Sexual Orientation Differences As Deficits: Science and Stigma in the History of American Psychology[1]

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Abstract

This article briefly describes how psychology, psychiatry, and the mental health professions (here collectively referred to as Psychology) treated sexual orientation differences as deficits for much of the 20th century, as well as some of the negative consequences that practice had for sexual minorities. The 1970s witnessed a remarkable turnaround when the American Psychiatric Association removed homosexuality from the Diagnostic and Statistical Manual of Mental Disorders and the American Psychological Association called for psychologists to work to remove the stigma historically associated with homosexuality. This history illustrates not only how cultural institutions play a central role in legitimating stigma, but also how they can recognize their own complicity in this process and work effectively to undo its harmful effects. It is argued that Psychology still has an important role to play in challenging the differences-as-deficits model in contemporary policy debates.

During much of the 20th century, the sexual minority experience in the United States was significantly defined by homosexuality's official designation as a mental illness.

Nonheterosexuals suffered considerable harm because Psychology[2] equated departures from heterosexuality with psychological deficits. The 1970s, however, witnessed a remarkable turnaround in the mental health professions and behavioral sciences which continues to have important ramifications for sexual minorities today. The history of Psychology's stance toward homosexuality and sexual minorities illustrates not only how cultural institutions play a central role in legitimating stigma, but also how such institutions can recognize their mistakes, reverse their policies, and become agents for societal change. The present article reviews that history as a case study in the making and unmaking of structural sexual stigma.

Stigma refers to the culturally shared knowledge that society regards the members of a particular group or category negatively and accords them inferior status in their social interactions with the nonstigmatized. It is "an undesired differentness" (Goffman, 1963, p. 5) whose significance and status are socially constructed and can change over time as norms and mores change. *Sexual stigma* is the stigma attached to any nonheterosexual behavior, identity, relationship, or community (Herek, 2007, 2009). Like other forms of stigma, it is fundamentally about power. Stigma-based differentials in power and status are legitimated and perpetuated by society's institutions and ideological systems in the form of *structural stigma* (e.g., Link & Phelan, 2001) which "is formed by sociopolitical forces and represents the policies of private and governmental institutions that restrict the opportunities of stigmatized groups" (Corrigan et al., 2005, p. 557).

Structural sexual stigma is also referred to as *heterosexism*. As a core component of society's institutions, heterosexism ensures that

[1] A version of this article was presented in the Presidential Symposium, *Stigma from Science: Group Differences, not Group Deficits* (Morton Ann Gernsbacher, Chair), Association for Psychological Science, Washington, DC, May 25, 2007. I express my thanks to Jack Dynis for his helpful comments on an earlier draft.

[2] *Psychology* is used here as shorthand for referring not only to scientific and clinical psychology, but also to psychiatry and related disciplines, the mental health professions, and the behavioral sciences in general. This usage necessarily obscures differences among the disciplines and professions, whose explication is beyond the scope of the present article.

nonheterosexuals have less power than heterosexuals by promoting a *heterosexual assumption*: All people are presumed to be heterosexual, and heterosexual behavior and different-sex relationships are considered normal, natural, and unproblematic (Herek, 2009). This assumption makes gay, lesbian, and bisexual people invisible in most social situations. When sexual differences become visible, homosexuality and bisexuality are problematized, that is, they are regarded as abnormal and unnatural forms of deviance that require explanation. Differences observed between sexual orientation groups are generally interpreted as indicating deficits or problems on the part of nonheterosexuals. In this manner, heterosexism defines sexual differences in terms that bestow greater power upon heterosexuals. By legitimating and reinforcing nonheterosexuals' undesired differentness and by according them inferior status relative to heterosexuals, heterosexism gives rise to actions against sexual minorities, including ostracism, harassment, discrimination, and violence (Herek, 2009). As summarized below, Psychology played a key role in justifying and perpetuating heterosexism in the years prior to 1973.

Sexual Orientation and Mental Health in Historical Perspective

In historical terms, sexual orientation is a fairly recent construct. Although heterosexual and homosexual desires and sexual behaviors are and have been ubiquitous in human societies, the meanings attached to those behaviors and attractions have varied across cultures and historical eras. It was not until 1868, for example, that the word *Homosexualität* (homosexuality) was first introduced by the Hungarian writer Karl Maria Benkert in a German-language pamphlet (Feray & Herzer, 1990). Heterosexuality (*Heterosexualität*) came even later (Katz, 1995). Before this time, attractions, behaviors, and relationships that are now characterized as "heterosexual" or "homosexual" – and, indeed, the very concept of "sexuality" – were understood quite differently from today.

Early in the 19th century, marriage was regarded mainly as an institution for securing wealth and property rights rather than a companionate relationship based on emotional intimacy and romantic love. Procreative acts were authorized by heterosexual marriage, whereas nonprocreative or improperly procreative acts were considered animalistic and condemned as sodomy by religious teachings and legal statutes. The construct of sodomy encompassed not only homosexual behaviors, but also masturbation, sex with animals, pre- and extramarital heterosexual behaviors, and even sexual acts between a husband and wife that did not involve vaginal intercourse; it did not include love. Love and sexual desire were widely regarded as polar opposites, reflecting a dichotomy between the soul and the body, the spirit and the flesh. Before Freud, "[n]ineteenth-century ideologists of eros imagined a crack in the world, with love on one side, lust on the other" (Katz, 2001, p. 333). In such a world, modern notions of "the homosexual" and "the heterosexual" do not readily apply (see generally Chauncey, 2004; Coontz, 2005; D'Emilio & Freedman, 1988; Katz, 2001).

The belief that individuals can be meaningfully defined by their sexual attractions and behaviors began to gain widespread currency only in the latter 19th century and achieved dominance in psychiatric discourse in the early 1900s with Freud's conceptualization of homosexuality and heterosexuality in terms of object choice (Freud, 1953; see also Chauncey, 1982-1983). Love and sex came to be viewed as intimately related, and heterosexuality was understood by psychiatrists to be their mature, healthy expression. Freud did not consider homosexuality to be the optimal outcome of psychosexual development but neither did he believe it was a mental illness.. In a now-famous 1935 letter to an American who had sought advice from him about her homosexual son, Freud wrote "it is nothing to be ashamed of, no vice, no degradation, it cannot be classified as an illness" (Freud, 1951, p.787).

By the 1940s, however, American psychoanalysis – then psychiatry's dominant theoretical framework – had broken with Freud and embraced the view that humans are naturally heterosexual (not bisexual, as Freud argued) and that homosexuality represents a phobic response to members of the other sex. According to the

conventional wisdom of the day, homosexuality was a sickness (Rado, 1940; see generally Bayer, 1987). Thus, although Psychology played an important role in depolarizing sex and love, thereby fostering a worldview that permitted people to be categorized according to the object of their sexual and romantic attractions, it also created a new dichotomy in which heterosexuality was equated with normalcy, homosexuality with disease. The language of diagnosis served to perpetuate society's longstanding legal and religious condemnation of sodomy in general and of same-sex sexual acts and desires in particular.

When the United States entered World War II, government personnel policies incorporated the illness model. Whereas existing military regulations already prohibited sodomy (including homosexual behavior), now the armed forces sought to bar homosexual *persons* from their ranks (Bérubé, 1990). As part of their charge to screen potential inductees and volunteers for a variety of pathologies, military psychologists and psychiatrists had the responsibility of detecting homosexuals. The screening was superficial, however, and mental health professionals often looked the other way, allowing homosexuals to enter the armed forces during the war's early years when personnel needs were great. As Menninger (1948) observed, "[p]robably for every homosexual who was referred or came to the Medical Department, there were five or ten who were never detected. Those men must have performed their duty satisfactorily, whether assigned to combat or to some other type of service" (Menninger, 1948, p. 227).

During the war's waning years, however, antihomosexual policies were vigorously enforced, witch hunts occurred frequently, and many gay men and lesbians received undesirable ("blue") discharges as sexual psychopaths. The circumstances surrounding their separation from service (or, for some, their initial rejection as inductees) were communicated to their hometown draft boards and prospective employers, effectively "outing" them to their family and community. Socially ostracized in civilian life, they were denied benefits under the GI Bill and often could not secure employment. As Bérubé (1990) noted, "Wherever blue-discharge veterans lived, employers, schools, insurance companies, veterans' organizations, and other institutions could use their bad discharge papers to discriminate against them on the basis of their undesirable status or their homosexuality. Sometimes their lives became so unbearable as exposed homosexuals that they had to leave home or tried to kill themselves" (p. 229).

Homosexuality's status as a mental illness also had serious consequences outside the military. Gay and lesbian civilians risked arrest not only in gay bars and other public settings, but even at gatherings in private homes. They were routinely charged with offenses such as disorderly conduct, vagrancy, public lewdness, and solicitation. Exploiting homosexuality's diagnostic status, many states passed sexual psychopath laws that put homosexuals in the same category as rapists and child molesters and permitted their indefinite confinement in a psychiatric institution until they were declared cured (Chauncey , 1993; Freedman, 1989). Homosexuality's classification as a mental illness also was used to justify federal and state laws and regulations that barred homosexuals from employment or prohibited them from obtaining professional licensure in numerous occupations. Thousands lost their jobs as government employees, teachers, and hospital workers (D'Emilio, 1983).

During this era, many psychiatrists and physicians attempted to "cure" homosexuality, that is, they tried to change homosexuals into heterosexuals. Their techniques were overwhelmingly ineffectual (American Psychological Association, 2009; Haldeman, 1994). Large numbers of homosexual men and women spent countless hours undergoing psychotherapy in what proved to be a vain effort to change their sexual orientation (for a personal account, see Duberman, 1991). When psychotherapy did not work, many resorted to (or were coerced into) more drastic methods, including hormone treatments, aversive conditioning with nausea-inducing drugs, lobotomy, electroshock, and castration (e.g., Feldman, 1966; Max, 1935; Thompson, 1949; see generally American Psychological

Association, 2009; Katz, 1976). Failures in these attempts led many homosexuals to suicide.

Challenges To The Illness Model

Although Psychology played a central role in legitimating and perpetuating heterosexism, not all mental health practitioners endorsed the policies and regulations that subjected homosexuals to discrimination and other forms of stigma (Bérubé, 1990; Freedman, 1989). And scientific challenges to psychiatric orthodoxy emerged in the 1940s and 1950s, even as homosexuality was listed as a mental illness in the first edition of what would eventually be called the *Diagnostic and Statistical Manual of Mental Disorders*, or DSM (American Psychiatric Association, 1952).

In 1948, Alfred Kinsey published his book on sexual behavior in the human male, followed in 1953 by the companion volume on female sexuality (Kinsey, Pomeroy, & Martin, 1948; Kinsey, Pomeroy, Martin, & Gebhard, 1953). Based on more than 18,000 interviews, the Kinsey team's finding that homosexual experiences were remarkably common – e.g., reported by more than one third of their male respondents – directly contradicted the heterosexual assumption. Around the same time, Ford and Beach (1951) published an extensive review of cross-cultural and cross-species studies of sexual behavior, concluding that same-sex sexual behavior occurs in many animal species and that homosexual behavior of some sort was considered normal and socially acceptable in a majority of the societies for which detailed ethnographic data were available (Ford & Beach, 1951). Like the Kinsey studies, their work revealed homosexual behavior to be common, not a rare and pathological form of sexuality.

In the mid-1950s, Evelyn Hooker conducted what would be the first published study comparing the psychological functioning of a non-clinical sample of homosexuals with comparable heterosexuals (Hooker, 1957). Hooker's research represented a dramatic break with previous work because she did not accept the conventional wisdom that homosexuality was a pathology. Instead, she used the scientific method to test this assumption. She administered projective tests to matched samples of 30 homosexual and 30 heterosexual men – none of them currently in therapy – and asked expert judges who were unaware of each subject's sexual orientation to evaluate the men's psychological functioning and to indicate whether each was homosexual or heterosexual. The judges classified most of the men – heterosexuals and homosexuals alike – in the highest categories of adjustment. Using the Rorschach, they could not distinguish the men's sexual orientation at a level better than chance. When the 60 Rorschach protocols were presented in random order, only six of the homosexual men and six of the heterosexual men were correctly identified by both judges. When the judges later attempted to identify the homosexual man in matched pairs of protocols, only 12 of the 30 pairs elicited correct responses from both judges (Hooker, 1958).[3] Hooker concluded that homosexuality did not constitute a clinical entity and was not inherently associated with pathology. Her findings were subsequently replicated in empirical studies of men and women (Gonsiorek, 1991; for a compelling account of Hooker's life and research, see Harrison, Haugland, & Schmiechen, 1991).

In retrospect, it can be seen that by hypothesizing that no aggregate differences in psychological distress should exist between heterosexual and homosexual samples, Hooker's research and other studies that followed it

[3] Hooker also assessed the utility of other Rorschach methods for identifying sexual orientation, including the Wheeler signs and the Schafer content themes. Although some analyses of the Wheeler signs yielded statistically significant differences between the homosexual and heterosexual men, she noted that the "very dubious validity of the individual signs" made their value questionable (Hooker, 1958, p. 51). She also concluded that the Schafer themes overall "would be of little or no value in diagnosing homosexuality in individual cases" but noted that a few themes differentiated the two groups and suggested that "further efforts to objectify and refine the scoring would … be warranted" (p. 47).

actually applied too strict a test. We know today that some stigmatized groups manifest elevated rates of psychological distress as a consequence of the stress imposed on them by stigma-related ostracism, harassment, discrimination, and violence (Herek & Garnets, 2007; Meyer, 2003). Such patterns do not mean that the characteristic defining the group is inherently pathological. Nevertheless, by demonstrating that well-adjusted homosexuals not only existed but in fact were numerous, these studies demonstrated that the illness model had no scientific basis.

How did the illness model persist so long in the absence of supporting empirical data? In a narrow sense, much of the explanation lies in poor theory and inadequate methods. Proponents of the model employed theoretical frameworks that uncritically adopted then-current cultural values surrounding sexuality. Their empirical research, insofar as they collected data at all, was seriously flawed. The samples were badly biased, typically consisting of homosexual individuals who were incarcerated, institutionalized, or undergoing psychiatric treatment. The methods for collecting data introduced additional bias. For example, information about a homosexual patient might be obtained from her or his psychoanalyst rather than through independent observation by a third party who was unaware of the individual's sexual orientation. It would have been surprising if such practices had not confirmed a priori assumptions about the psychological functioning of nonheterosexuals.

More broadly, the basis for the illness model's persistence was the fact that sexual stigma led psychiatrists and psychologists to equate sexual difference with pathology and to interpret their observations accordingly. As Gonsiorek (1991) noted, for example, when the overall family patterns observed in a homosexual sample differed from those of a heterosexual comparison group, the former's experiences were typically assumed to be indicative of pathology whereas the latter's were seen as indicating mental health. This assumption was made without independent confirmation that the homosexual sample manifested greater psychopathology than the heterosexuals. Through a circular logic, homosexuals were assumed to be mentally ill because they often reported family patterns that some psychoanalytic theories presumed were pathological, and the "proof" that the family patterns were pathological was that they were often observed among homosexuals (Gonsiorek, 1991).

Given Psychology's central role in legitimating heterosexism, it is perhaps not surprising that data such as those reported by Hooker and the researchers who followed her were not sufficient to change professional opinion. Indeed, homosexuality was still listed in the 1968 edition of the *DSM* (American Psychiatric Association, 1968). Change came only when the mental health profession was pressured by the targets of stigma themselves. In the 1970s, gay and lesbian activists directly confronted the psychiatric and psychological establishments, conducting protests at professional meetings and demanding that longstanding diagnostic assumptions be subjected to scientific scrutiny and debate.

Faced not only with the empirical evidence but also with changing cultural views of homosexuality, Psychology radically altered its stance. In 1973, the American Psychiatric Association's Board of Directors voted to remove homosexuality from the *DSM* (Bayer, 1987). The American Psychological Association endorsed the psychiatrists' actions, passing a resolution that stated, in part: **"**Homosexuality per se implies no impairment in judgment, stability, reliability, or general social and vocational capabilities: Further, the American Psychological Association urges all mental health professionals to take the lead in removing the stigma of mental illness that has long been associated with homosexual orientations**"** (Conger, 1975, p. 633).

When Psychology reached a consensus that homosexuality is not a mental illness, one of heterosexism's supporting pillars crumbled and a principal justification for sexual stigma vanished. Moreover, in the course of reversing its longstanding position on homosexuality, Psychology committed itself to undoing the harms that the illness model had inflicted on sexual minorities. The focus of clinical practice

shifted from "curing" homosexuality to assisting sexual minority individuals in leading fulfilling and happy lives. Scientific research began to examine the social psychological roots of heterosexuals' prejudice against sexual minorities. Psychologists shared their scientific and clinical expertise about sexual orientation and sexual minorities with the courts, with legislative bodies, and with the general public. This remarkable reversal has been important in influencing societal attitudes and providing a basis for reversing many of the antigay policies and laws that were enacted in the 20th century. It continues to have significant consequences up to the present day (Herek, 2007).

Challenging the Sexual Differences-As-Deficits Assumption Today: Parenting

Despite Psychology's repudiation of its former legitimation of heterosexism, the differences-as-deficits model persists in American society and still warrants an ongoing response. One example is found in contemporary policy debates about the status of sexual minority adults as parents. Many gay, lesbian, and bisexual people have children – whether from past heterosexual relationships, through artificial insemination with a current partner, by adoption, or through other means (Patterson, 2000; Goldberg, 2010). Given homosexuality's historically stigmatized status, it is not surprising that sexual minority parents have frequently been the targets of hostility and discrimination. A parent's homosexuality has often been grounds for denying her or him custody in divorce proceedings. In many states, second-parent adoption rights either have not been established or have been ruled by courts not to be permitted under current law. And some state laws explicitly prohibit adoption or foster parenting by gay individuals, same-sex couples, or individuals cohabiting with a same-sex partner.[4] Parenting has also been a central issue in debates about marriage equality for same-sex couples (Herek, 2006).

Science figures prominently in public discourse about sexual minority families. In addition to presenting religious and political arguments, the detractors and supporters of gay- and lesbian-parented families also routinely attempt to demonstrate that their position is supported by empirical research. Proponents of antigay family laws and policies, for example, have often cited scientific research to justify their claim that the legal recognition of marriage between partners of the same sex would jeopardize the well-being of children. The assertion by one conservative Christian organization that "study after study has found that boys and girls not raised by both of their biological parents are much more likely to, among other things, suffer abuse, perform poorly in school, abuse drugs and alcohol and wind up in trouble with the law" is typical (Focus on the Family, 2004, cited in Herek, 2006; see also National Association for Research and Therapy of Homosexuality, 2008; Stanton & Focus on the Family, 2005; Toalston, 2004).

Such claims inappropriately use studies that compare the children of intact heterosexual families with children being raised by a single parent as a consequence of divorce, separation, or the death of a spouse. Those studies generally show that, all else being equal, being raised by two parents is more beneficial for a child than having a single parent (e.g., McLanahan & Sandefur, 1994), but this body of research has not addressed questions about the parents' sexual orientation. Dozens of published empirical studies have directly examined sexual minority parenting, most of them focusing on lesbian and bisexual mothers and their children. The studies vary in their methodological quality but the findings to date have been remarkably consistent. Comparisons between heterosexual and sexual minority families do not reveal reliable disparities in the children's mental health or social adjustment, or in the parents' fitness or parenting abilities (for reviews, see Goldberg, 2010; Herek, 2006; Patterson, 2000, 2006). Antigay activists have dismissed these findings wholesale as methodologically flawed (e.g., Bennett, 2001; Stanton & Focus on the Family, 2005).[5]

[4] At the time of this writing, some of these laws are in the process of being challenged in state courts.

[5] The exception has been an embrace of the one

Two observations about this controversy are relevant to the present article. First, the fact that advocates for each side in the debate claim support from empirical research demonstrates how the public looks to science for answers in this area and underscores the importance for scientists to do all we can to ensure that research findings are accurately communicated to the lay public and to policy makers. Second, the heterosexual assumption greatly influences the terms of the debate. When behavioral scientists publicly discuss research in this area, we can easily find ourselves implicitly endorsing the proposition that heterosexual parenting is the gold standard to which other family forms must measure up, thereby validating the equating of sexual differences with deficits.

For example, questions are routinely raised in policy debates about the adult sexual orientation of children raised in a sexual minority household. The empirical data on this topic are limited but are consistent with the conclusion that the vast majority of those children eventually grow up to be heterosexual (Herek, 2006; Patterson, 2000). Simply reporting these findings, however, can communicate a tacit endorsement of the value assumption that it would be a negative outcome for the children of sexual minority parents to grow up to be gay themselves.

Similarly, questions are raised about the gender conformity and attitudes of children with nonheterosexual parents. The published data have not revealed consistent differences in gender role conformity between the children of lesbian versus heterosexual parents (Herek, 2006, Note 6; Patterson, 2000). Reporting this fact, however, might be interpreted as endorsing the differences-as-deficits model, that is, agreeing that systematic differences in gender attitudes or behavior between the children of heterosexual and nonheterosexual parents would be problematic if they were detected and could be attributed to the parents' sexual orientation. Yet it may be psychologically healthy for children to hold flexible attitudes about gender roles, for example, for girls to aspire to traditionally masculine occupations such as astronaut, doctor, lawyer, or engineer (e.g., Barrett & White, 2002). It is difficult to convey this message in a court brief or in expert testimony when the immediate goal is to avert the separation of children from their parents or to prevent sexual minorities from being further stigmatized.

Conclusion

The history of Psychology's stance toward homosexuality illustrates how scientific theories, research methods, and clinical practices often incorporate and reproduce cultural values to the detriment of society's less powerful groups. But it also shows how institutions can change. During the past century, Psychology has transformed itself from a profession that once provided an institutional foundation for sexual

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published empirical study that found children with lesbian or gay parents to be functioning substantially more poorly than children with married heterosexual parents (Sarantakos, 1996). This study has been promoted despite its use of a relatively small convenience sample, a characteristic that conservative activists have decried as a fatal flaw in the studies that found no differences in the adjustment of children according to the sexual orientation of their parents. In addition, its methodological shortcomings have been ignored. For example, parental sexual orientation was confounded with divorce: Most of the children of same-sex couples had experienced parental divorce (many in the recent past) but the children of married parents apparently had not. Whereas having gay or lesbian parents has not been linked to poor adjustment or academic performance, the negative effects of divorce on children are well documented (e.g., Amato, 2001). Moreover, the children in the sample with homosexual parents faced such high levels of prejudice that some of them had to transfer to a different school or their families had to move to another town. These factors and other methodological weaknesses most likely explain the study's anomalous results. However, antigay groups have cited this article from an Australian social work journal as scientific confirmation of their claims, even as they dismiss the bulk of published research in this area (e.g., Family Research Institute, 2001; Rekers, 2005).

stigma to one that is now dedicated to actively challenging that stigma through research, practice, teaching, and advocacy.

Nevertheless, the differences-as-deficits assumption remains pervasive in public discourse about sexual orientation and sexual minorities. In addition to discussions of sexual minority parenting, as noted above, it is evident in debates about the legal recognition of same-sex intimate relationships (in which heterosexual marital relationships are routinely treated as the gold standard), the "cause" of homosexuality (in which the origin of heterosexuality is typically not questioned), and many other issues about which Psychology has relevant expertise.

In making good on Psychology's pledge to eradicate the stigma historically associated with homosexuality, it is important that we not only challenge widespread factual misconceptions in these domains but that we also address the deeper structures that perpetuate sexual stigma. Even as we continue to share our specific research findings and clinical insights about sexual orientation with the lay public, we should also promote a fundamental questioning of the assumption that differences between the nonstigmatized majority and a stigmatized minority group inevitably reflect the latter's deficits.

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