environment where one is assumed straight until proven gay. Medical practitioners can improve health care by

asking open-ended questions about the patient's sexual history and creating an atmosphere of acceptance and compassion. They can exemplify the Hippocratic oath that stipulates do no harm.

This Capstone Project gives the history of medicalization of "homosexuality" in order to better inform the audience of pertinent issues and help them to revise their attitudes about "homosexuality." Hopefully, the information contained in this project will enable people to make better decisions and create a more hospitable atmosphere for gay men and lesbians in clinical settings.

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CAPSTONE SUMMARY

Description of the Project

Originally, this Capstone Project consisted of three sections: medicalization of the “homosexual” body, the intertwining of race, class, and gender biases with the diagnosis and threat of “homosexuality,” and an examination of a modern dilemma related to gay and lesbian bodies. The latter looked at Dean Hamer’s search for the “gay gene” to ascertain what underlying assumptions were still at work. After the project advisor reviewed the first full draft, it became clear that these sections constituted separate theses; the topics were too broad and there was too much relevant information for all of them to be examined in a single project. Furthermore, the secondary sources used were inadequate because they made a unique analysis of the material very difficult. Because of these problems, I chose the medicalization section as the focus of the project.

The project now consists of the examination of primary sources related to the scientific inquiry of “homosexuality” from 1864 until 1946. These dates were not chosen because they represent a period of uniformity in perception of “homosexuality,” but because they capture the major shifts from scientific/medical approaches to psychological approaches. 1946 was chosen as the end date because the 1950s mark the beginning of sexology as a field and a scientific way of thinking about “homosexuality.”

These shifts lend themselves many analytic frameworks. The one chosen for this project is the sequence of diagnosis of “homosexuality” that implies pathology that can be treated and/or cured. This project focuses on

four questions. First, how do the doctors, psychologists, and scientists of the period define and diagnose “homosexuals”? In other words, what are the characteristics of “homosexuals” by which one can recognize them? Second, what are the underlying assumptions of these professionals’ methodology? Third, how are these ideas progressive gay men and lesbians for the time period and how are they problematic? Fourth, what therapies are prescribed for treating or curing “homosexuality” and what is goal of treatment? The purpose of this project is to gain enlightenment on the history of the ways in which gay and lesbian bodies have been subjected to medical scrutiny and the implications of these processes. Although this project is chronological, the analytic framework and the questions examined give shape to it, differentiate it from other works on the subject, and hopefully render it more interesting for the reader. Contemporary views are also included to show how the history has influenced the present.

Methods Used

Jennifer Terry’s book, An American Obsession: Science, Medicine, and Homosexuality in Modern Society proved to be a useful text because it provided detailed summaries of many of the scientific authors of the time. It proved to be engrossing and so complete that initially, it was used as the keystone source for the medicalization section of the project. “Scientific Racism and the Invention of the Homosexual Body” by Siobhan Somerville served as the foundational text of the race section of the project. This strategy

proved problematic because the Capstone Project became more of a book report that attempted to capture all the facts but was lacking in organization and analysis.

After reassessing the project, several things became clear. First, medicalization of the “homosexual” body was the most important chapter and should be the focus of the revised project. Second, primary sources should make up the bulk of the project. Third, the material should be presented chronologically.

Primary sources were identified many different ways. First, the references lists in secondary texts were paramount to pinpointing the most relevant sources or most influential writers. Second, sources were identified by the second reader of the project. Third, internet searches on scholarly databases and general internet searches on sexology provided the names of influential writers, whose works were then explored. Secondary sources were utilized in order to consider a different outlook on the material, as well as identify sources for the project (Bland & Doan 1998, Conrad & Schneider 1992, Terry 1999).

The availability of sources should be mentioned briefly. In the original Capstone Proposal the third part of the project was going to be a literature search of relevant, modern medical texts. As it turned out, all of the medical textbooks from 1950 to about 1985 had been purged from Upstate Medical Library in the interest of space. This kind of decision jeopardizes the veracity

and thoroughness of the historical record. Without those texts, it is impossible to examine period works and identify shifts in thinking. We lose our history.

As the project evolved, it became clear that this was not a problem reserved for the medical library. As expressed in the introduction of Sexology Uncensored: The Documents of Sexual Science, many of the early primary sources in sexology are difficult to find. This means that readers are forced to rely on secondary sources that may or may not be accurate, and therefore they cannot give a complete picture of the original work. It was difficult to obtain the sources used in this project—the library, Illiad, and internet databases were searched, but some sources were impossible to obtain. Nevertheless, this project deals with a number of texts from the time period in order to identify shifts in thinking from 1864 until 1946.

The Project's Significance

This Capstone Project takes an analytic, chronological approach to an important topic during a specific time period. Lesbian and gay individuals are still marginalized and disenfranchised. The dominant discourses during the time period of this study left deep footprints in medical analysis of “homosexuality.” Traces of these discourses still live and breathe in modern medical texts. It becomes apparent that medicalization runs in cycles, but it is a recurring theme in the history of gays and lesbians in the United States. Reviewing history provides us with the opportunity for reform in the present. By examining the underlying assumptions scientists and medical professionals

had about “homosexuals” and the consequences of these beliefs we can better understand why the current system of homophobia functions as it does.

Furthermore, providing this kind of history and promoting education on the subject can beget an understanding of the struggles of gay and lesbian populations both historically and today. It can also lead to improved policy.

For instance, “homosexuality” was removed from the DSM in 1973 because the psychologists and psychiatrists responsible found that Medicine has come to dominate the study of gay men and lesbians again with the studies on genetics. It is critical that we look at the potential pitfalls of this kind of analysis given the history, and gain an understanding of arguments against a biological and/or psychological approach.