A Comphrensive Response to Objections of the Treatment of Homosexuality by the American Psychological Association (APA) From The National Association of Research and Therapy of Homosexuality (NARTH)

The American Psychological Association (APA) asserts the following as their objections to the treatment of homosexuality:

(1) There is no conclusive or convincing evidence that such therapeutic attempts offer actual change.

(2) Efforts to change sexual orientation are shown to be harmful and can lead to greater self-hatred, depression and other self-destructive results.

(3) There is no greater pathology in the homosexual population than the general population (cite needed).

The Scientific Advisory Committee and the Board of Directors of The National Association for the Research and Therapy of Homosexuality (NARTH) presents the following data in reponse to these objections:

(1) Whereas, the APA sates: There is no conclusive or convincing evidence that such therapeutic attempts offer actual change,

We contest that while there has been no published study that has sought a random population of clients to assess treatment success rates, outcomes of interventions aimed at changing sexual orientation have been widely documented within the literature since the late 18th-century. Various paradigms and approaches

have been applied and have shown various outcomes of changes in sexual orientation. Largely, however, the treatment of homosexuality has evolved from interventions aimed at changing sexual orientation to acceptance and normalization.

Well over a decade, there have been interventions with people aimed at changing their sexual orientation, along with documented octcomes. These paradigms are often referred to as conversion therapies, sexual reorientation therapies, reparative therapies, or ex-gay religiously mediated therapies. The methodology and techniques are varied. The outcome or treatment success, as they are sometimes referred to, are usually defined by a shift in sexual desire from homosexuality[1] toward heterosexuality either through self-reporting or through measurements such as penile plethysomography, the 7-point Kinsey scale (Kinsey, Pomeroy, & Martin, 1948), the multi-item Klein Sexual Orientation Grid (Klein, 1978), and others (Sell, 1997). Since there is no consensus of what a successful outcome is, each author maintains his or her own autonomy in defining or not defining outcomes or successes. However, change has been measurable, and remains so.

As for the Kinsey scale, "An individual may be assigned a position on this scale, for each period in his life.... A 7-point scale comes nearer to showing the

[1] The term *homosexual* is used throughout this report as per its historical and scientific tenses. The authorship is aware that the terms *lesbian* and *gay* are preferred when referring to specific groups.

many gradations that actually exist" (Kinsey, et al., 1948, p. 656). The 7-points are as follows: 0- Exclusively heterosexual; 1- Predominantly heterosexual, only incidentally homosexual; 2- Predominantly heterosexual, but more than incidentally homosexual; 3- Equally heterosexual and homosexual; 4- Predominantly homosexual, but more than incidentally heterosexual; 5- Predominantly homosexual, only incidentally heterosexual; 6- Exclusively homosexual.

The Klein Sexual Orientation Grid (KSOG) refined the Kinsey scale. It remains with 7 intervals, but investigates sexual experience and fantasies in three times: the present (the most recent 12 months), the past (up to 12 months ago), and the ideal (which is as close as one can get to intention and prediction of future behaviors).

Klein allowed the concept that people's sexuality can change over time. Nevertheless, these are not the only innovations Klein made. Even more important than considering that sexuality is fluid was Klein's introduction of many different factors that can influence identity. On the KSOG, subjects are also asked to consider the following in the present, past, and ideal: Sexual attraction (To whom are you sexually attracted?); sexual behavior (With whom do you actually have sex with?); sexual fantasies (Who do you fantasize about?); emotional preference (Who do you

feel more drawn or close to emotionally?); social preference (With whom do you like to socialize?); lifestyle preference (In which community do you prefer to send your time? In which do you feel most comfortable?); and self-identification (How do you label or identify yourself?).

Glover (1960) divided the degrees of treatment success into three categories: (1) *cure*, the abolition of conscious homosexual impulses and development of full extension of heterosexual impulse; (2) *much improved*, the abolition of conscious homosexual impulses without development into *full* extension of heterosexual impulse; and (3) *improved*, increased ego integration and capacity to control homosexual impulses.

Karten (2006) defined treatment success as: (a) increased sexual feelings and behaviors towards the opposite sex, (b) decreased sexual feelings and behaviors towards the same sex, (c) a stronger heterosexual identity, and (d) improvement in psychological well-being.

Some have taken a more simplistic, yet concrete view of success for example, religious-based interventions whereas celibacy is an acceptable outcome (Harvey, 1987, 1996). Even then, one does not necessarily change sexual orientation, but rather sexual identity. Others see change simplistically in other directions, for example in sexual performance only, as in the study Conrad and Wincze (1976) who treated 3 male homosexuals with masturbatory conditioning

(orgasmic reconditioning) whereas the 3 men were pleased with being able to perform with women and no longer had a need for male sexual partners. The men reported complete adjustment to their sexuality. Thus, the study was considered successful. This is not stated to consider endorsement, but rather as a means to say change is possible along with matching client self-determination.

As with any intervention, there are complete failure rates, relapses and potentials for perceived harm (Shidlo & Schroeder, 2002; Shidlo, Schroeder, & Drescher, 2001). Accordingly, of course, client-determined motivation in compliance to treatment foretells the greatest positive response in most therapeutic endeavors (Fine, 1987).

Some attempts to change sexual orientation have been invasive, for example, those using aversion therapies such as electroshock, which are now avoided given their ethical considerations, although they have shown documented treatment success in the past (Thorpe, Schmidt, Brown, & Castell, 1964; McConaghy,1969; Hallam & Rachman, 1972)[2]. Even without intervention, studies have shown that sexual orientation is not a unitary, one-dimensional construct (Weinrich & Klein, 2002). Kernberg (2002) mentioned women, whom therapists find have an *elective orientation*: "a late onset homosexuality that usually is preceded by an extended

[2] References are listed in chronological order, from here out, unless otherwise indicated, a deviation from the *Publication Manual of the American Psychological Association* (5th ed.) which suggests alphabetalization.

heterosexual life style and that may revert to a heterosexual life style." (p. 16).

As far as non-clinical sexual fluidity, homosexuals have shown evidence of this within the literature. Self-reported homosexuals showed variance in their sexualities and experiences when measured on a continuum as found by Bell and Weinberg (1978). In that study, 65% of homosexual men and 84% of homosexual women reported heterosexual intercourse (Bell and Weinberg, 1978). In another finding, of the homosexual women interviewed, 70% said their first sexual experience was with a man (Paczensky, 1984 in Warczok, 1988). Another study found that 43% of homosexual men had more than once engaged in heterosexual intercourse (Dannecker and Reiche, 1974 in Warczok, 1988). Finally, seeing an attractive women "intensively" excited 13% of a sample of homosexual men as reported by Warczok (1988, p. 181).

It was clear that on comparisons of cross-preference scales among homosexual and heterosexual men, homosexual men were likely to accept cross-preference sexual feelings while heterosexual men were not. That is, the heterosexual men do not report thinking about sex with the same gender; but, the homosexual men, will on occasion think about women, sexually. Thus, a shift in erotic preference is more likely in homosexual men, but not in heterosexual men:

one-third found in homosexual men, none reported in heterosexual men (Storms, 1980).

There is little documentation about shifts in erotic preferences of exclusively heterosexual men. While Greer and Volkan (1991) say that it is not unusual for heterosexual men to report "homosexual fantasies" (p. 109) in the course of psychoanalysis or intensive psychotherapy, erotic arousal was said to not accompany the fantasies. In their work with non-incarcerated men, Goyer and Eddleman (1984) reported that a previously self-identified exclusive heterosexual man changed his sexual preference as a result of being sexually assaulted by two men. According to Goyer and Eddleman,

> Mr. K, age 22, felt that his change in sexual preference was related to his having been raped by two men ... He claimed that before the assault he had a heterosexual orientation. After the assault, he experienced sexual identity confusion and began engaging voluntarily in homosexual activity (p. 578).

To add clinical weight to this phenomenon, Goyer and Eddleman (1984) presented other cases like Mr K's in their report.

Several approaches to report change in sexual orientation from homosexual to heterosexual have been documented in the literature using psychoanalysis,

hypnosis, behavior therapies, cognitive therapies, sex therapies, group therapies, religious-mediated interventions, pharmacology, spontaneous healing, unknown methods, combination of therapies, and others, which follow below.

Pre-Freudian

Charcot, in 1882 published a paper titled, *Inversion of the Genital Sense*. He united pristine psychiatry and congenital homosexuality through hypnosis. Charot, already famous for his treatment of hysterics through hypnotic induction, applied the same therapeutic modality to homosexual men and reported success in that "the homosexual patients became heterosexual" (Horstman, 1972, p. 5).

Albert von Schrenck-Notzing (1892) also recounted a case of treatment success using suggestion and hypnosis therapies. Prince (1898) reported treatment of sexual paraphilias, including homosexuality, and stated that 70% were essentially improved or cured (Fine, 1987). The terms *cured* and *improved* seemed to match those defined by Glover (1960).

Psychoanalysis

Sigmund Freud referred to homoeroticism as an *inversion*. Although many of his colleagues outright condemned homosexuality, Freud did not. He theoretized that the etiology of the male homosexual occurred as a result of a rejecting father and a close, binding mother, which intensified the oedipal rivalry as to inhibit the choice of a female partner (Hunt, 1993). Freud felt that given these circumstances,

homosexuality (*inversion*), in some cases, could be successfully treated (Freud, 1920a, 1920b). Suggesting psychoanalysis, Freud offered that a homosexual could change orientation if desired; however, he felt it was not always predictable or necessary (Freud, 1951). As Mitchell (2002) has pointed out, Freud was rather pessimistic about the possibility of a full reversal from exclusive homosexuality to exclusive heterosexuality.

It was alleged that Jung inspired a male homosexual to conversion through dream analysis and the break down of the negative child-mother bond, which had so intensified his sexuality (Fordham, 1935).

Following the tradition of Freud, Gordon (1930) reported a case where his homosexual patient made a *heterosexual adjustment*. Again, there was the problem of what exactly adjustment consisted of. Stekel (1930) reported 3 cases of complete cure using psychoanalysis after a 1-year follow-up. Anna Freud (1949, 1952) referred to 4 cases of which she claimed led to complete heterosexual orientation.

London and Caprio (1950) reported successful psychoanalysis with 2 men whereas they allegedly became heterosexual. Caprio (1954) expressed that there was ample evidence in the scientific literature to show treatment success of homosexuality. After 18 years of treating lesbianism, although no specific numbers were given, Caprio reported that many patients who resolved former childhood conflicts had been restored to complete heterosexual adaptation.

Bergler (1956) cited his 30 years of practice in which he had successfully concluded analysis of 100 homosexuals and stated that real cure toward *unfaked heterosexuality* had occurred. Bergler and his associates, using psychoanalysis, reported a 33% cure rate; that is, these patients where able to function heterosexually whereas prior to treatment they were exclusively homosexual. Ellis (1956) showed distinct changes in orientation with 11 out of 40, or 28% of patients treated, while 48% showed considerable improvement. Eidelberg (1956) claimed 2 out of 5 cases as successful after a 3-year follow-up.

An unpublished report of the Central Fact-Gathering Committee of the American Psychoanalytic Association in 1956 showed 56 cases of homosexuality undergoing psychoanalysis by members of the association, which described eight in the completed group (which totaled 32 cured, 13 improved, and 1 unimproved). This constituted of one-third of all the cases reported. Of the group of 34 that did not complete treatment, 16 were improved, 10 unimproved, 5 untreatable, and 5 transferred. In all reported cures, follow-up communications indicted assumption of full heterosexual role and functioning.

Curran and Purr's (1957) study of 100 homosexuals demonstrated only 1 subject completely changed in orientation and 5 who made a change *toward* heterosexuality. Allen (1958) reported treatment success in a number of cases, although the total number was not clear. In Berg and Allen's (1958) work, 3 out of

10 homosexual males showed successful treatment in terms of the diminution of homosexual interest and actions. Hadfield (1958, 1966) reported a 53% treatment success at a 30-year follow-up.

Robertiello (1959) gave a thorough report of a female homosexual, who after analysis with free association and dream interpretation, became aware of her unconsciousness, which led to oedipal resolution, whereas she became heterosexually adjusted. After a 2-year follow-up, she had not returned to her previous homosexuality. Beukenkamp (1960) treated a male subject with group psychoanalysis, which resulted in the subject's reorientation to heterosexuality in both behavior and experiences. Monroe and Enelow (1960) treated 4 men using psychoanalysis methods and after a 5-year follow-up found all of them *heterosexually orientated*.

Bieber et al. (1962) in a 9-year study of homosexual men, used an analyst team of 77 members, and provided information on 2 patient samples consisting of 106 homosexuals who undertook psychoanalysis. The results found 29 out of 106, or 27% of those completing treatment became exclusively heterosexual. Bieber (1967) found in a 5-year follow-up that 15 out of 20 subjects that they kept in contact with remained exclusively heterosexual. After 7 years, this success rate was still reported (Bieber, 1969). The subjects were followed for as long as 20 years, and treatment success defined by, excusive heterosexuality, was still confirmed

(Bieber & Bieber, 1979).

Coates (1962) treated 33 males and reported an outcome whereas 15% of the men resolved homosexual activity as a result of psychoanalytic intervention. Ovesey, Gaylin, and Hedin (1963) successfully treated 3 men and followed them as long as 7 years, reporting that all of them remained heterosexual. Cappon (1965) reported a 50% treatment success rate for males, and 30% for females. Mayerson and Lief (1965) reported that 47% of their 19 patients who had been in treatment at the Hutchinson Memorial Psychiatric Clinic of the Tulane University Department of Psychiatry and Neurology to be functioning heterosexuals after a follow-up with a mean of 4-1/2 years.

Mintz (1966) claimed to successfully treat 2 out of 10 patients during an 8-year period. Kaye et al.'s (1967) report of a research committee documented that 50% of homosexual women in treatment could be helped by the use of psychoanalysis. They also found that 56% of exclusive homosexual women treated made a shift to heterosexuality.

Socarides (1968) cited a 50% success rate in the psychoanalytical-based conversion treatment of homosexuals. Ten years later, treatment success was still supported; 20 out of 44 patients (44%) treated by psychoanalysis had developed to full heterosexual functioning, having no homosexual thoughts, behaviors, or fantasies (Socarides, 1978).

Jacobi (1969) referred to 60 patients treated in which 6 of them (10%) made a *definite* transformation to heterosexuality. Lamberd (1969), after a 1-year follow-up, reported 3 cases to be successfully treated. Ovesey (1969), after a 5-year follow-up, found 3 cases to be successful. Wallace (1969), after a 6-year follow-up, recounted that his subject reported continued heterosexuality; he married and led a normal heterosexual existence. While working with 12 homosexual women, Siegel (1988) found that more than half of them became fully heterosexual.

Berger (1994) described 2 cases of treatment success. One case "resulted in the patient marrying and fathering three children and living a heterosexually fulfilling and enjoyable life" (p. 255). The other was a "successful long-term psychodynamic psychotherapy treatment [which] helped relieve the patient of his original presenting symptoms and enabled him to become comfortably and consistently heterosexual" (p. 255).

Finally, a survey of 285 anonymous members of the American Psychoanalytic Association conducted by MacIntosh (1994) revealed that out of 1,215 homosexual patients analyzed by those members, 23% changed to heterosexuality from homosexuality, and 84% of the total group received significant therapeutic benefits.

Behavior and Cognitive Therapies

Behavioral-based therapies, not only have been used to treatment ego-

dystonic homosexuality, but used to treat, with said success, a variety of sexual conditions such as, impotence, frigidity, voyeurism, exhibitionism, transvestism, fetishism, and others (Rachman, 1961). Aversion therapies, aimed to change sexual behaviors of homosexuals have been used as early as the 1930s (Max, 1935). Davison and Wilson (1973) rated over 200 behavioral therapists and found a mean of 60% claimed success in treating homosexuality.

By use of adaptational therapy, a 40-year-old man who practiced homosexuality for 22 years was successfully treated, whereas he ceased his homosexual behavior, married, and claimed complete cure (Poe, 1952). Albert Ellis (1959) by us of Rational-Emotive Therapy (RET), of which he made famous, reported a subject changed to heterosexuality after a 3-year follow-up. Shealy (1972) reported another patient changed from homosexuality to heterosexuality by use of RET.

Despite problematic behavioral intervention, Freund (1960) reported that 26% of his patients treated reached heterosexual adaptation. Stevenson and Wolpe (1960) by use of assertiveness training reported treatment success of 2 homosexuals, which led to their establishment of heterosexuality. Treatment success was also confirmed at a 4-year follow-up. James (1962) reported successful treatment with the use of aversion therapy and a successful outcome in which the patient had no self-reported recurrence of homosexuality after an 18-month follow-up (James &

Early, 1963).

Schmidt, Castell, and Brown's (1965) treatment outcome after assessment by independent raters found 30% of the study's exclusive homosexuals had been *cured*, similar to the definition by Glover (1960). Solyom and Miller (1965) treated 6 male homosexuals, all but 1 suffering from neurotic anxiety, with the use of a double (differential) conditioning technique in which a projection of a picture of a seminude male was accompanied by an electric shock, while a photograph of a female was positively reinforced by termination of a continuous electric shock. Using plethysmograph response for objective assessment of therapeutic results, no change was found in autonomic responses to male pictures but there was an apparent increase in responses to sexually stimulating female pictures.

Mather (1966) reported that out of 36 homosexuals treated with behavioral and aversion techniques, 25 were considered much improved on the Kinsey scale. Kraft (1967, 1970) treated 2 men with systematic desensitization and some psychoanalysis and found that they responded as heterosexuals after treatment. MacCulloch and Feldman (1967) treated 43 homosexual men with aversion therapy and dedicated a career in the treatment of homosexuals using aversion therapy. Larson (1970) after use of an adaption of MacCulloch's and Feldman's approaches (anticipatory avoidance learning) also reported treatment success, however without specific counts.

Serban (1968) reported treatment of 25 homosexuals using existential therapeutic approaches. He conducted a case review and concluded that after his subject's erotic perceptions were changed, so did the subject's sexual orientation.

Fookes (1969) summarized the clinical experience of 5 years of aversion treatment given in 27 cases of sexual disorders. Success ranged from 60% with homosexuality to 100% with fetishism-transvestism, and no harmful effects of aversion treatments were discernible. The patients were said to have welcomed the changes, which consisted of the loss of desire for the behavior (seen as a *perversion*). McConaghy (1969, 1970, 1975) and McConaghy, Proctor, and Barr (1972) found successful subjective and penile plethysmography responses with applied aversion therapy in the treatment of various male homosexuals.

In Bancroft's (1970) study, 5 out of 15, or 33% desensitized treated homosexuals yielded significant shifts toward heterosexual behavior. Hatterer (1970) found in a follow-up of his treatment of 143 homosexuals that 49 or 34% recovered completely, that is, achieved a heterosexual adjustment. Using covert sensitization techniques, Cautela and Wisocki (1971) recounted a 37% success rate after a 1-year follow-up.

Feldman and MacCulloch (1971) worked with 36 patients using anticipatory avoidance learning therapy. They found a 57% treatment success after a 1-year follow-up. Feldman, MacCulloch and Orford (1971) reported follow-up results on

research done between the years of 1963-1965 with 63 male homosexual patients. They reported that 29% of the patients who had no prior heterosexual experience had changed. Change was indicated by the cessation of homosexual behavior, only occasional homosexual fantasies or attractions, and strong heterosexual fantasy, behavior, or both. Van den Aardweg (1971) related that 9 out of 20 patients treated using exaggeration therapy were completely cured. Cured, meaning no homosexual fantasies or behaviors were reported.

Hallam and Rachman (1972) administered a course of electrical aversion therapy to 7 patients complaining of "deviant sexual behavior" including homosexual impulse, and 4 made discernible progress while 3 failed to respond. After treatment, significant changes in heart rate response to sexual stimuli were detected. The successful cases showed a significant increase in the time required to imagine sexual material. The results were seen as providing some support for the conditioning theory of aversion therapy, although the use of electrical aversion is seen as unethical today compared to the 1970s.

Barlow and Agras (1973) found a 30% decrease of homosexual behavior in patients up to 6 months in follow-up utilizing the flooding technique. Maletzky and George (1973) reported on 10 homosexual males who were treated with covert sensitization behavioral therapy; after a 12-month follow-up, they indicated a 90% success rate.

Utilizing avoidance conditioning, classical conditioning, and backward conditioning, McConaghy and Barr (1973) found one-fourth of their patients ceased homosexual behavior totally after a 1-year follow-up. Freeman and Meyer (1975) used behavioral approaches and reported a 78% successful treatment rate in patients who were exclusively homosexual after an 18-month follow-up.

McCrady (1973) presented his work with a 27-year-old male, using a behavioral technique involving slide images with the goal to increase heterosexual responses measured by penile circumference measurements and the Sexual Preference Rating Scale. The client had been aware of homosexual attractions since about age 14. Initially, the client became fully aroused only at increments 19-22 (increment 20, for example, is the fading point where the nude female slide was only 10% visible and the nude male slide was 90% visible). As treatment (sessions 2-12) progressed, the penile circumference measures indicated that the client became sexually aroused earlier in each fading sequence. In sessions 9 and 10, peak erection occurred, on average, at increment 6 (the fading point where the nude female slide was 75% visible and the nude male slide was 25% visible). However, the client's degree of sexual arousal based on the Sexual Preference Rating Scale (done in sessions 1 and 13) was unchanged toward females and slightly increased toward males. Thus, no conclusive statements about change in attraction could be made.

The discrepancy may be due to an unintended conditioning. Initially, the

client became aroused only once the slide of the highly arousing male was fully visible. After a while, the client's earlier arousal while seeing the female slide may have been due to that slide signaling that the male slide would increasingly be appearing, and thus he became aroused in anticipation. During and after treatment, two other changes occurred. First, the client began to identify himself as no longer being homosexual. In the group therapy that he attended, he "frequently used or implied the phrase, 'When I used to be homosexual'" (p. 260). He also reported numerous occasions of heterosexual fantasy. No heterosexual sexual activity was reported, and there was no evident change in homosexual behavior or fantasy. Thus, all that can be said for certain is that the client's self-identification changed and heterosexual fantasies had either started or increased. Since no explicit statements were made about the prior existence of such fantasies, it is not clear which of the two is more accurate.

Cantón-Dutari (1974, 1976) used desensitization, aversion, and contraction-breathing technique to help active homosexual males to control their sexual arousal to homosexual images. Out of 54 patients, 48 were considered successfully treated, as they had attained the primary goal of controlling sexual arousal in the presence of a homosexual stimulus. Forty-four of 49 were able to perform adequately during heterosexual intercourse. Twenty-two were followed for an average of 3-1/2 years. Eleven of them remained exclusively heterosexual; the other 11 masturbated to

homosexual imagery but did not involve themselves in homosexual behavior. Four of the patients married.

Herman (1974) studied the use of classical conditioning of sexual response to female stimuli, using slides and films with homosexual content in 3 homosexual identified men using single subject experimental designs. Critical variables in the classical conditioning procedure were systematically introduced and removed while objective and subjective measures of homosexual and heterosexual behavior were recorded (e.g., penile responses and self-reports of sexual urges and fantasies). Subjects completed the Sexual Orientation Method before and after each experimental phase. In 2 subjects, classical conditioning was an effective procedure for increasing heterosexual arousal. In a 3rd subject, classical conditioning was not effective.

Orwin, James, and Turn (1974) reported the effective reorientation of a male homosexual by using electric aversion therapy. Tanner (1974) assigned 8 men who identified themselves as homosexuals to an automated aversive conditioning group (shock) and eight others to a waiting list control group following a pre-training assessment. At the end of 8 weeks, all subjects participated in a second assessment. The aversive conditioning group showed significant decreases in erectile response to slides of male nudes in self-rated arousal to male slides and on the Masculinity-

Femininity Scale (Mf) scale of the Minnesota Multiphasic Personality Inventory (MMPI), while showing significant increases in reports of frequency of sex with females, frequency of socializing with females, and the frequency of sexual thoughts about females versus males.

Tanner (1975) assigned 10 males completing avoidance training to modify homosexual behavior to either a booster or a nonbooster condition. Booster subjects received 5 additional sessions during the year following termination, while the control subjects had no contact during that year. One year after termination, subjects returned for an evaluation consisting of erectile response to slides of nudes, self-report of arousal while viewing the slides, the Mf of the MMPI, self-report of frequency of sex with men and women, frequency of thoughts about sex with men and women, frequency of socializing with men and women, and number of categories of sexual behavior engaged in with both sexes. No significant difference was found between the groups for any of the measures. When repeated measurement tests were used, however, 5 of 7 tests attained significance at the .05 level or beyond, indicating that the avoidance training per se was effective, but that the booster sessions did not increase the effectiveness of the procedure.

Using covert sensitization methods over a period of several years, Callahan, Krumbolz, and Thoresen (1976) reported at the 4-1/2 year follow-up that his client

said there was "no problem with homosexual arousal and that he has a good sexual relationship with his wife" (p. 244). According to measurement on the Kinsey scale, he was considered predominantly heterosexual. Others using covert sensitization also reported successful outcomes of shifts from homosexual behavior to heterosexual behavior (Mandel, 1970; Kendrick & McCullough, 1972; Segal & Sims, 1972).

By use of systematic desensitation, Phillips, Fischer, Groves, and Singh (1976) reported a successful behavioral outcome of a male patient. Their definition of success meant that the man was able to initiate heterosexual contact with an 18-month follow up with no homosexual activity. Similar behavioral results using systemic densitation were reported by Kraft (1967), Ramsey and van Velzen (1968), Bergin (1969), Huff, (1970), and S. James (1978).

McConaghy, Armstrong, and Blaszczynski (1981) attempted to evaluate behavior therapy for homosexuals in response to ethical objections of such treatment. Twenty subjects requesting behavior therapy to reduce compulsive homosexual urges were randomly allocated to either receive aversive therapy using electric shocks, covert sensitization, or both. Both groups were studied for 1 year. There was no consistent trend for one therapy to be more effective than the other in reducing the strength of compulsive homosexual urges, and the response to both was

similar to that reported in previous studies. It was suggested that aversive therapies in homosexuality does not work by establishing a conditioned aversion or by altering subject's sexual orientation. The authors concluded that they reduced aversive arousal produced by behavior completion mechanisms when subjects attempt to refrain from homosexual behavior in response to stimuli that have repeatedly provoked such behavior in the past.

Pradhan, Ayyer, and Bagadia (1982) demonstrated that by utilizing behavioral modification techniques, 8 out of 13 male homosexuals showed a shift to heterosexual adaptation that was maintained in a 6-month and 1-year follow-up. Van den Aardweg (1986a, 1986b) reported treating over 100 homosexuals using cognitive approaches and found that one-third of them had been *radically changed* in heterosexual adaptation.

As Throckmorton (1998) discussed, many behavioral counselors, largely from the 1970s era, have advocated for the use of a variety of behavioral techniques to achieve sexual shifts toward heterosexuality (Barlow, 1973; Barlow & Durand, 1995; Bergin, 1969; Blitch & Haynes, 1972; Freeman & Mayer, 1975; Gray, 1970; Greenspoon & Lamal, 1987; Hanson & Adesso, 1972; Marquis, 1970; Rehm & Rozensky, 1974; Tarlow, 1989; Wilson & Davison, 1974).[3]

[3] References listed in alphabetical order.

Finally, the level of success in decreasing homosexuality, claimed by behavioral therapists is essentially a third or more in reported cases (Birk et al. 1971; Bancraft, 1974). As stated previously, a high percentage of behavioral therapists surveyed said they were successful when they had a goal of helping them achieve heterosexual shifts (Davison & Wilson, 1973). The rates of success may be quantatively available for behavioral therapy outcomes; however, ethical issues, and advances in psychotherapy, prohibit the use of aversion procedures.

Group Therapies

Eliasberg (1954) presented an account of group therapy with 12 homosexuals and found 3 members who were able to experience a shift from homosexuality to heterosexuality. Thus, group techniques (group analyses of dreams) in 3 cases were considered successful. Hadden (1958) reported in the *American Journal of Psychiatry* that he treated 3 homosexual subjects where 1 experienced a shift to heterosexual adjustment. Smith and Basin (1959) treated 2 men in group therapy and noted 1 as having had marked improvement while the other sought heterosexual adjustment.

According to Litman (1961), a homosexual man was reported to have changed sexual orientation facilitated by group therapy. Hadden (1966) reported after treating 32 homosexuals in group therapy a 38% success rate in which subjects progressed to an exclusively heterosexual pattern of adjustment and showed marked

improvement in, or disappearance of, other *neurotic* traits after follow-up. Birk, Miller, and Cohler (1970) also reported a similar success rate of 33% and claimed significant improvements in a number of cases.

T. Bieber (1971) related over a 40% success rate by use of group therapy. Hadden (1971) confirmed a one-third success rate. Pittman and DeYoung (1971) expressed that 2 out of 6, or one-third of homosexuals treated received maximum benefit and established the goal of heterosexuality.

Truax and Tourney (1971) related that group treatment of 30 patients compared to 20 untreated controls increased heterosexual orientation, decreased homosexual preoccupation, reduced neurotic symptomatology, improved social relations, and increased insight into the causes and implications of homosexuality. Changes in sexual behavior included increased heterosexual dates, decreased homosexual experiences, and increased heterosexual intercourse. More improvement was seen in the associated neurotic symptomatology than in the homosexual orientation, although this latter parameter of functioning improved with further therapy.

Birk (1974) reported a 38% success rate after a 6-year period from a sample of 26 subjects (16 from the earlier study). Birk (1980) reported that 10 of 14, or 71% of men in treatment for over 2-1/2-years, and who were exclusively homosexual prior to treatment, were heterosexually adjusted (married) at follow-up.

Group therapy combined with other therapies has shown various, yet consistent, treatment successes over a 10-year period (Ross & Mendelsohn, 1958; Finny,1960; Buki,1964; Mintz,1966; and Miller,1968). Like behavioral therapy reports, group therapy reports a treatment success rate of one-third or more of cases making a shift in orientation.

Sex Therapies

Alfred C. Kinsey reported treatment of more then 80 homosexual men who had made satisfactory heterosexual adaptation (Pomeroy, 1972). Conrad and Wincze (1976) treated 3 male homosexuals with masturbatory conditioning (orgasmic reconditioning) whereas the 3 men were pleased with being able to perform with women and at the same time had no thought or a need for male sexual partners. The men reported complete adjustment to their sexuality. Thus, the study was considered successful.

In Masters and Johnson's (1979) treatment of 90 homosexuals, a 28.4% failure rate was reported after a 6-year follow-up (Schwartz & Masters, 1984). Masters and Johnson chose to report failure rates to avoid vague concepts of success. Although the failure rate was not equated in terms of success rate, it seemed valid to compare the success of their work with those reported in other studies dealing with change of orientation, according to Diamant (1987).

Hypnosis

As reported earlier, Charcot (1882) applied hypnotic induction to homosexual men and reported success whereas "the homosexual patients became heterosexual" (Horstman, 1972, p. 5). Albert von Schrenck-Notzing (1892) had similar findings (Fine, 1987). Cafiso (1983) related successfully treating a homosexual man by strengthening his ego through hypnosis. This corresponds with the positive reports of hypnosis from Regardie (1949), Alexander (1967), and Roper (1967).

Pharmacological Interventions

Owenshy (1940) reported 6 patients ceased all homosexuality due to the use of Metrazol. Similar findings with the use of Brevital, in conjunction with Wolpe's relaxation methods, were found in Kraft's (1967) report. Golwyn and Sevlie (1993) reported adventitious change in the sexual orientation of a 23-year-old homosexual male. After receiving Phenelzine for shyness and anxiety, the man reported he no longer had sexual interest in other men. The authors concluded, "Social phobia may be a hidden contributing factor in some instances of homosexual behavior and that Phenelzine, like other dopaminergic agents, might facilitate male heterosexual activity" (p. 40).

Other Interventions

Being coerced into therapy does not seem to work as in the case reported by

Fry and Rostow (1942) whereas 16 established homosexual men where pressured by Yale University to consult therapists which led to a *not at all satisfactory* outcome.

Woodward (1958) asserted 28 of the 48 patients who completed forensic treatment no longer had homosexual impulses. Seven of them moved to the full heterosexual category of the Kinsey scale. Whitener and Nikelly (1962) relate that 30 homosexual college students in treatment showed good results in one-third of selected cases. The Braaten and Darling (1965) study, also conducted on college students, showed that out of 76 male homosexuals treated in a college setting, 29% moved toward a heterosexual reorientation. There was no follow-up, however.

Martin (1967) reported on a 36-year-old homosexual man who was diagnosed with "character disorder" and received 2 years of individual therapy (two-year group therapy and aversion therapy) without success. After using LSD and working through an aggressive love-hate relationship with his mother, which eventually resolved through transference and a mystical experience, he was able to develop a strong heterosexual relationship with a woman he later wished to marry.

Experiential electrode brain stimulation, with the purpose to change sexuality, did not gain popularity past the 1970s, and the literature on the procedures remained scant. Moan and Heath (1972) conducted experiential septal stimulation on a 24-year-old, clinical, fixed, overt homosexual male patient with the purpose to

explore the possibility of using it to bring about heterosexual behavior. After completing the procedure's protocol, the patient's mood improved, he was more relaxed, and he became sexually interested in heterosexuality (he began watching heterosexual pornography), and later he participated in sexual intercourse with a female.

Liss and Welner (1973) recounted a client who received supportive therapy after failed attempts with aversion therapy. They reported that there was a complete reversal in his sexual behavior and that he became attracted to women. The authors did not disclose whether the client had homosexual fantasies or whether his attraction to men remained. The Kinsey writers acknowledged that some homosexual adults have allegedly been "cured" by brain surgery to destroy "inappropriate" sexual response centers (Bell, Weinberg, & Hammersmith, 1981, p. 219).

Eighty-six men who attended a non-clinical, experiential weekend retreat aimed at ameliorating same-sex attractions titled *Journey into Manhood* responded to a multi-question survey initiated by the organization (People Can Change, 2006). The men were asked what described their sexual feelings both before and after the weekend. The results showed that after the weekend retreat there was a 6% increase in the men reporting sexual feelings as "exclusively heterosexual, with no homosexual or interest at all" and a 13% increase in men reporting feelings that were

"primarily heterosexual, but with some slight homosexual feelings or interests." There was also a 4% decrease of men who described themselves as exclusively homosexual and having no heterosexual feelings or interests before the weekend, whereas they shifted to another category of describing themselves as having at least slight heterosexual feelings or interests after the retreat.

Dr. Nicholas Cummings is past president of the American Psychological Association and served for years as Chief of Mental Health with the Kaiser-Permanente Health Maintenance Organization. During the 20 years he was at Kaiser-Permanente (1959-1979) in San Francisco, he saw over 2,000 patients with same-sex attraction, and his staff saw another 16,000. Of those they saw in psychotherapy, 67% had good outcomes. They did not attempt to reorient same sex attraction to heterosexuality unless the patient strongly indicated this as the therapeutic goal. Twenty percent of the 67% successful psychotherapies did so reorient.

Spontaneous Change

Wolpe's (1969) patient, who was in treatment for assertiveness training, reported a spontaneous shift to heterosexual behavior even when the focus was not on changing it. Fluker (1976), a medical doctor treating gay-identified men for sexually transmitted diseases (not homosexuality) learned from one of his patients,

who was not in conversion therapy, that he no longer had homosexual inclinations and was happily married to a woman. Cameron and Crawford (1985) discovered that 2% of their random sample claimed they had once been homosexual which was not reportedly due to any intervention. Nichols' (1988) study mentioned a client who had spontaneously developed heterosexual interest and became bisexual to heterosexual in mid-life. Shechter (1992) reported spontaneous change in a male client who had been in psychoanalysis with her (not for treatment of homosexuality). She reported that he broke up with his male lover and was no longer actively homosexual. He began to fantasize exclusively about women. He got a girlfriend and said, "I can't keep my eyes or hands off of her, and she loves it" (p. 200). No clear statement was made about self-identification, except a quote by him where he asked, "Can someone like me suddenly be heterosexual?" (p. 200).

Michael, Gagnon, Laumann, and Kolata (1994) found that based on a national survey, some people even change their sexual orientation without psychotherapy. As mentioned previously, even without intervention, studies have shown that sexual orientation is not a unitary, one-dimensional construct (Weinrich & Klein, 2002).

Ex-Gay or Religiously Mediated Therapies

Christians view recovery from homosexuality as early as biblical times citing,

"… and this is what some of you (homosexuals) *were"* (1 Corinthians 6:11, New International Version, emphasis added). Exodus International, a parent Christian ministry for a coalition of more than 100 ministries and Christian counselors worldwide, offers individual, group, and educational therapy. Consiglio (1993) offered an overview of religiously mediated therapy for homosexuals and reported that Exodus International had evidenced 85% of the people it served as experiencing sexual reorientation.

Robinson (1998) provided a report about the results of interviews with 7 men from Evergreen, a ministry affiliated with the Church of Jesus Christ of Latter Day Saints (LDS). Robinson associated "change" of the subjects with 9 components, one was that they adopted a new interpretive framework concerning the causes and implications of their same-sex attraction, and another was that they no longer identified themselves as gay.

Pattison and Pattison (1980) reported successful religiously mediated change of 11 homosexual men while they participated in a Pentecostal fellowship. They used both pre and post surveys. On the post-change survey, 5 of the 11 participants reported no homosexual fantasies, behaviors, or impulses (0 on the Kinsey Scale). Three men reported a Kinsey rating of 1; and 3 other men reported a rating of 2.

Mesmer (1992) surveyed more than 100 people participating in an ex-gay ministry who had reported leaving the homosexual lifestyle and found 41% of them

had achieved complete heterosexual orientation.

Ponticelli (1996, 1999) conducted a qualitative study looking at the workings of Exodus International from the years of 1992-1994. She took a dual role in the study as both an observer and a participant. She interviewed 15 women and read testimonies of 12 women. She noted more about the women's change in their sexual identities and social supports, along with more positive spiritual outcomes, rather then a change in actual sexual orientation, per say. Erzen (2006) and Wolkomir (1996, 2006) found similar findings in their ethnographical studies of ex-gay residential programs.

Schaeffer, Hyde, Kroencke, McCormick, and Nottebaum (2000) surveyed 248 men and women at an Exodus International Annual Conference to determine if they were experiencing success in changing their sexual orientation and found a statistically significant effect based on changes over time. On both the feeling and behavior scales, participants rated their current sexual orientation as significantly more heterosexual than when they were 18 years of age. However, the study was severely limited as there was a lack of a detailed sexual history to verify the participants' self-rating or to determine whether there were significant shifts in behavior or feeling in the periods before and after age 18. In a follow-up study of 140 of the original participants, Schaeffer, Nottebaum, Smith, Dech, and Krawczyk (1999) found that 61% the male and 71% of the female participants had maintained

abstained from any same gender sexual contact in the past year of the study. Twenty-nine percent of this sample indicated that had changed their sexual orientation (0 on the Kinsey scale) in the past year of the study, and 65% said they were in the process of change.

Extending on the previous studies, Nottebaum, Schaeffer, Rood, and Leffler (2000) compared a 105 gay- identified sample with a sample of Exodus participants. The 2 groups reported good mental health, but the gay-identified group scored higher in that area. Both groups reported similar same-sex identities prior to age 18, but in the present study, the Exodus group reported more current heterosexual identification.

Anecdotal Accounts of Change

A number of personal stories of change have been produced over the years, mostly found through religious channels. Aaron (1972) wrote, "For twenty years I was homosexual ... Today, years away from all that ... I am functioning heterosexually and enjoying it" (p. 14). Offering spiritual guidance to others, Worthen (1984) shared his personal conversion out of homosexuality, as did Konrad (1987), Comiskey (1988), and Judkins (1993).

Breedlove, Plechash, and Davis (1994) also gave personal accounts of religiously mediated change as did, Strong (1994) who provided an account of his personal experience. Along these lines, Davies and Rentzel (1993) offered

testimonies of change in both male and female homosexuality.

Assemblies of Persons Claiming Sexual Orientation Can Be Changed

Ex-gays have collectively stood up to be counted. On May 22, 1994, in Philadelphia, for the first time in history, the American Psychiatric Association was protested against, not by pro-gay activists, but by a group of ex-gays claiming that change was possible (Davis, 1994, May 22). This was repeated at the 2000 convention in Chicago (Gorner, 2000, May 18) and at the 2006 American Psychological Association Convention in New Orleans (Foust, 2006, Aug 14).

Meta-Analyses

Clippinger's (1974) meta-analysis of the treatment results of homosexuality demonstrated that out of 785 homosexuals treated, 307 (40%) were cured or at least made some heterosexual shift.

James (1978) concluded that when the results of all research studies, up until that time, were combined, approximately 35% of the homosexual clients recovered, 27% improved, and 37% did not recover or improve. Based on this finding, she concluded that pessimistic attitudes about the prognosis for homosexuals changing their sexual orientation are not warranted, saying: "Significant improvement and even complete recovery [from a homosexual orientation] are entirely possible …" (p. 183).

Goetze (1997) brought together 17 studies and found a total of 44 subjects

total, who where exclusively or predominately homosexual, experienced a shift of some sort to heterosexual adjustment. Again, the issues of definitions were found to vary.

Jones and Yarhouse (2000) used meta-analysis to review 30 studies conducted between the years of 1954-1994. Of the 327 subjects from all the studies, 108 or 33% of them were reported to have made at least some heterosexual shift.

Byrd and Nicolosi (2002) used the meta-analytic technique for 146 studies evaluating treatment efficacy. Most studies were published prior to 1975, and 14 of which were published between 1969 and 1982 were used for the outcome analysis. The analysis revealed that the treatment for homosexuality was significantly more effective than alternative treatments or control groups for homosexuals. They concluded that the average patient receiving treatment was better off than 79% of those undergoing alternative treatments or when compared to pretreatment scores on several outcome measures.

Surveys of Consumers

Nicolosi, Byrd, and Potts (2000), with large efforts from the National Association for Research and Therapy of Homosexuality (NARTH), retrospectively surveyed 882 dissatisfied homosexuals with a 70-item, client-answered scale. After receiving therapy or engaging in self-help, 20-30% of the participants said they shifted from a homosexual orientation to an exclusively or almost exclusively

heterosexual orientation. Of the 318 who identified as exclusively homosexual before treatment, 56 or 17.6% reported that they viewed themselves as exclusively heterosexual at the time of the study.

With a smaller sample, Becksttead (2001) used a structural interview with 18 men and 2 women who claimed to have benefited from sexual orientation therapy. He reported that while their sense of peace and contention improved, he was not convinced of a change in sexual orientation. He stated, "Overall, a change in how to define sexual identity seemed to occur rather than a direct change in sexual orientation" (p. 103).

Shidlo and Schroeder (2002) interviewed (via 90-minute interviews, either in person or by telephone) 182 men and 20 women who were consumers of sexual orientation conversion interventions to find out how they perceived its harmfulness and helpfulness. The researchers recruited participants by advertising on gay and lesbian websites, in e-mail lists and newspapers, in non-gay newspapers, and via direct mailings to gay and ex-gay organizations. Of the 202 participants, 176 were considered as having failed conversion therapy and 26 as having been successful. Twelve were still struggling in that they reported "slips" or some incidences of homosexuality; 6 were still not struggling with same-sex attractions in that they were managing them; and 8 were termed to be in a "heterosexual shift period" (p. 253), whereas they rated 3 or less on the 7-point Kinsey scale, self-labeled as

heterosexual, reported having heterosexual behaviors and in a heterosexual relationship, and denied homosexual behavior.

Spitzer (2003), from Columbia University, interviewed 200 subjects who had participated in sexual reorientation processes by using a telephonic sexual orientation interview consisting of 114 closed-ended questions. Prior to intervention (using the Sexual Attraction Scale, "PRE"), 46% of the males and 42% of the females reported exclusive same-sex attraction. After intervention, (using the Sexual Attraction Scale, "POST") 17% of the males and 54% of the females reported exclusive opposite-sex attraction. By way of his findings, Spitzer stated, "Thus, there is evidence that change in sexual orientation following some form of reparative therapy does occur in some gay men and lesbians" (p. 403).

Karten's (2006) dissertation examined the sexual reorientation efforts of 117 dissatisfied same-sex attracted men who had undergone some type of intervention to change orientation. Using a 7-point sexual self-identity scale with 1 indicating exclusive homosexuality and 7 indicating exclusive heterosexuality, he found that on average at the onset of intervention, men reported a mean score of 2.57 (2 = almost entirely homosexual; 3 = more homosexual than heterosexual), and at the time of the study (after intervention), they reported a mean score of 4.81 (4 = equally homosexual and heterosexual; 5 = more heterosexual than homosexual). The shift was statistically significant.

Finally, a compliation and average of 3 recent consumer survey reports (Nicolosi, Byrd, & Potts, 2000; Shidlo & Schroeder, 2002; and Spitzer, 2003) can be found in Table 1, which yielded a 31% success rate. There was a huge disconnect in the success rates between the Nicolosi et al, 2000 and Spitzer, 2003 studies compared to the Shidlo and Schroeder, 2002 study. This was likely due to the researechers' methods of sampling. Nicolosi et al, 2000 and Spitzer, 2003 used samples from sourses that would likely give positive results (e.g from organizations such as NARTH), while Shidlo and Schroeder, 2002 used samples from gay sources, more likely to yield negative responses to reparative therapies. Nevertheless, in the end, the average still yielded a 31% success rate.

Limits of Studies

These outcomes studies, like all studies have limits. Particularly, the single case studies have limits because the data is objective, based on an individual therapist's reports, and not generalized to a larger body. Anecdotal accounts, are just that, and are not well received when more scientific means of study are available. While some studies rely on larger samples, they are often limited by self-reported data, non-randomization, retrospective issues, and other issues such as cognitive dissonance and social desirability. Many studies are limited due to the absence of control groups and correlative values, while many studies are criticized for lacking ideal measuring techniques, having methodological flaws, and

inadequate longitudinal and replicative factors.

Additionally, studies are weakened because sexual orientation is generally not clearly defined or understood (Gonsoriek, Sell, & Weinrich, 1995; Sell, 1997). For example, one may define himself or herself as *heterosexual*, yet still have homosexual tendencies; while another person may define himself or herself as *heterosexual* and have no homosexual tendencies. Yet, both may describe themselves as *heterosexual*. As for reporting success rates, complications remain. For example, in some reports, clinicians state success in that a client had heterosexually married, however as we know being married does not mean one is necessarily straight.

According to Schneider, Brown, and Glassgold (2002), *sexual orientation* is perplexing because one's self-identified sexual orientation may not be congruent with his or her sexual behavior. They say sexual orientation is best conceptualized as a continuum, rather than as a category.

General Commentaries

In a review of treatment successes, Karpman (1954) stated, "Every psychotherapist of experience must have in his records at least a few cases of analysis of homosexuality, exhibitionism, transvestitism, etc. that he has treated and cured or improved" (p. 390). Johnson (1955) related that change of sexual orientation, or homosexual to heterosexual, is possible with the best prospects for

counseling being the younger and motivated patients. These factors were also affirmed by Mendelsohn and Ross (1959). Bergler (1956) said, "The homosexual's real enemy is his ignorance of the possibility that he can be helped" (p. 176). Rubinstein (1958) reviewed his 10-year delivery of psychoanalytical treatment to persons desiring to diminish homosexuality and reported that a fair number of his patients were helped and improved well beyond original expectations. Fried (1960) verified previous analytical studies and reports that homosexual patients can and have been treated successfully.

Tarail (1961) stated that homosexuals could change through reconditioning therapy, physical and environment withdrawal psychotherapy, and motivation therapy, while Hastings (1963) optimistically stated that homosexuals treated with psychoanalysis may very well be cured of homosexuality. Ellis (1965) stated, "Fixed homosexuality is definitely curable ... Every homophile who truly wants to learn how to enjoy (and not merely tolerate) heterosexual relations can, with the help of a good therapist, do so" (p. 265).

Other authorities felt that change in orientation would follow once the patient disputed faulty assumptions of his distorted views through the use of existential analysis process (Brenda, 1963; Wolman, 1967). Doyle (1967) stated that treatment success can be obtained if the patient does not resist change and if the patient willingly works with an analyst for a sufficient period of time. According to Frank

(1967), homosexuals can be appreciably helped through psychotherapeutic techniques. Mohr and Turner (1967) plainly stated that all treatment of homosexuality was possible but unsuccessful if the patient was not motivated for change. Hadden (1966) found that "[Homosexual patients] give every indication of processing toward a reversal pattern" (p. 15).

Janov (1970) verified behavioral treatment of homosexuality and stated that by offering reality and educational type therapies, homosexuals could be cured. Newman, Berkowitz, and Owen (1971) stated, "We've found that a homosexual who really wants to change has a very good chance of doing so. Now we are hearing all kinds of success stories" (p. 22). In a Lacanian analytic persceptive, Dor (2001) asked, “What happens when certain analysts make the disappearance of the patient’s homosexuality the primary aim of treatment?” (p. 70). He offered the answer that, “only an idelogical argument implicitly based in sexual norms can underlie such a practice…[however] the only norms that exist in clinical psychoanalysis are those that govern the space of the treatment….this being the case, heterosexuality is a possible outcome of the treatment of a homosexual patient” (p. 70).

Frank (1972) stated in a paper to the National Institute of Mental Health, "A large number of case reports and systematic studies report that some homosexuals can be successfully treated" (p. 63).

West (1977) stated in an objective format that many studies performed on conversion from homosexual to heterosexual orientation have produced success not less then 30% for behavioral therapies, and about 25% for psychoanalysis. West went on to state that if facilities were more available and more practical, and if social and moral climates allowed it, statistics on treatment success would improve.

According to Marmor (1975), "There is little doubt that a genuine shift in preferential sex object can and does take place in somewhat between 20 and 50 percent of patients with homosexual behavior who seek psychotherapy with this end in mind" (p. 1519). According to Kronemeyer (1980), about 80% of homosexual men and women in his practice have been able to free themselves and achieve a healthy and satisfying heterosexual adjustment. Wolpe (1982), a world famous behaviorist, reported in a 20-year retrospect, successful behavioral therapy in treating several conditions, including homosexuality. Fine (1987) reported that regardless of the type of treatment, a motivated and willing patient will yield a large percentage of success. Nicolosi (1991, 1993) gives practical methods for treating the male homosexual and cites his and other's evidences of treatment success. Throckmorton (1998) reviewed the outcome literature, up until 1998, and concluded that, change in orientation was possible, but then said he did not know if he ever successfully helped anyone change sexual orientation because he did not know how

to define it. What he did admit to was that he saw clients who were attracted primarily to the same gender later declaring they were primarily attracted to the opposite gender.

Barnhouse (1984) related that psychiatrists and psychologists who state that changing orientation is untrue are falsifying scientific data. Wilson (1979) expressed, "Treatment using dynamic individual psychotherapy, group therapy, aversion therapy, or psychotherapy with an integration of Christian principles will produce object-choice reorientation and successful heterosexual relationships in a high percentage of persons ... Homosexuals can change their orientation" (p. 167).

Within the religious domain, Moberly (1983) expressed that change is possible with the help of religious motivation. Consiglio (1991), who worked with homosexuals for more than 15 years, also supported religious mediated change in his work. Keefe (1987) stated, "I have seen some homosexuals in treatment and have met more former homosexuals (including those who were exclusively so) ... who now respond physically and emotionally as heterosexuals in successful marriages" (p. 76). *Courage*, an apostolate of the Roman Catholic Church follows a simplistic, yet concrete view of success whereas celibacy is an acceptable outcome: "By developing an interior life of chastity, which is the universal call to all Christians, one can move beyond the confines of the homosexual identity to a more complete one in Christ" (Courage, 2007, ¶ 2).

While claiming that homosexuality is untreatable, Hemphile, Leitch, and Stuart (1958) did not offer scientific data as to why this is true but based their findings on the Curran and Purr (1957) study which failed to define what specific technique(s) was used and only claimed 1 case of sexual reorientation.

Past critics of sexual reorientation success allege that they lack conclusive evidence (Acosta, 1975); such evidence is not confirmed (Tripp, 1975); is unethical (Davison, 1976); immoral (Davison, 1978); unconvincing (Coleman, 1978); has methodological flaws (Haldeman, 1991); and has high failure rates (Murphy, 1991). The Kinsey Institute has long stopped their prior endorsement of interventions aimed changing sexual orientation. The explanation that the Kinsey Instititute gave about treatment endeavors, however, was that the studies' reported, "varying success rates" (Reinisch, 1990, p. 181) and that it was not socially acceptable (Bell, Weinberg, & Hammersmith, 1981). Other famous sexologists did not follow the Kinsey Institute's path rather stated that, with effective therapy, "very often a man's latent heterosexuality will blossom" (Helen Singer Kaplan in an interview with D. Klein, August 1981, p. 92). Kaplan made it clear that, "…with modern methods – many homosexuals can change to a heterosexual orientation if they want to do so" (p. 92).

Dr. Nathaniel McConaghy, whose many behavior therapy reports are mentioned herein, feels that predominantly omosexual men do not seek to be cured,

whereas it is mainly anxious, socially intimidated males at the fringe of heterosexual orientation who adopt a black-versus-white posture and seek professional help (Letters, July 2000). In Bancroft's (1970) study, 5 out of 15, or 33% desensitized treated homosexuals yielded change in orientation and behavior, however in Bancroft's own opinion, homosexuality did not need to be cured (Brancroft, 1975).

Duberman (1991, 2001), a gay-identified writer, wrote about his own negative experiences in reorientation therapy and generalized that it is impossible for anyone to pursue successful change. Along the same fashion, Ford (2001) and Moor (2001) told their own stories of unsuccessful attempts and self-perceived harm. Shidlo and Schroeder (2002) in their empirical study learned from several consumers who received reorientation therapies "that they were plagued by serious psychological and interpersonal problems during the therapy and after its termination" (p.254), however this was from consumers who were recruited for the purposes of documenting harm.

Beckstead (2001) said, "Hopes of experiencing heterosexual attractions and eradicating homosexual attractions may turn into disappointments" (p. 106). According to Beckstead, for those who fail therapy, the time spent in it is often perceived as painful. However, this draws from partisan opinion verses empirical data. Drescher (2001) criticized reparative therapists saying they only reinforce the

stigma of homosexuality that was present prior to the removal of homosexuality from the Diagnostic and Statistical Manual (DSM) in the 1970s. He felt they have moved toward embracing conservative religious dogma in their attempts to change homosexuals, therefore "stifling dissent" (p. 22). Schneider, Brown, and Glassgold (2002) asserted that mental health professionals who made a pathological diagnosis from homosexuality, "promulgated risky and often harmful 'treatments' aimed at creating sexual conformity" (p. 273).

Schroeder and Shidlo (2001) criticized the practice of therapies aimed at changing sexual orientation as not being ethically sound and feel they are of poor practice. Forstein (2001) does not believe it necessary to change a person's sexual orientation, but says there is no scientific proof that reparative therapies are necessarily harmful and unethical. However, he offered methodological questions for therapists to consider and provided basic guidelines for ethical intervention.

Ethics of the clinical use of reorientation-based interventions have been the primary concern of the major mental health organizations and professionals (Yarhouse, 1998; Throckmorton, 1998). In terms of ethical alternatives, "until the scientific debate is settled", Lasser and Gottlieb (2004) offer the following:

> Despite the obvious risks associated with conversion therapy, there are two possible advantages to treating the patients in this manner. First,…we must accept that in some isolated

and rare circumstances, conversion therapy might be effective. Second, even if the treatment is not successful, the patient may benefit in at least three ways. First, a genuine failed attempt may help the patient accept his or her sexual orientation. Second, the treatment may foster gains in other areas as a by-product. Third, the patient-therapist relationship is maintained, whereas a refusal to consider conversion therapy has the potential to prematurely terminate the patient-therapist relationship. (p. 198).

Even when therapies have shown failure of changing sexual orientation, secondary relieves such as discovery of sexuality identity, increased social supports, spiritual awakening, decreased anxiety, and other psychological benefits have been seen (Erzen, 2006; Karten, 2006; Lasser & Gottlieb, Nicolosi, et al, 2000, Schroeder & Shidlo, 2001; Spitzer, 2003).

Conclusion

Although there had been variants of treatment modes and attitudes, across various disciplines, towards the treatment of homosexuality (Lamberd, 1971), much of the premise for therapy of homosexuality had been that the homosexual condition was developmental in nature (hence, psychoanalysis) or learned (hence, behavioral

therapies) and could be changed to heterosexual adjustment. The outcomes of interventions aimed at changing sexual orientation varied. The outcome measures or *success rates* were generally defined by a shift in sexual desire toward heterosexuality either through self-reports, therapist reports, or through measures such as penile plethysomography, the 7-point Kinsey scale, the multi-item Klein Sexual Orientation Grid, and others.

Various paradigms and approaches have been used, such as: psychoanalysis, hypnosis, behavior therapies (including aversion), cognitive therapies, sex therapies, group therapies, religious-mediated interventions, pharmacology, spontaneous/unknown, combination of therapies, and others. The problem with most reports is the lack of clearly defining sexual orientation, homosexuality, heterosexuality, and what change means.

The reviews of psychoanalysis have shown that outcomes vary. Usually a consistent one-third success rate is synthesized from reports of behavior, cognitive, and group therapies. A 31% success rate was drawn from 3 recent consumer report studies (Nicolosi, Byrd, & Potts, 2000; Shidlo & Schroeder, 2002; and Spitzer, 2003).

As mentioned in the *General Commentaries* section above, some advocates of these therapies claimed they were helpful, and that change, in some cases, was fixed. Many have agreed that sexuality is fluid (Bell & Weinberg, 1978; Weinrich

& Klein, 2002; Kernberg, 2002). Critics of these specific therapies claim they can be harmful, while anecdotal accounts say the same (Duberman, 1991; Shidlo, Schroeder & Drescher, 2001; Shidlo & Schroeder, 2002). But, as Forstein (2001) said, "There are no studies … to provide these data" (p. 177). Largely, however, the shift of the treatment of homosexuality, due to its removal from diagnostic criteria as a mental illness, has evolved from amelioration to acceptance and normalization. The topic of sexual conversion has largely reduced to a social debate recently with medias like *People* magazine, the *Montel Williams Show*, and *CNN* making it a public forum, rather confusing, bias, and unscientific. Non-scientific advocacy groups such as the Human Rights Campaign, set out to discredit reorientation therapies without the credentials to do so (Human Rights Campaign,1998, August).

We trust that this comprehensive compilation of studies will highlight that there is documentation that change in sexual orientation is possible matching cleint's self-determination. The main limit of this report however, is that while we presented a narrative chronological review of the literature, we did not provide much in the way of a discussion of the studies' weakeness and strengths. Overall, we will say that the research literature is limited by sampling, assessment, and follow-up issues, however dispite the methodolical limitations of individual studies, there is nontheless compelling body of eveidence that some individuals can shift identity and

behavioral components of their sexual orientation after undergoing intervention. Most of the research has been conducted on men, however a number of theorists have argued that women's sexuality is more fluid and situationally influenced then men's sexuality. A gold standard study on interventions to change sexual orientation would be to include a randomized design, however, until we are at that point, we cannot conclude that change is not possible and therefore deny a client's right to treatment and self-determination. We must admit that once the 1973 decision to remove homosexuality as a mental disorder from The *Diagnostic and Statistical Manual II*, there as been a shortage of research in the area of homosexual identity development and treatment. As far as treatment, even gay-identified scholars state clearly that clinicians "have the ethical obligation…[that] regardless of pathology, cultural trends, or current political rhetoric, mental health issues for homosexuals remain clinically significant and, like all others, must be addressed by the clinician with competence" (Monachello, 2006, p. 56). The American Psychological Association (APA) code of ethics states, "Psychologists respect the dignity and worth of all people, and the rights of individuals to privacy, confidentiality, and self-determination" (*APA code of ethics* (2003), *General Principles, Principle E*). While homosexuality is no longer considered pathology per DSM, distress concerning sexual orientation is still considered as a DSM-IV subcategory, *Sexual Disorders Not Otherwise Specified*. Therefore, "The

developmental issues that contribute to 'the persistent and marked distress' about one's sexual orientation are valid areas of investigation (Morin & Rothblum, 1991, p. 3).

As one gay-idenified scholar has put it, "We should defend the homosexual client's right to choose professional support and assistance toward fulfilling his/her goals in therapy according to the client's own values and tradition. We should be committed to protecting our homosexual client's right to autonomy and self-determination in therapy" (Monachello, 2006, p. 57).

Table 1
Compilation and overall average outcome of recent consumer surveys

Survey	N	No. reporting exclusive opposite sex attraction shift; *fully successful*
Nicolosi et al. (2000) (1)	318	114
Schroeder & Shidlo (2002)	202	8
Spitzer (2003) (2)	183	96
	703	218 (31%)

(1) There was a total N=883 for the entire study; however, only 318 reported being exclusively homosexual pre-treatment and 114 exclusively heterosexual post-treatment.

(2) There was a total N=200 for the entire study; however, only 183 were calculated in the PRE and POST values to determine exclusive opposite sex attraction.

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(2) Whereas, the APA states: Efforts to change sexual orientation are shown to be harmful and can lead to greater self hatred, depression, and other self-destructive results.

We find a fair assessment is that both qualitative and quantitative studies have their value. It can be, for example, that therapy succeeds brilliantly for a few

individuals, but not others surveyed. The generalization that therapy rarely works would be highly misleading. It would be highly unethical to deny the use of therapy to all informed and volunteering clients, even if it were shown to fail for most of them. A drug which cured cancer in 1% of those who took it, but failed with 99% of clients, and in the short term made them nauseous as well, would not be banned but ethically endorsed as at least worth a try. Those using the therapies under discussion are anecdotally asserting considerably higher success rates than 1% (Throckmorton, 1998, 2002).

In the last few decades of the twentieth century, therapies diversified to the extent that proper sociological tests were very difficult to implement. This occurred because the modest numbers of clients for each therapy denied most sociological tests adequate statistical power. The few studies that were carried out lumped many different therapies together. Alongside this, post-modern philosophy insisted in the continuing validity of individual testimony. Thus, it implicitly endorsed both positive and negative stories of therapy without attempting to supply an objective means of resolving the conflict between them.

Three studies using sociological techniques were: Shidlo and Schroeder (2002); Spitzer (2003); and Karten (2006). Shidlo and Schroeder (2002) assembled negative instances for five years and the latter two papers assembled positive instances in much shorter time periods. Although this is tentative, the trend is for

negative instances to be much harder to find than positive outcomes. Shidlo and Schroeder (2002) chiefly collected stories of harm from therapy reported by individuals, presenting as many descriptive statistics as they could. The former two present stories of varying degrees of success of therapy with similar statistics. Since none of the papers from a sociological point of view could comment on the number who were temporarily in therapy but did not continue, the value of these three papers (as attested by their authors) is restricted to saying that, some people report positive results while some report negative results. This is almost certainly what an objective observer would probably conclude as well. An accurate success rate or harm rate is not attainable from these studies, and both rates might conceivably be extremely small, or quite substantial.

Nicolosi, Byrd, and Potts (2000), in their survey of 882 clients, found that in only 7.1% of cases clients said they were worse on three or more items of a list of negative consequences, which suggests minor sequela for those who stayed in therapy.

Undue harm as a result of reparative therapy is not supported by the literature. Brown (1996) declared reparative therapies to be "clear violations of the ethic of doing no harm" (p. 905), but, once again, the only authority for this was the anecdotal Haldeman (1991) paper and others of similar vintage.

If the criterion for valid therapy is taken from the results of sociological

surveys, then the standard must be open, universally agreed upon, and applied across all therapies in psychology. This has not been done; therefore, the playing field is not level.

Principles for Therapy

The National Association for Research and Therapy of Homosexuality (NARTH) agrees that usual professional standards should apply to therapies which try to change sexual orientation. Among those is the principle, "First, do no harm." Therapy ought not to lead to significant, immediate, or avoidable harm. Thus, NARTH believes it would be highly unprofessional to approve therapies which create large amounts of immediate self-hatred, depression, and other self-destructive results. Similarly, NARTH does not endorse any aversive therapy, and to its knowledge none of its members use such therapy. NARTH also believes any known significant down-side to therapy should be a matter of prior informed client consent, and any long-term negative effects of therapy which might be revealed by future research should be forestalled during therapy as far as practical.

All therapies (apart from those which try to change sexual orientation) may, and sometimes do, lead inadvertently to later indirect harm beyond the time frame of therapy. There is no valid literature which shows that this is any greater for therapies offering orientation change than for other therapies. At the most, there are collected cases of accusations by the dissatisfied, similar to what one would find for

any therapy in any field. It surprises many even in the caring professions to learn, for example, that there are many clients very disgruntled with standard treatments for alcoholism.

It may be argued that given the intensely political nature of the subject, there are surprisingly few accounts in the open published literature of harm resulting from reparative therapies. If such therapies were universally harmful, one would expect, in the current climate of opinion, a flood of reports giving numerically high harm percentages.

The statement, "shown to be harmful," is almost meaningless in the present context. In the absence of detailed literature it is simply untrue in a quantitative sense. If it means the therapies being discussed produce some harm, then all therapies in the entire field of psychology are equally guilty – all will have caused (usually inadvertently) damage at some time. We insist that a therapy with no obvious universal ill effects and anecdotal good ones, and historically a professionally supported case, is innocent until it is proven guilty.

Avoidance of Even Greater Harm

The prospect of not allowing therapy creates much worse harm. None of us can accurately predict future swings in public opinion. It is quite conceivable that refusal to offer reparative therapies to a client or class of clients, a large minority of whom subsequently die of AIDS, will in future be the subject of extremely

damaging class action suits. Precedents are found for this in institutional inmates suing parent organizations many decades later for defective care. The APA or other professional organizations could quite plausibly be sued in the future by relatives of ego-dystonic homosexuals for not providing desired service or preventing risks of the gay lifestyle. For example, many who come for reparative therapy, come so for the fear of the physical results of remaining in the lifestyle. Statistically the risk of life-threatening disease in the gay community is greater than the risk for any activity for any comparable sized group. Death is a much greater harm than self-hatred, depression, and related traits. Someone who wishes to avoid the risk of death should be helped – it is a disgraceful dereliction of duty on the part of a therapist not to do so.

Therapies and Harm

The statement that says, "Efforts to change sexual orientation are shown to be harmful and can lead to greater self hatred, depression and other self-destructive results," is a statement that does not specify which therapies. In view of the great variety of therapies actually used, this is impossible. It is attempting to say that all possible therapies now and in the future lead to harm.

Twenty-nine percent of therapists for all mental health conditions see client suicide (Anonymous, 1993). Therefore, therapy in general could be argued to lead to harm, which is a ludicrous conclusion. A better analysis would be that many were

prevented from committing suicide, and those that did commit suicide would mostly have done so with or without therapy.

Similarly, the recidivism rate of rapists after therapy, as given by Maletzky (1997) and Marques (1999), is 20%. This failure of therapy does not invalidate therapy for rape offenders (although they have not been obviously harmed by this failure).

Various professional organizations have position statements discussing disapproval reparative therapies, but no formal ban on such therapy has been put in force and would be met with extensive legal action if it were. Several discussions give the false impression that positions of professional organizations are more extreme than they actually are. Probably the most spectacular counseling/therapy failure in history, resulting in the death of tens of thousands, is probably that associated with safe-sex counseling. Rates of HIV infection have been resurgent in recent years, and in many countries they are as bad as before safe-sex counseling started. Although this may be associated with mental fatigue from overexposure to the safe-sex message, it is ludicrous to say that the counseling led to harm. Similarly, though less life-threatening, counseling to avoid teenage pregnancy has not avoided the emergence of a large group of sole mothers, often near or below the poverty line. No one would argue counseling in these areas should stop because it has not entirely fulfilled its ideal aim. Similarly, reorientation therapies, which have

been trying to avoid the greatest long-term harm imaginable to clients, cannot be fairly targeted as leading to harm.

Suicidality

Although Shidlo and Schroeder (2002) suggested that perhaps the most significant harm resulting from the therapies under discussion was suicidality, we now wish to show that an examination of their work demonstrates that long-term suicidality has not increased after therapy. On the contrary, it has significantly decreased.

From their account, we note the following numbers of persons they record were involved in suicide attempts before, during, and after therapy respectively were: 25, 23, and 11. From their demographic description, it can be inferred that the respective mean time periods involved were: 13 years, 2 years, and 10 years. (The pre-therapy figure of 13 years assumes an estimate of the establishment of a gay identity at a mean of 15 years). These are means only, and if distributions are highly skewed, adjustments could be needed. Taking into account the time periods involved, the expected suicide attempts (rounded down), assuming therapy had no effect, would be 29, 4, and 23; an equal rate per year in all three periods. A standard chi-square test examines whether the observed numbers, 25, 23, and 11, could be produced by random fluctuations of the expected numbers 29, 4, and 23. The probability of producing the observed distribution by chance is a negligible 8E-22.

The observed figures are not compatible with the hypothesis that they reflect a nil effect of therapy. What do they reflect?

Inspection shows that there is a relatively high number of attempted suicides during therapy (4 expected and 23 observed), and an unusually small number after therapy (23 expected and 11 observed). At first sight, this might seem to imply that therapy might be uniquely causing large numbers of suicides during its progress, but this is not so. Rather, it reflects the universal pattern seen in all psychotherapy. As demonstrated numerous times (Erlangsen, Zarit, Tu, & Conwell, 2006; Qin & Nordentoft, 2005; Qin, et al., 2006), when psychiatric patients are admitted to a hospital, attempted suicide rates rise to a very high level in the first week after admission, and there is a secondary peak the first week after discharge. However, the long-term effects are that the mean suicide rate is much less per unit of time than pre-admission, and decreases exponentially with age or even faster. This is usually interpreted as saying that treatment in hospitals has protected against suicide long-term, in spite of the short-term increased risk immediately post-admission and post-discharge. The same pattern is seen in Shidlo and Schroeder's (2002) data for those in reorientation therapies. This says that the increase during therapy is nothing abnormal, and that like therapies for other conditions, the long-term suicidality is less than pre-therapy, and in this case, because the worst possible examples were chosen, at least halved. It follows that, if anything, the risk of suicidality is

decreased by therapies in their study. Although causal links for suicidality are related by ex-clients, the sum of the actual attempted suicides are less than they would have been without therapy.

A fuller check on this would involve better controls, using detailed suicidality rates in matched gay people who did not undergo any therapies of the type described by Shidlo and Schroeder (2002).

Greater Homophobia

It is suggested by critics that one outcome of reparative therapy is a negative attitude towards homosexuality. "Conversion therapies by their very existence exacerbate … homophobia" (Haldeman, 1994, p. 225). This is a vague criticism. It is not clear whether it refers to clients, the general public, professional bodies, or all of them.

Professional bodies have increasingly been producing statements critical of re-orientation therapies, which shows the effect on them has been nil. Nor has internalized homophobia increased in the gay community as a whole. It should be noted from Figure 1 that opinions among the gay and lesbian community about origins of same sex attractions have changed far faster than for the public at large. Almost all of them believe they were born that way and are not to be blamed. This means that the continuing availability of therapy, and a considerable growth in the size of NARTH over that time, has had negligible effect on the self-evaluation of the

gay community as a whole.

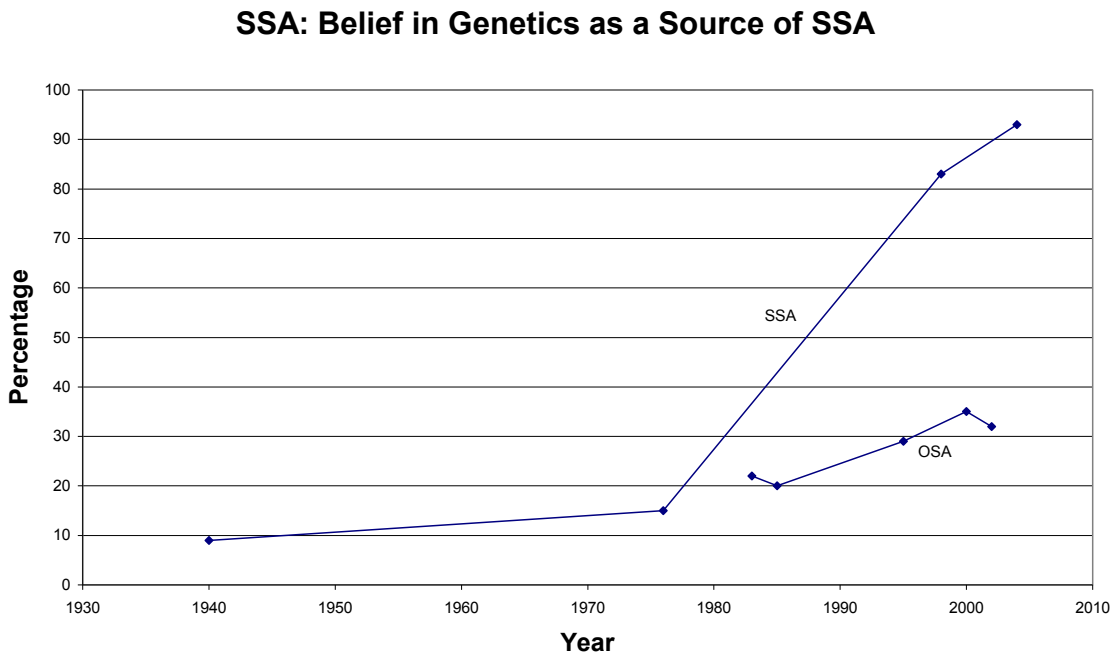

Figure 1. Changes in how Same-Sex Attraction (SSA) individuals have viewed the origins of their trait with time. A few Opposite Sex Attration (OSA) points are inserted for comparison (Cameron, 1988; Bell, 1976; Kryzan & Walsh, 1998; Otis & Skinner, 2004; Herek, 2002; Harris Poll 2000 cited in Schneider, 2006).

We show in the next few paragraphs that the public is certainly not affected. A clear trend in the last few decades, as shown in more detail in Figures 2 and 3 below, is for a greater belief in both the general public and the gay community that one is born that way. That indicates a growing belief in all communities that those with SSA are not to blame. The various therapies have had an unmeasurably small effect on general opinion, which has become much more positive.

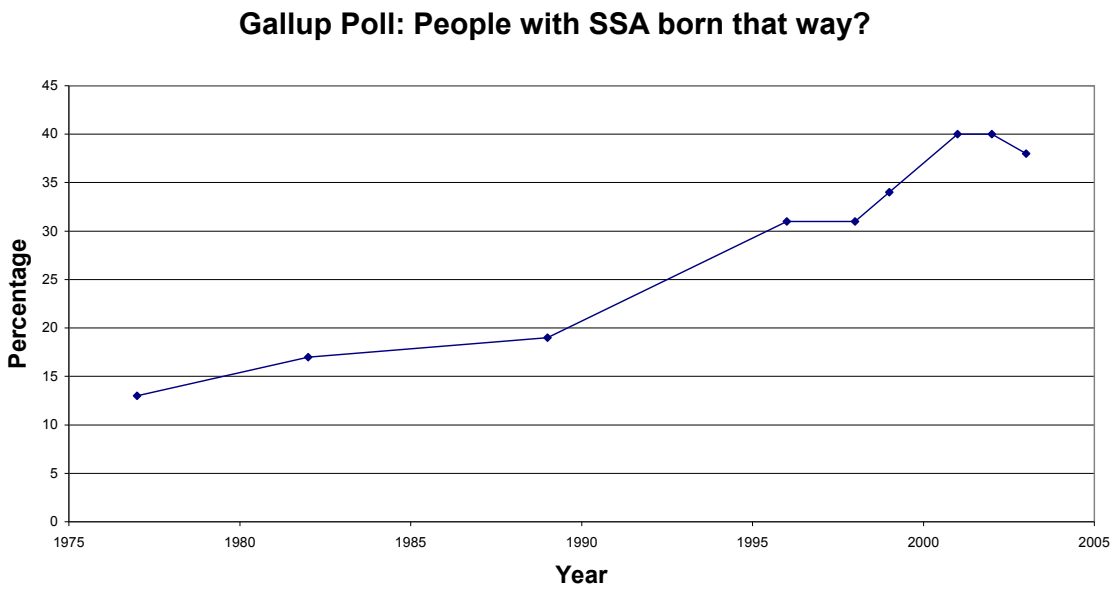

Figure 2. Changes in opinions of the general population about origins of SSA with time (Robinson, 2006).

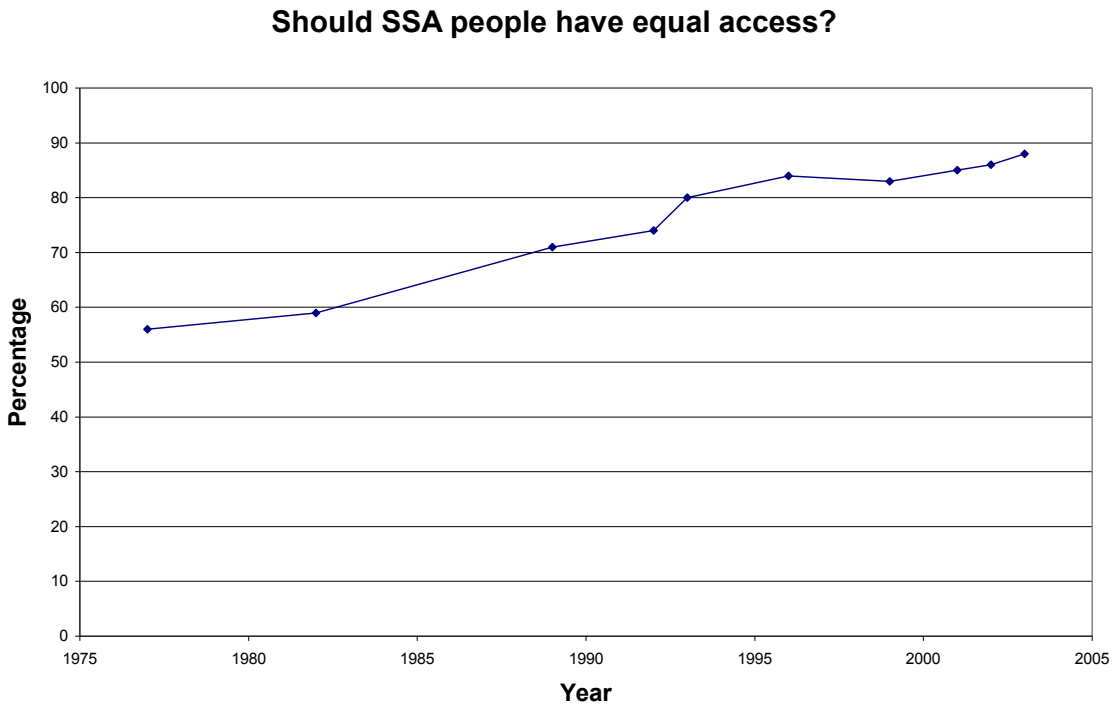

Figure 3. Changing opinions as to whether discrimination against people with SSA should be permitted (Robinson, 2006).

Figure 3 shows the increase of positive attitudes to those with SSA.

However, if the statement about homophobia is intended to not apply to the general public, but that those who have elected therapy gain more negative attitudes to SSA, this would be a valid criticism only if attitudes unsupported by the objective evidence were always inculcated by therapy, and this were shown to be an inevitable side-effect of all therapy. NARTH believes that objective facts should be the basis of attitudes and opinions, and that nothing beyond this needs to be given to clients, but is usually irrelevant to therapy, which does not necessarily deal with such issues

Summary

In summary, efforts to change sexual orientation have not been shown to be systematically harmful, nor to lead inevitably to psychological harm, and certainly in very many cases have psychological benefits beyond amelioration of SSA.

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(3) Whereas the APA sates: There is no greater pathology in the homosexual population than the general population.

We find that the pathology, unique to homosexuals, is not monolithic, rather seen in several paradigms:

AIDS-risk:

The prevalence, consistency, and relapse of high Acquired Immunodeficiency Syndrome (AIDS) risk-behavior among homosexuals is much higher than among heterosexuals. Even more strains of Human Immunodeficiency Virus (HIV) are being detected; a new drug-resistant strain was found in a gay New York man in his mid-40s who had unprotected sex with multiple men (Lombardi, 2005).

The incidence of apparent heterosexual transmission of AIDS in the United States had been rather low during the twenith century; approximately 10% of the total AIDS cases (Huether & McCance, 1996). Homosexual HIV/AIDS incidence was approximately 430 times greater than among heterosexuals (Odets, 1994a). Gays represented the highest rates of AIDS cases, for example in San Francisco, close to 96% of the city's AIDS cases represented gay men (Eskstrand & Coats, 1990).

Research data heavily confirmed epidemiologist's estimates. When one

cohort of 357 gay men (average age was 36, and most college educated) were interviewed regarding their sexual patterns, 4 months after the interview, the men were tested for antibodies to HIV and 36% were found to be positive (Martin, Garcia, & Beatrice, 1989). In another cohort of 508 gay men in San Francisco, 50% tested positive for HIV antibodies (Hays, Turner, & Coates, 1992).

There was really no difference between HIV-positive and HIV-negative homosexual groups in terms sexuality. In a sample of 121 in each group, both groups had considerable variability in sexual partner numbers and behaviors, and both put themselves at the same type of risk-related situations (Meyer-Bahlburg et al., 1991).

In terms of social characteristics and sexual behavior of self-identified bisexuals it was found that one-third of the male subjects reported unprotected anal intercourse with men in the previous 6 months (McKiran, Stokes & Doll, 1995).

In contrast to homosexuality, the risk of AIDS associated with the lack of condom use was greatly lower in heterosexuals (Satinover, 1996). Despite AIDS education, which was argued by pro-gay advocates to be essential in preventing AIDS risk, poor results had been yielded (Odets, 1994b). Higher education levels of gay men were not associated with safer sex motives. The Talking Sex Project conducted in Canada, found there was no impact of education on the knowledge of HIV risk through anal sex (Myers et al., 1992). The conclusion was that gay men would engage in unprotected anal intercourse repeatedly, despite the consequences.

Although previous studies were encouraging, to some, that the AIDS risk behaviors among gays had decreased (Martin 1987; Ekstrand & Coates, 1990), other

studies that had shown a high rate of low-risk behaviors, maintained that their numbers of inconsistency remained high (McCombs & White, 1990). Even when the reductions in high-risk activities were found, they only represented a small percentage, especially in reference to anal intercourse participators (McKusick, Horstman, & Coates, 1985).

Studies that found a large percentage of gays adopting safer behaviors, a still large percentage continued to engage in risky behaviors (Siegel, Bauman, Christ, & Krown, 1988). Even though gays proved to practice "safer sex" at some portions of the twenith century after the AIDS scare, they eventually relapsed from "safer sex" practices to riskier, more common practices (Kelly et al., 1991; Morbidity & Mortality Weekly Report, Nov. 22, 1991). This held true in longitudinal behavioral studies (1984-1991), in that more than one-third of a sample of 310 gay men relapsed to risky sex behaviors, while less than 9% reported consistent no-risk behaviors (deWit et al., 1993). Additionally, data derived from 402 gay men revealed that 72% of them reported at least 1 episode of unprotected anal intercourse during the follow-up phase of the study (deWit & van Griensven, 1994). According to Signorile (1995), "In a study financed by the Centers for Disease Control and Prevention, two-thirds of the gay men participating [said] they had had unprotected sex in the previous 18 months" (p. 5).

In a nationwide study in Canada, of 4,803 gays recruited from gay-identified sources, 23% reported at least 1 episode of unprotected anal intercourse prior to the study (Myers, Godin, Lambert, Calzavara, & Locker, 1996). In another nationwide study in Canada (Men's Survey 91: a sample of 500 men from 35 cities), the

proportion of those who "never" used a condom was 12.2% for insertive anal intercourse, and 11.5% for receptive anal intercourse. Given the risk of AIDS in the population (e.g. gays who frequent baths) those figures represented a significant risk factor in Canada. For example, a high proportion of unprotected anal intercourse was found in many Canadian sites: Montreal (57.1%), Ontario (73.3%), Vancouver (56.3%), and (Myers, Godin, Calzavar, Lambert, & Locker, 1993).

Health education did not seem to effect those participating in homosexual sexual activity. When a dozen risk reduction studies were reviewed, the researchers stated, "Even using cross-sectional designs, the efficacy of health education interventions in reducing sexual risk for HIV infections [among homosexuals] have not been consistently demonstrated" (Stall, Coates, & Hoff, 1988, p. 883).

And sadly, HIV/AIDS education findings suggest that there was little or no observable benefit to an increased sense of risk (Pryor & Reeder, 1993). However, it was consistency that mattered. The fact was that while risk knowledge was high among homosexual active men, it did not mean compliance to reduce high-risk activity (Kelly, et al., 1990a). The fact remained that only 1 incident of risk relapse was all that was needed to acquire the fatal disease of AIDS.

Homosexuals had great difficulty maintaining safer sex behaviors during the 20th century. They continued, repeatedly, to practice unprotected anal intercourse (deWit et al., 1993). Even with aggressive safer sex motives, the effectiveness was only partial at best (Kelly, 1992).

Gay or bisexual men knowingly infected with HIV continued to be promiscuous and seldom notified their partners of their HIV status. When 111 men

infected with the HIV virus (93% gay identified) were researched, 929 individual sexual partners were reported collectively among them. Less then 6% of their partners were informed of their risk by these men (Marks, Richardson, Ruiz, & Maldonado, 1992). Despite their knowledge of their HIV status, they deliberately infected others or put them at grave risk.

In a survey of 823 men who were either gay or bisexual were interviewed in reference to their beliefs about AIDS. During the 2 month prior to the study, 64% had engaged in at least 1 sexual behavior that was classified as "unsafe". They also reported having many sexual partners and frequently used drugs. They were also unlikely to discuss safer sex with their partners. Only 1% were reported as solely practicing safer sex. In the past 6 months before the study, the average number of sex partners was averaged at 11.4. It was also found that 24% reported at least 1 episode of unprotected active anal intercourse with ejaculation. Another 21% reported at least 1 episode of unprotected anal receptive intercourse with ejaculation (Linn, Spiegal, Mathews, Leake, Lien, & Brooks, 1989).

While anal sex with ejaculation is the highest most common risk for HIV infection among gays, evidence supported that oral transmission of HIV was also possible (Keet et al., 1992), and HIV seroconversion has been documented in homosexual men receiving receptive oral sex (Lifson, et al., 1990).

Sex, even with a condom, is not 100% safe since condoms can fail as high as 10% of the time. (Goldsmith,1987 cited by Martin, 1990). Failure rates are also contributed to errors in use (Martin, 1990). Condoms were found to likely break during anal intercourse due to greater amounts of friction and other stress involved

(Health and Human Services Publication FDA # 90-4239). The actual transmission of a virus is not visible to the human eye, thus homosexuals never fully see the risk of even their subtle behaviors. In addition, a person infected by the HIV virus can be asymptomatic for many years, thus many homosexuals spread the disease and think they are fine. The numbers have it, however, that many were not fine, in fact, epidemic portions of homosexuals either have died of AIDS or, are carrying the virus now.

HIV/AIDS in the United States afflicts a high percentage of those involved in homosexual behavior. About 63% of all cases have been amongst the gay population since the inception of the epidemic. This meant that gays were infected at the rate of 24 times the general population (Davies et al., 1993), assuming the 10% gay population theory by Kinsey, Pomeroy, & Martin (1948) was true; other recent studies reported a smaller percentage of the population as being homosexual, if that were the case then the rates of HIV would be that much greater.

By the early 1990's, about 60% of the cases of AIDS on the east coast were gay related, and 90% on the west coast. Twenty-seven percent of which were in 3 highly gay populated cities: Los Angeles, New York, San Francisco -- approximately 20-50% of total gay population at the time of the study (Kelly, Lawrence, & Brasfield, 1991). Specific gay neighborhoods were severely infected: Castro (80% gay) in San Francisco had an AIDS rate 7 times the rest of the city and Chelsea/Village in New York City, 4 times the surrounding urban complex, at the time of the study (Journal of AIDS, August, 8 1994). In addition, a significant portion of IV-drug users were also gay-identified, thus between the two groups a

large number of all AIDS cases were then represented (Bartlett, 1994). Although Los Angeles, New York, and San Francisco were considered "AIDS epicenters", homosexuals in smaller and less gay populated cities, were just as largely affected at the time of the study (Ruefli, Yu, & Barton, 1992).

Considered hallmark during the 20th century was unprotected anal intercourse among homosexual men. Some studies showed that over half of gay-identified men admitted to never using condoms during receptive anal sex (Valdiserri et al.,1988). In another study, the men who had 16 different partners in the year prior to the study averaged between 18 and 19 unprotected anal sex experiences in that same period (Kelly, Lawrence, Hood, & Bradsford, 1989). Over half of a cohort of 435 gay men in San Francisco reported practicing unprotected anal intercourse (McKusick, et al., 1990). In that same study, only 73 of 508 gay men reported being monogamous, although the exclusivity of their partner was not mentioned, and of them over 70% reported practicing unprotected anal intercourse. As mentioned previously, in a countrywide study in Canada, of 4,803 gay men recruited from gay-identified sources, 23% reported at least 1 episode of unprotected anal intercourse in the previous 3 months (Myers, Godin, Lambert, Calzavara, & Locker, 1996).

In 1988, gays' sexual behavior was studied from samples drawn from 4 Seattle gay bars. Over 400 surveys were completed and it was discovered that 29% of the respondents reported engaging in unprotected anal intercourse at least once 2 month prior to the survey. In 1994, the authors stated that the rate of unprotected anal intercourse had not changed much since the findings of the 1988 study, despite

the increase in the knowledge of AIDS (Steiner, Lemke, Roffman & Roger 1994). In a sample of 526 gay men from mid-size cities, 37% admitted to engaging in unprotected anal intercourse in the previous 3 months of the study (Kelly et al., 1990b). The latter study's sample were very educated and well aware of the AIDS risk. However, risk-taking was still commonplace, thus suggesting that a deeper psychological phenomena explained the risk involvement of gay men because a lack of education was not applicable. The gay dynamics in and of themselves predicted their vulnerability to AIDS risk and relapse behaviors (Kelly, St. Lawrence, & Brasfield, 1991).

In a sample of 61 gay-identified college males, over half admitted to having experienced anal sex, and a quarter who reported not using protection, reported unprotected anal intercourse between 4 and 5 times, 13% had done so 10 or more times (D'Augelli, 1992).

The San Francisco Young Men's Health Study, a household study of 380 unmarried men 18-29 years of age, revealed that 68% of homosexual and bisexual men had tested HIV seropositive. Sixty three percent of these men reported 1 or more receptive anal intercourse partners and 41% of these men did not use any protection such as a condom. The study noted that despite post-AIDS awareness, gays continued to practice risky behavior and thus widened the epidemic (Osmond, Page, & Wiley 1994). In fact, another study stated that unsafe sex was subconsciously accomplished due to gays' lack of wanting to survive, or as a way for them to more strongly identify with the gay community (San Francisco Department of Health, 1993).

In a sample survey of 6,000 men entering gay bars in 16 small American cities, to assess sexual behaviors and predictors of risky sexual practices, 27% of the homosexual men reported engaging in unprotected anal intercourse in the previous 2 months of the study. The risk also included having a large number of different male partners. These men also had a weak intention to use protection and believed that safer sex was not a norm in the gay community (Kelly et al., 1995). However, 1 single act of unprotected anal intercourse with a 20- to 30-year-old gay man carried with it a transmission risk of about 1 in 165 (Satinover, 1996).

Young gays also reported high incidents of unprotected anal intercourse (Lemp, Hirozawa, & Givertz, 1994). According to Dr. Linda Valleroy of the U.S. Centers for Diseases Control and Prevention, HIV was very high among young gay men, compared with the general population of U.S. youths. A 1996 survey of 1,781 men, aged 15-22, in 6 urban counties found that more than a third of these young men had anal sex, without a condom, 6 month prior to the study.

Among street youth, some 50% in New York and 40% in Seattle were gay-identified and close to 10% of them were already infected with the HIV- virus and it was estimated that even more were undetected or unreported, while the majority of them remained at risk (Messina, 1992). A study in London also found that half of young male street workers were gay-identified, and 21% of a sample of 50, said they had been found to be HIV positive (West, 1993). These findings were staggering since these youth represented fewer than 4% of the population at the time (Messina, 1992).

In another study, New York City gay and bisexual male adolescents

reportedly used protection such as condoms only after a year when they become sexually active. Protection such as condoms was either "never used" or "inconsistently used" by 52% of the 131 participants (Rotheram-Borus et al., 1994).

Offir, Fisher, Williams and Fisher (1993) conducted a qualitative, exploratory research project of open discussions about the increase of AIDS-prevention behaviors with 41 gay men. For many of the respondents, actual sexual practices of safer sex were erratic and, "respondents did not express motivation to initiate further behavior change" (p. 62). In terms of condom use, 39 out of the 41 admitted to at least 1 instance of unprotected sexual practice. One-third reported unprotected insertive sex and over half of them "indicated a general reluctance to use condoms during oral sex" (p. 64). The respondents however felt that their risky behaviors were merely atypical, situationally based, and not a true health risk.

Gay men were found, in fact, to be apathetic about their HIV test results. Two-thirds of those who volunteered for HIV testing did not even want to learn of the results. This was found in a multicenter AIDS cohort study from 1984-1990 of over 1,000 gay men in Chicago (Ostrow, Beltran, & Joseph, 1994). What revealed pathology was the fact that the majority of gays had unprotected intercourse and did not even perceive what they were doing was risky (McLean et al., 1994).

For reasons stated previously, unsafe sex is two-fold, not only sex without a condom, but sex with one also. In terms of the pathology of riskiness, anal intercourse and fellatio are health risk practices with or without a condom. Homosexual sex is not anatomically correct, a fact which is supported by the medical literature. Dr. Bernard J. Klamecki, a graduate of Marquette University

School of Medicine and a physician and surgeon specializing in proctology, wrote,

> The lining of the mouth cavity and rectum was not designed to be conductive to traumatic, ongoing push/pull motion of sodomy or fellatio. In contrast, the lining of the vagina is composed of cells that lubricate themselves and are resistant to the mechanical forces of intercourse. Persistent rubbing easily abrades, breaks downs, or injures the tissues of the mouth and rectum" (Yamamoto, 1990, p. 119).

Gays are often noted not only the use of the penis for insertive sodomy and fellatio, but use of large sized dildos, full fist and forearms, and other objects. As mentioned previously, anal sex with a condom is not safe. The Department of Health and Human Services issued a warning from the Surgeon General of The United States in their publication, Condoms and sexually transmitted diseases...especially AIDS (HHS Publication, FDA 90-4239), which stated very clearly:

> Condoms provide some protection, but anal intercourse is simple too dangerous a practice... even if a condom doesn't break, anal intercourse is very risky because it can cause tissue in the rectum to tear and bleed. These tears allow disease to pass more easily from one partner to the other. (p. 7, itailized emphasis added)

In another study, the gay men who had used condoms, 26% of them reported

at least 1 condom breakage during usage (D'Augelli, 1992). The risk of condom failure (e.g. breakage, slippage) in a single episode is extremely high for those who participate in condom usage during anal intercourse (Thompson, Yager, & Martin, 1993). As previously mentioned, condoms are not safe, and are more likely to break during anal intercourse (HHS Publication, FDA 90-4239).

Although the pathology is rapidly present here, some homosexuals argue and justify unsafe sex, as in this example:

> Unsafe sex can emerge from good and honorable motives. Although dismissed by hard-line scientists, statements such as "I want to please you" or "It seemed like the right thing to do" are not wimpish excuses but potential reasons. Unsafe sex is not irrational, but a different sort of rationally. (Davies et al., 1993)

In an article titled, "Sodomy and Stigma", Bruce Parnell says, "We need to acknowledge that it is reasonable for people to want to fuck without condoms", and the most appropriate strategy is to encourage individuals to, "consider for themselves what is and what is not appropriate behavior for themselves" (Molenaar, 1994, p. 2). It is this type of rhetoric, for example, which were very prevalent in the mainstream gay literature found in the 20th century.

Gay men regularly reported that out of boredom or despair, they'd practice unsafe sex (Kirp, 1995). Gay men stated that condoms were a barrier to intimacy and that their risky behaviors were considered to be "an important role in their lives" (Brendstrup & Schmidt, 1990). The prediction was that in a decade to follow, a

third or more of all gay men who were 20 years old would be infected, or dead from the AIDS virus (Kirp, 1995).

The fact remained that homosexually active individuals, well aware of the risk and despite the knowledge, at the time, continued to engage in unsafe practices. This was not sane. Some argued that risky homosexuals were not representative of the whole. However, when this was studied, it was found that there was no difference between homosexual males practicing safer sex and those practicing risky sex (Siegel, Mesagno, Chen, & Christ, 1989).

As stated previously, despite their knowledge, homosexuals repeatedly, continued in potentially fatal practices. Only after a brief time after the onset of the AIDS epidemic did the numbers decrease significantly. But they arose, nevertheless. This is not sane. Some researchers suggested it resulted from a cognitive distortion. They found that when it came to the gay individuals' interpretation for themselves, they revolted into a variety of misconceptions (Bauman, & Siegel, 1987). This too is not sane. Brenner (1991) in psychoanalytic work with gay men found that, for some gay men, there is an unconscious wish to develop AIDS.

Cognitive research does reveal that homosexual men do differ cognitively from others. In a discussion of cognitive research, it was reported that in 3 groups of 38 subjects each (heterosexual men and women, and homosexual men) the cognitive pattern of homosexual men was significantly different from the heterosexual men, but not significantly different from that of the heterosexual women (McCormick & Witelson, 1994).

The fact of the matter was also attitudinal. In a multi-site analysis study (Albany, Denver, & Seattle), 314 gay-identify men were asked about their intents to perform in specific sexual behaviors. The study found that the gay men's attitudes were the more important determinant of their intentions to engage in AIDS-related sexual behaviors (Fishbein et al., 1992). Gays obviously did not have a positive attitude since a positive attitude was better associated with behaviors that minimized AIDS risk. Ultimately, gays did not represent, collectively, those who consistently minimized AIDS-risk behaviors (Cochran, Mays, Ciarletta, Caruso, & Mallon, 1992).

A review of qualitative data has also revealed that, in fact, gays were not even concerned about the risk, for them, having unprotected sex outweighed the risk, which in the case of AIDS is 100% fatality. Quantitatively supporting this, despite the risk, 40% of homosexuals "never" used a condom during anal sex (Satinover, 1996). Thus, it went beyond apathy, lack of information, cognitive distortion or perception - rather, it could only point to a unique pathology.

What is really alarming, is the fact that gays with AIDS were left alone and estranged. Ethnographic fieldwork in Houston from 1984 to 1991 revealed that out of the examined individual cases of gay men with HIV/AIDS, all of them, except 1, lived alone. It was not merely the AIDS phenomenon that contributed to the estrangement; in the first part of the ethnographic work, 64 men were studied, and a high level of family estrangement was found to be independent of the AIDS phenomena itself (Lang, 1991).

Lesbians and AIDS

Contrary to popular belief, lesbians were no exception to the AIDS risk in the 20th century. The AIDS deaths among lesbians exceeded that of females in general by a considerable margin (Cameron, Playfair, & Wellum, 1994). Reports from the CDC showed that HIV was and still is, a health risk for women, and in fact is was the fourth leading cause of death for women between the ages of 25-44 years in the United States. This was most likely the case for lesbians since they report more cross-sexual behavior (sexual fluidity) (Bell & Weinberg, 1978; Einhorn & Polgar, 1994).

In a study of lesbian and bisexual women in the San Francisco and Berkeley area, of 498 surveyed, 6 had tested positive for the HIV virus. The rate of 1.2% exceeded the rate of .35% for women in general (Lemp, et al, 1995).

Another California survey by the San Francisco Department of Health also found that of the women surveyed - all of whom self-identified as lesbians – 22% claimed to have had sex with a man during the past 3 years and 47% said that did not always use a condom. Newsline sated that "additionally, over 10% of the women surveyed were injection drug users, and of this group, 71% have shared needles. It also appears that lesbians and bisexual women were much more likely to have sex and share needles with gay or bisexual men than heterosexual women [were]" (Lambda Report, July 1994, p. 9).

Lesbian activists said the data was more accurate than stereotypes in reflecting the reality of how lesbians and bisexual women lived their lives. "What we're really talking about is what lesbians really do," said Marj Plumb, the National Gay and Lesbian Task Force's health policy director, who told Out magazine,

"Lesbians drink and sometimes sleep with men or have unsafe sex..." Another study of lesbians, by the Kinsey Institute, found that 46% of self-identified lesbians in one survey had had penile-vaginal intercourse since 1980, and fewer than 6% used condoms (Lambda Report, July 1994, p. 9).

Sexual risk behavior among HIV positive homosexuals continues to be grim, dispite education and decreased social stigma. Van Kesteren, Hospers, and Kok (2007) reviewed research on sexual risk behavior among HIV-positive men who had homosexual sex after the year 2000. The review included 53 published studies that reported on unprotected anal intercourse (UAI) in cross-sectional and longitudinal surveys of HIV-positive men who had sex with men (MSM), and MSM who have mixed HIV status. Men were self-identified as either gay, bisexual, or as just men who have sex with other men. The findings indicated high levels of UAI among HIV-positive MSM, particularly with HIV-negative or HIV status unknown partners. In studies of MSM of mixed HIV status, they found that the rate of UAI among HIV-positive MSM was much higher than that of HIV-negative MSM. Furthermore, the prevalence of UAI among HIV-positive MSM had increased in recent years. Although studies indicated that HIV-positive MSM had adopted some risk reduction strategies, roughly 2 in 5 HIV-positive MSM continued to engage in UAI, which the risks and consquences are well known.

Summary

In the 20th century, homosexual HIV/AIDS incidence was approximately 430 times greater than among heterosexuals. Only after a brief time after the onset of the AIDS epidemic did the numbers decrease significantly. But the numbers rose again

as gay men relapsed back into their same behaviors. Having HIV/AIDS did not curtail the sexual behaviors of gay men. Studies showed that there was really no difference between HIV-positive and HIV-negative homosexual groups in terms of their sexuality. The rates of unprotected anal sex among gay men was found to be commonplace. Gay youth reported high incidents of unprotected anal intercourse and HIV was very high among young gays, compared with the general population of U.S. youths. Lesbians were no exception to the AIDS risk in the 20th century. The AIDS deaths among lesbians exceeded that of females in general by a considerable margin. The disposition of HIV/AIDS among homosexuals is just as grim as it always has been, dispite increased risk knowledge and decreased social stigma.

Violence

Another symptom underlying homosexuality is violence. Research in the twentieth century has shown that lesbians were found to be especially violent against others, mainly in their primary relationships. The role of rivalry, hostility, ambivalence, and over-idealized love objects added to this hallmark. This was found to be true in a study of subjects in psychoanalysis by Calef and Weinshel (1984). In an empirical study, a sample of 279 female college students revealed that the lesbians were generally more criminal and violent compared to heterosexual females (Ellis, Hoffman, & Burke, 1990).

Consistent with earlier findings, The National Coalition Against Domestic

Violence estimated that same-sex relational battering occurred in as many as 1 in 3 relationships (Berry, 1994). It is, and was, no secret that gay domestic violence is a serious problem within the gay community (Island, & Letellier, 1991). A problem which "has existed ever since gay men began coupling..." (Island, & Letellier, 1991, p. 1). Finally, gay men's domestic violence rate has shown to be greater than in the heterosexual community. (Seligsom & Peterson, 1992).

In a selected sample of 48 lesbians and 50 gay men, 47 percent of the sample had used physical assertive tactics within their intimate relationships. In comparison, the lesbians tended to report less physical aggressive partners than the gay men (Kelly, & Warshafsky, 1987). The prevalence of partner abuse in lesbian relationships was estimated between 25-33 percent (Koss, 1990).

Brand and Kidd (1986) compared 75 self-identified heterosexual women with 55 self-identified homosexual women who were demographically similar. The study claimed to show no significance between the frequencies of physical aggression in the primary relationships of the 2 dyads. Twenty-seven percent of heterosexual women reported abuse by male partners, while 25 percent of homosexual women reported abuse by female partners. Statistically, while this is not significant, there was a difference between heterosexual women and homosexual women in how frequent their committed partner physically abused them. As the study showed, the level of domestic abuse in lesbian relationships was similar to

heterosexual relationships statistically, but this did not reveal the real factor involved, which was that men overall are more violent than women in general. Therefore, the statistics should have been much lower for lesbian dyads compared to heterosexual dyads, but as the study showed, they were not. Therefore, the conclusion was that lesbian dyads were considered more violent than heterosexual dyads.

It was found in a non-statistical report that physical violence, emotional abuse, and acts of intimidation do occur with sufficient frequency in lesbian relationships (Hammond, 1989). Hammond, a psychotherapist, had personally found lesbians to be terrorized in their relationships. Patterns of violent incidents were found to be commonplace in the lesbian relationship. It was also found that "the battered lesbian may report that the emotional abuse and consequent diminishment of her sense of self [was] ultimately more damaging than her physical injuries" (p. 91).

Since violence among lesbians was so rampant, The National Coalition Against Domestic Violence published an anthology, titled Naming the Violence: Speaking out about Lesbian Battering. Several lesbians revealed their truths about lesbian violence. One lesbian, who was describing the lesbian bar, was quoted as saying, "On almost every occasion that I went and stayed until closing, there was an episode of violence..." (p. 11). Robon (1992) did not blame society for the violence

among lesbians, as so many homosexual advocates have done. She wrote, "The violence among us [meaning lesbians] is a serious problem. I do not think we should tolerate threats to our survival, even when they are self-generated" (p. 163).

In a 12-page questionnaire given to 42 lesbian couples, a large amount of respondents were found to be violent (Coleman, 1990). A survey of more than 100 lesbians who were self-identified and who volunteered the information, revealed that 9 out of 10 of them had observed or been the recipient of some form of aggression, whether physical, verbal, or sexual, in their family of origin. As adults, nearly three-quarters of these women reported experiencing aggressive acts, and more than half reported their past relationships as "aggressive." Nearly 45 percent reported physical aggression, 64.5 percent reported verbal/emotional aggression and 57 percent reported sexual aggression. Of those surveyed, 68 percent reported having used aggression in their lesbian relationships. About one-third of those reported the aggression as self-defensive measures, one-third as mutual aggression, and another third as both mutual and self-defensive (Lie,1991). In another study it was reported that 52 percent of the lesbian respondents had been abused by their partner (Lie & Gentlewainer, 1991).

Renzetti (1992) at one time taught her college students that the "lesbian relationship [was] not characterized by power struggles [which] plaque heterosexual relationships...(p. 1). However, one day after class one of her students handed her a

copy of the Philadelphia Gay News. In the edition, she read about a lesbian battering forum. After inquiring such, she learned that battering was a severe problem in the lesbian community. Subsequently, she devoted the next10 years of her tenure studying lesbian battering. In those 10 years of study, she was able to confirm that the lesbian relationship was, in deed, characterized by battering, and power and control.

In Rensetti's (1992) study of 100 lesbian women, 40 were personally interviewed. The study found that nearly two-thirds of their relationships, lasting between 1 to 5 years, were abusive. Twenty-five percent of the lesbians were involved in an abusive relationship for less than a year and 14 percent remained involved in an abusive relationship for more than 5 years. Experience of the abuse was early in the relationship, 77 percent of the participants experienced their first abuse less then 6 months into the relationship. In those relationships that lasted for 23 months or more were almost all abusive.

Although Rensetti (1992) found that violence in lesbian dyads appeared to occur at about the same frequency as violence in heterosexual dyads, the factors that gave rise to the abuse in lesbian dyads was significantly different. Interestingly, the lesbian, who was abusive, appeared to be intensely dependent on her victimized partner (usually the opposite is true in heterosexual dyads). Once the batterer grew more dependent, the partner exercised more independence. Rensetti (1992)

concluded:

> This in turn, posed a threat to the battered, who would subsequently try to tighten her hold on her partner, often by violent means. The greater the batterer's dependency, the more frequent and severe the abuse she inflicted on her partner. (p. 116)

In another study, questionnaires completed by 284 lesbians detailing the nature of their intimate relationships, confirmed that lesbian violence is not rare. Ninety percent reported one or more acts of verbal abuse. Although the type of abuse usually took more of a non-physical form, physical abuse, including severe forms, were employed as the primary method of resolving disputes. Thirty one percent of the lesbians reported one or more incidents of physical abuse. The physical abuse was reported to erupt around issues of power imbalance and/or a struggle for varying levels of interdependency and autonomy within the relationship (Lockhart, White & Causby, 1994).

From the advocate lesbian perspective, "butch" lesbians are considered as the most violent. Kennedy and Davis (1993) found that "both solidarity and aggressiveness, whether it be in protecting the ‘femme’ lesbian and the community or in testing their femme's loyalty, supports this assertion of control and power" (p. 320).

Prisoners are thought to be more violent than the general population but when matched groups of heterosexual and homosexual female prisoners were studied, serious violent crimes against persons were more characteristic of the female homosexual prisoner (Climent et al., 1977).

Criminality, Arrests, and Social Order

As stated earlier, in a sample of 279 female college students, the lesbians were generally more criminal and violent when compared to heterosexual females (Ellis, Hoffman, & Burke, 1990). Homosexuals were said to be more detrimental to social order, by their disproportional involvements with the criminal justice system, as reported in a controversial, non-random study of men and women by Cameron, Cameron, and Proctor (1989). In an earlier larger scale, non-random study of homosexual and heterosexual men and women, nearly half of the white homosexual men and one-third of the black homosexual men had been arrested or picked-up by police. These arrests were unbiased since the majority of the offenses were unrelated to their homosexuality. At the same time, a quarter of the homosexual women, whether black or white, had been arrested, thus comparative to the study's heterosexual sample, the homosexuals were more likely to be arrested and therefore considered more detrimental to social order (Bell & Weinberg, 1978).

Homicide

A high rate of violent crime leading to deaths is also a component of the

homosexual lifestyle. The lesbian murder rate was reported as higher than the non-lesbian murder rate (Cameron, Playfair, & Wellum, 1994). A study of samples from homicidal cases was conducted to determine sexual homicide (those charged with murders involving a sexual encounter with the victim). The sample covered a period of time from 1955 to 1973 and revealed that 3 out of the 5 or 60 percent of these cases involved homosexuality (Swigert, Farrell, & Yoels, 1970).

Rape/Sexual Coercion

A high rate of sexual coercion was found in homosexuality during the twentieth century. When 36 women and 34 men in homosexual relationships were asked about sexual coercion in their relationships, 12 percent of the men and 31 percent of the lesbians reported being a victim of forced sex by their current or most recent partner, at the time of the study (Waterman, Dawson, & Bologna, 1989). These are high rates considering such a small sample size.

Homosexuality and unprotected sex was also linked with coercion. A study on homosexual relationships found that 29 percent of the subjects reported being coerced into unwanted sexual contact; 92 percent of the time the coercion involved unprotected anal intercourse, thus increasing the already high risk of HIV infection (Kalichman & Rompa, 1995). Cross-culturally, similar findings were characteristic of homosexual active males in England and Wales, whereas 28 percent said they had been sexually assaulted or coerced against their will. One-third had been forced into

same-gender anal intercourse or other sexual activity by someone they had consensual sex with in the past (Hickson, et al., 1994).

Forced or coerced same-gender sex has been reported to have extreme consequences on it's victims. Prison is an environment where forced homo-sex is often noted. It usually serves as a power control issue coupled with the fact that opposite sex partners are not available. It should be noted, however, that heterosexual deprivation usually results more in abstinence and masturbation and not homosexual behavior (Kirkham, 1971).

In their work with non-incarcerated men (13 victims during a 2-year period), Goyer and Eddleman (1984) described a male patient, who had been sexually assaulted by 2 other men. According to Goyer and Eddleman (1984), because of the sexual assault, the patient discovered a change in his sexual preference:

> Mr. K, age 22, felt that his change in sexual preference was related to his having been raped by two men..... He claimed that before the assault he had a heterosexual orientation. After the assault he experienced sexual identity confusion and began engaging voluntarily in homosexual activity. (p. 578)

Another male patient complained after assault of heterosexual difficulties, "Mr. L attributed his difficulties in heterosexual relationships to his sexual assault three years earlier, [and] also experienced sexual identity conflicts" (P. 578).

Another victim exclaimed, "I don't feel like a man no more" (p. 577). The researchers also found their subjects to report somatic disturbances and mood disturbances in addition to problems of sexual identity and difficulties with peer relationships. This correlated with the earlier statements by Feldman (1956) who found that homosexuals shifted from heterosexuality to homosexuality because of some type of traumatic situation (see Chapter 1: The Clinicians).

In an earlier study, Guze et al. (1969) interviewed and followed incarcerated men for up to 9 years. Ten percent of them had been self-identified as homosexual before being incarcerated, but 14 percent were homosexual at the time of follow-up.

Goyer and Eddleman (1984) reported that they were convinced that adult male victims of sexual assault were more common than what had been suggested in the medical literature. In an earlier study, it was found that 18 percent of the gay men studied, admitted to being raped, of them, more than one-third experienced rape multiple times. The authors concluded, "...many men have been raped or forced to have sex (especially when younger or inexperienced)....these statistics indicate it occurs with alarming frequency in the gay male community (Jay & Young, 1979, p. 592). The authors noted however, that "rape as a subject for fantasy is not unusual [among gay men]" (p. 592). Finally, to reiterate earlier discussions, lesbians were found to report more rape than their heterosexual counterparts.

Summary

Domestic violence within homosexual dyads during the twentieth century was direful. The rates of battery were disproportionately higher in lesbian dyads and in gay dyads, compared to heterosexual dyads. The lesbian, who battered, appeared to be intensely dependent on her victimized partner (usually the opposite is true in heterosexual dyads). The lesbian relationship was discovered to be based on an imbalance of power and dependency and characterized by dysfunctional embeddedness and fusion. Along with the lesbians' domestic violence rates, gay men's domestic violence rates in the twentieth century were greater than in the heterosexual community.

Lesbians were found to be generally more criminal and violent compared to heterosexual females. A high rate of violent crime leading to deaths was also found to be a component of the homosexual lifestyle. A high rate of sexual coercion, including same-sex rape, was also found in homosexually oriented men during the twentieth century.

Substance Abuse

Alcohol

In a study by McCord and McCord (1960) overt homosexuals were most likely to become alcoholics. Swanson et al. (1972) found that lesbians had greater potential to have partners who were alcoholics. Sixy-seven percent of 28 black

lesbians in another study went to a bar at least once a week and 8 were classified as heavy drinkers (Sterne & Pittman, 1972). In the Weinberg and Williams (1975) study, most of the gay men went to bars, and close to 30% drank a lot more then they felt they should.

Researchers have consistently documented that up to a third or more of all gay American men were afflicted with drug and alcohol dependencies (three times greater than the general population) (Beaton, & Guild, 1976; Craig, 1987; Fenwick, & Pillard, 1978; Fifield, 1975, 1977; Lewis, 1982; Lohrenz, Connelly, Gyne, & Spare, 1978; Meisner, & Morton, 1977; Saghir, & Robins, 1973, Saunders, 1984; Skinner, 1994; Ziebold, 1979). Inconsistent with the majority of the findings, however, Stall and Wiley (1988) in their study analysis calculated a lower prevalence of frequency at 19%.

In studying metropolitan areas, researchers have indicated that approximately 1 out of 3 gay male adults abuse or are dependent on alcohol. This phenomena, however, is not limited to larger gay populated cities such as Los Angeles, New York, and San Francisco, but up to a third also in midwestern communities (Lohrenz, Connelly, Gyne, & Spare, 1978). At the time of study, Smith (1979) formulated that 1 out of 10 gays abuse or depend on alcohol in the entire population at large.

There is also evidence, which suggest that there is an association between drinking and participation in anal intercourse, and as we have learned, the incidence of anal intercourse is extremely high within the gay population (Martin & Hasin,

1991).

Many have argued that since gays are not afforded social benefits such as marriage for example, they somehow become maladaptive and therefore more likely to drink, however, the 1990 National Household Survey on Drug Abuse, which was representative of the general population at the time, noted that those in a gay relationship drank even more than those not in a relationship (Cameron, 1995). Another study that compared the prevalence rates of illicit drug use compared to the National Household Survey on Drug Abuse, re-confirmed that homosexuals had a greater use than nonhomosexuals (Skinner, 1994).

Polysubstances

Reductions in substance abuse behaviors amongst homosexuals have changed little over the century, and this fact has been supportively documented. Homosexuals consistently used drugs and alcohol moreover than their heterosexual counterparts (Holly, et al., 1989). (See also subsection, "Comparison to Homosexuals", below). A study in Boston between the time frame of 1985 to 1988 found that 80% of over 400 homosexuals used marijuana, 70% used amyl nitrate (also know as "poppers"), 60% used cocaine, 30% used amphetamines, and 20% used LSD (Seage, et al., 1992). When over 200 homosexual active men completed another questionnaire, it yielded that over 85% also reported alcohol use during the past 6 months prior to the study (Knowlton et al., 1994).

Amyl nitrite

Amyle nitrites (poppers) were popular among gay men in the 20th century not only for its euphoric effects, but because it made the muscles in the anus relax,

making anal sex more enjoyable. After interviewing 150 homosexual men, it was discovered that the use of amyl nitrite was strongly related to a number of unconventional deviant sexual practices as well as certain medically related problems. The findings held that 57% of those interviewed admitted to using amyl nitrite at least once in the past 6 months prior to interview (Goode, & Troiden, 1979). In another study published in the Lancet, of 250 gay men, 86% had inhaled nitrites within the past 5 years of the study, a proportion simlier to the 86.4% reported in STD clinics in Atlanta, New York, and San Francisco (McManus, Starrett, & Harris, 1982).

Intraventus (IV) Drug Use

Tens of thousand of gay American men have sought treatment for their drug addictions (Kus, 1987). Two government studies show that there is a heavy use of both non-injecting drugs and injecting drugs among gay men with 17% having used intravenous drugs (Lauritsen, 1993).

Teens

Nearly two-thirds of gay teens were classified as alcoholics (Leukefeld, Battjes, & Armsel, 1990). A survey of 131 gay and bisexual adolescent males in New York City revealed that the use of drugs and alcohol were mostly reported and their gay/bisexual sexual acts were significantly related to alcohol and drug use at the time of the study (Rotheram-Borus, et al., 1994).

Bing-drinking

Binge-drinking among gays was more frequent than those in society at large (Ostrow, 1990). In a sample of 1,000 gays, 90% of the respondents reported alcohol

binging. In addition to binging, other drugs such as amyl nitrite, marijuana and cocaine were also widely reported (Ostrow, Beltran, & Joseph, 1994).

Early Familial Constellations

Parker (1969) found that the gay males' alcohol disposition was attributed to a disproportionate level of feminizing in the family, preference for mothers, and absence of fathers, as well as the lack of masculine role model and that deviant sexuality (e.g. homosexuality) anteceded the onset of alcoholism. Earlier, Levine (1955) found that a large proportion of male alcoholics came from homes with overpowering mothers and greatly dependent, passive, and distant fathers.

Etiologies

Although Craig (1987) disagreed with Isaelstam and lambert (1983) that homosexuality was likely a cause of drug abuse or alcohol abuse, he stated that, "One question not answered by prevalence data is whether homosexuality preceded drug abuse, or whether drug abuse preceded homosexuality" (p. 1144).

It has been argued that societal pressures put homosexuals at high risk for substance abuse (Weinberg, 1972). However, such are merely claims without facts. A publication by The US Department of Health and Human Services (1994, Oct) while validating that, "It is commonly believed that factors such as stigma, denial, alienation, discrimination....place lesbians, gay men, and bisexuals at higher risk...", it concluded that, "... much more research [is needed] before we can substantiate this belief."

Lesbianism and Substance Abuse

Lesbian advocates have not denied that alcoholism is a widespread problem

in the lesbian community (Anderson & Henderson, 1985). In a national study of close to 2,000 lesbians found that 83% regularly used alcohol, 25% did so more than once a week and 6% every single day while 47% smoked marijuana (Ryan & Bradford, 1993). An ethnographic study of 53 lesbians in long-term alcohol recovery discovered that they had multiple addictions and core difficulties such as childhood traumas (Hall, 1994b).

The National Institute on Alcohol Abuse and Alcoholism once estimated that 30% of Los Angeles county lesbians had alcohol abuse problems (Fifield, 1974). In St. Louis, 36% of lesbians were reported to have alcohol abuse problems (Sandmaier, 1979). In support of these findings, it was confirmed that approximately one-third of lesbians studied abused alcohol (Fifield, 1980; Saghir & Robins, 1973).

There is scant literature on exploring the underlying reasons behind the lesbian's alcoholism. One study, however, which was an intensive descriptive study of 10 lesbians alcohol abusers, revealed that they had strong dependency needs and low self-esteem. One interviewee said she drank in order to overcome her sexual inhibitions. Her partner was said to be emotionally distant. Even when issues were resolved, there was high relapse (Diamond & Wilsnack, 1978).

It is certainly no secret that there is a strong association between lesbianism and alcoholism. It was suggested that it may be a myth that women drink in order to overcome sexual inhibitions, rather they drink due to their dissatisfaction of their sex life. In general, more than half of alcoholic women studied, reported dissatisfaction with their sex lives. Surprising is that the average women alcoholic reports a

decrease in heterosexuality (Schurkit, 1972), thus the aim of lesbianism.

Comparisons to heterosexuals

Research literature of the 20th century revealed that homosexual men compared to their heterosexual counterparts are about 3 times as likely to have an alcohol or drug abuse problem (Craig, 1987; Lewis, 1982; Saghir & Robins, 1973, Saunders, 1984; Skinner, 1994). A neuropsychology study yielded that homosexual men were also more likely to try drugs than heterosexual men (Hucker et al., 1986).

A review of the existing literature on the prevalence of alcohol use and problems among lesbians was conducted and it was found that fewer lesbians than heterosexual women abstain from alcohol use. The fact that more lesbians than heterosexual women have alcohol problems was found by Huges and Wilsnack (1994). The incident of alcoholism among lesbians was found to be 5-7 times that of heterosexual women (Johnson & Palermo, 1992). The fact that most lesbians find escapes from stressors through abuse of alcohol and other psychoactive substances have been documented consistently throughout the literature (Anderson & Henderson, 1985; Burke, 1982; Diamone & Wilsnack, 1978; Nardi, 1982; Weathers, 1980; Ziebold & Mongeon, 1982). Lesbian alcoholism is embedded so deeply that even with a support system such as Alcoholic Anonymous (AA), they do not respond as well as their heterosexual female counterparts (Hall, 1994a).

The lifetime prevalence of alcoholism traits was significantly higher in samples of lesbians when compared to demographically matched samples of heterosexual women. A systematic study of 57 homosexual woman and 43 single

heterosexual controls found clinically significant difference between the 2 samples in the increased of prevalence of alcoholism. In terms of excessive drinking, 25% were homosexual compared to 5% that were heterosexual. Over one-half of the homosexual women abused non-prescription drugs compared to 9% of the heterosexual controls (Saghir, Robins, Walbran, & Gentry, 1970; Saghir & Robins, 1973). Furthermore, lesbians claimed to get high on drugs more regularly than their heterosexual counterparts (Cameron, Cameron & Procter, 1989). The lifetime prevalence of heavy and problematic drinking was significantly higher for homosexual women compared to a demographically matched sample of heterosexual women (Lewis, Saghir, & Robins, 1982).

There are clear findings and agreement in the literature that supports the fact that homosexuals are more likely to experience alcohol problems than heterosexuals (Blume, 1985; Brandsma & Pattison, 1982). A survey of 2603 gays and 748 lesbians in a cross-sectional analysis found that, "Significantly fewer homosexuals abstain from alcohol or drugs than the general population, and rates of alcohol problems were high" (McKirnan & Peterson, 1989a, p. 555). The questionnaire that was used measured the frequency of alcohol intoxication and frequency of marijuana and cocaine use. On average, 42% of the gays and 32% of the lesbians reported that their social or recreational activities of which the authors noted were part of already being out, included alcohol use. This was significant since it was found that recreational uses of drugs and alcohol strongly correlates with alcohol problems. Therefore, this outness showed statistically to be a correlation to substance abuse, more so with the male homosexual. Thus, alcohol use, not correlated with core

difficulties in the homosexual community, has been established (Ziebold & Mongean, 1982).

The message was so clear in the 20th century that homosexuals had a greater substance abuse potential that it sparked capitalistic advertising strategies. For example, Earl Nissen of the Coors Brewing Co., told Advertising Age that gay consumers drank twice as much as the straight consumers so they adapted ads which would attract more gays to use their brand, and of course, yield more capital gains.

Drug use and sex

Substance use, prior to or during sexual activity, has always been a significant predictor of high-risk sexual behavior among gays. In the study by Mulry, Kalichman, and Kelly (1994), use of alcohol and other drugs before sex, above other factors, classified over 86% of a sample of over 100 gay men. In the San Francisco Men's Health Study it was discovered that there was a strong association between sexual behavior and drug and alcohol use in the gay community. Approximately three-fourths of a sample of over 500 combined sexual behavior with some form of drug use during the 6 months previous to data collection (Stall & Ostrow, 1989). However, gays did not see that as high risk behavior, but rather perceived it as general sexual motivation (Exner, Meyer-Bahlburg, & Enrhardt, 1992).

Drugs like amyl nitrite, referred to as "poppers", were found to be used widely by gay men to enhance sexual activity (McKirnan & Peterson, 1989b), this, however was not common with heterosexuals (Newmayer, 1992). It was also found that the use of amyl nitrite to intensify orgasms had passed into every corner of the

gay lifestyle (Silverstein & White, 1977).

Both amyl and butyl nitrites were commonly used among gay couples (McWhirter & Mattison, 1984). The use, however, was found to relate to a wide range of unconventional practices and consequences in which users were 30% more likely to contract a venereal disease than nonusers (Goode & Troiden, 1979). In a sample of 323 homosexual men in Alaska, nitrite, alcohol, and barbiturates use was indeed a prediction of AIDS-risk behaviors (Fisher, DeLapp, Roggenbuck, & Brause, 1992).

Earlier studies showed that drugs and alcohol was used in conjunction with sexual contacts by close to one-third of gays and lesbians with some frequency (Jay & Young, 1979). Forty-three percent of the respondents in The Spada Report admitted to drug use during sex (Spada, 1979). A later study in Boston of over 200 male subjects found that 40% used drugs with sex, and 57% used alcohol with sex (McCusker, et al. 1992). Consistent to the findings, it was stated that gays had an active enjoyment of both drugs and sex, and lesbians are more likely to use drugs in order to go through with sex acts (Newmeyer, 1992).

Research has shown that substance use among homosexuals in conjunction with their sexual activity is strongly related to unsafe sex and subsequential risks (Leigh, 1990; Stall, et al., 1986) (See also Chapter 2: AIDS Risk).

Another question, why has drug use during sex not been seen as a high risk behavior, but rather a general sexual motivation, as found by Exner, Meyer-Bahlburg, & Ehrhardt (1992)? According to one gay activist, not only was drug used for sexual motivation but also as an excuse to have sex without protection.

Greg Scott, a HIV positive gay activist in Washington, DC reported, "'But using drugs and alcohol allowed me to have sex without condoms. It provided the excuse'" (Signorile, 1995, p. 5).

Summary

Research in the 20th century has found that homosexuals were 3 times more likely to be dependent on drugs or alcohol than the general population. Other research has shown that nearly two-thirds of gay-identified teens were classified as alcoholics. Combining drugs and sex was found to be rampant in the homosexual community, the latter really a euphemism for heterosexual capitalistic plots and homosexual sex marketing. In the lesbian community, alcohol use is widespread and was often used as gateway to sexual activity.

Issues Across the Life Span

Gay Youth

Remafedi's (1992) exclusive study of 35,000 junior high and senior high students found that the majority (88%) described themselves as heterosexual, however 10% described themselves as "unsure" of their sexual orientation and only 1.1% described themselves as bisexual or homosexual. Discussing this study, Smith and McClaugherty (1993) stated that these findings suggested, "sexual orientation 'unfolds' between childhood and adulthood" (p. 34). Again, this gave weight to homosexuality as being a developmental, not a biological condition.

Savin-Williams (1994) found that gay youth were associated with school

problems, run away behaviors, substance abuse problems, prostitution, suicide, and other problems. A number of studies have also shown these facts (Erwin, 1193; Kourany, 1987; Prenzlauer, Drescher, & Winchel, 1992, Remafedi, 1987b; Rich, Fowler, Young, & Blankush, 1986; Roesler & Deisher, 1972; Rotheram-Borus, Hunter, & Rosario, 1992; Rotheram-Borus, et al., 1992; Saunders & Valent, 1987; Scheider, Farberow & Kruts, 1989). Subsequently, gay and bisexual youth were at greater risk for homelessness (Kruks, 1991).

Although some social scientists would say that parental and peer pressures were the stressors that led to the gay youths' maladaptation, Savin-William (1994) on the other hand, stated that that view was, "suggestive", and acknowledged "...a causal link between these stressors and outcomes has not been scientifically established..." (p. 261).

Aging

The excessive need and value for youthfulness and the despair of old age in the gay culture has been remarkable, unlike their heterosexual counterparts. "The dread of growing old is a noticeable feature of male homosexuals...", said West (1967). These features have been noted to cause significant distress among homosexuals. Gays "base their perceptions on beliefs found in the dominant heterosexual society," according to Bennett and Thompson (1991) however, if this were the case, then why was the youth-orientation more stronger in the gay community, and why did gay men see old age at around 54 years of age? One study summed up of the answer, years earlier, by their findings which concluded, "While [the] American society places an inordinate emphasis on youth, the homosexual

community, by and large, places greater emphasis on this fleeting characteristic" (Gagon & Simon, 1973).

A qualitative review discovered that gay men who have described the gay lifestyle in reference to the youthfulism and the despair of aging. The following was noted:

> [The homosexual] needs a life mate even more desperately, he feels, because of his increase need for communication with others like himself, so he need not feel so lonely. As a result, he searches for the idea type of person, who, he imagines, might help put an end to his problem and his search. He may not be a drinker, but he goes to gay bars, cruises the streets, and makes regular appearances at other places where homosexuals congregate, in hopes of meeting his idea type. Each passing sexual encounter is hoped to be the "one and only", but numerous short-lived affairs are usually the result. Time goes by. Years pass. The attractiveness of youth fades. The muscles become flabby. Gray hair increases. Bald spots appear. The affairs continue. As the man gets older, he must work harder to coax others to take an interest in him. If this fails, there is despair of old age, to be ended only by the inevitability of death. (Cory, & LeRoy, 1963).

Another homosexual man put it this way, "ninety-nine out of a hundred times, the older man is rejected sexually--not only by the young, but by the old"

(Ebert, 1977, p. 1). Another says, "There is ...the panic that one day you'll wake up to the fact you're through...that everyone has had you, that those who haven't have lost interest...that you've been replaced by the fresher faces...younger than you are now...and...someone will say about you: 'I had him when he was young and pretty'" (Rechy, 1963, p. 10).

It has also been found that there is much adomosity between the young and older gay (Berger, 1982) with the older homosexual, subsequently lonely. Homosexual men and women experienced more loneliness than heterosexuals in general. When older homosexual men and women were studied, consistently, more than half of them reported being alone (Friend, 1980; Kimmel, 1979; Minnigerode & Aldelman ,1978; Quam & Whitford, 1992; Weinberg, 1970, Weinberg & Williams, 1974). Isolation and depression was also found to characterize the middle years of the homosexuals' life (McDevitt, 1974).

The San Francisco Department of Health (1993) tells of a man who wanted to die for the fear of old age, "My boyfriend is willing to have unsafe sex with me. He doesn't want me to live to be fifty. He doesn't want [me] to be another aging queen, being jeered at by people like himself, being laughed at" (p. 11).

In the gay community, older gays are very frequently shunned by younger gays, many are referred to as "old trolls" and "aging queens". The above man's statement is supported by research proposed at a Dallas summit by Gil Gerald and Associates, et al. (1995). They reported that ageism among gay men created such negative feelings about getting old that many in the community had minimal interest in staying HIV-negative and living to experience old age.

Lesbians experienced ageism unlike heterosexual women since they dealt with the effects of being a triple minority, the combination of their age, gender, and sexual preference (Deevey, 1990). Lesbians, in comparison to gay men, placed less emphasis on youth and/or beauty (Kirkpatrick, 1992). Lesbians, like heterosexual men, did not place beauty on themselves. In contrast, heterosexual men, placed the value of beauty to their opposite sex attraction. Heterosexual women tended to place value on their own beauty. Therefore, heterosexual women were paralleled to homosexual men in that regard, while homosexual women were paralleled to heterosexual men.

The gay youth culture, during the 20th century, made it so that the person did not count, only the body counted. There was an extreme worship of youth and beauty (Hay, 1988).

Gay aging was also associated with a shift from family traditions (e.g. holiday celebrations). This was not the case among aging heterosexuals, who valued family tradition more so. In a field study, one gay respondent reported,

> Around holiday time I'd get very depressed. Everybody I knew would be going home to spend time with their families and I'd go too. It got tiresome playing the bachelor uncle. Although I liked the kids, everybody would talk about things I couldn't care less about....I stopped trying to make that scene. (Francher & Henkin, 1973, p. 671)

One study argued that factors such as positive coming out, greater support

networks, and the fact that gays had faced earlier crisis helped make adjustment better for the aging gay than their heterosexual counterparts. Nevertheless, on the other hand they stated that the older gays were maladjusted and had less positive aging experience than heterosexuals because of their lack of institutional supports. However, similarly, many heterosexuals experienced a lack of institutional support as well as ageism. So, where was the dichotomy? The author also used the argument there was diversity among older gays like there was diversity among older heterosexuals, however that never fully answered the question (Friend, 1980).

Finally, it would seem that older gays would have done away with "secretive adventures" and would have become more minstream, however it was stated that, "...many older homosexual men still interpret the closet and the secret society not as furtive, but adventuresome and special" (Lee, 1987, p. 63). This however does not support other theorists, who, repeatedly, claimed that homosexuals were, and are, closeted because of the pressures of society.

Self-worth

In the journal, Contemporary Sociology (vol. 2, no. 1) it was noted that, "...the evidence is strong that homosexuality arises in most instances from...poor self-image [and] low feelings of self-worth" (p. 3). Statistically, homosexuals generally scored lower on measures of self-acceptance than heterosexuals (Bell & Weinberg, 1978).

Data on eating disorders revealed that gay men and heterosexual women share emphasis on physical attractiveness and worry more about it. For the

heterosexual women this was a characteristic of their femininity, although overcompensated as in the case of eating disorder. Ultimately, lesbians and heterosexual men were less worried or concerned with their own physical attractiveness (Siever, 1994).

Heterosexual men targeted their functioning toward areas of achievements, success, personality, and intelligence rather than physical appearance and narcissism, the later, which was found to be more characteristic of homosexual men (Friend, 1987). Interestingly, Sulzberger (1955) observed heterosexual men who have failed in their ambitions reported homosexual fantasies; "As soon as status has been satisfactorily established…their temporary disinterest in the female sex disappears." (P. 436).

It is evident that heterosexual men have a different value about their physical appearance than homosexual men who, on the other hand, worry and overcompensate for it (Friend, 1987). This is likely due to the homosexuals' earlier imposed poor self-image of their own gender issues as well as underlying narcissism. As discussed earlier, homosexual men reported less masculinity and therefore had lower self-esteem compared to heterosexual men. This held true because when masculine scores increased, so did mens' self-esteem scores (Carlson & Stever, 1985).

Lesbians on the other hand, generally tend to be less concerned about

physical appearance than their female counterparts, which is also indicative of lower self-image. On the other hand, heterosexual women tend to concentrate on their physical appearance as a characteristic of their femininity. This held true because when feminity scores increased so did the women's self-esteem scores (Carlson & Stever, 1985).

Emotional conflict

Homosexuals are very likely to have emotional conflict. This was found in the measurement of independent and dependent variables. In a study of Belgian gays, whose country has been very tolerable of them, the independent variable of personal characteristics, and the dependent variable of unprotected anal sex behavior revealed that gays who experienced emotional conflict (independent variable) had lower scores on condom use (dependent variable). In addition, disapproval by significant others led to higher levels of unprotected receptive anal intercourse. Those with high belief in mastery (e.g. being in control) had higher risk taking behavior. Thus, if the gay experienced a negative variable such as emotional conflict, he was more likely to have sex without a condom, and if he experienced a positive variable, such as high mastery, he was more likely to go out and engage in a high risk behavior. In conclusion, the homosexual, whether experiencing a positive or negative variable, continued to engage in unprotected anal intercourse (usually receptive). As learned, homosexuals report extremely high rates of unprotected anal intercourse and since this was the case, they also had high levels of emotional conflict as the study showed (Vincke, Bolton, Mak, & Blank, 1993).

Healthcare problems

The healthcare problems and concerns of homosexuals tend to differ uniquely from heterosexuals at large. As a response, homosexuals have published specific handbooks about disease and health concerns related specifically to homosexuality, as well as the establishment of particular foundations and conferences during the century (Schwaber & Shernoff, 1984).

AIDS, a major health concern as discussed earlier, and other sexually transmitted diseases prevalent among homosexual, which will be discussed in more detail later, do not exhaust the many health concerns of homosexuals. For example, a high proportion of proctological practices among gays have been associated with anorectal and other colon diseases, one such was coined as Gay Bowel Syndrome (GBS) (Kazal, 1976).

Homosexuals compared to heterosexuals reported more somatic symptoms, (e.g. headaches, dizziness, pain, and nervousness symptoms) (Bell & Weinberg, 198). A sample a 102 homosexual men who attended a health fair, found that there was "strikingly higher" prevalence rates of intestinal parasitic infections among gay men compared with rates in the non-homosexual control group (Markell, Havens, & Kuritsubo, 1983, p. 177). The researchers concluded that, "...these infections are present in a large percentage of the gay community..." (p. 178).

Sadly, lesbians tend to disregard healthcare, or they seek out nontraditional alternatives and are therefore underrepresented in healthcare data. Although scant, some studies have been presented to show some healthcare concerns among lesbians. When large samples of lesbians and heterosexual women were compared, lesbians reported more appendectomies, and had begun menstruation later compared

to controls (Kenyon, 1968). Lesbians have also been found to have higher levels of testosterone and lower level of oestrone excretion (Loraine, et al., 1970). There were specific genecolgic concerns for lesbians, and vaginal infections of all types occured in women who were exclusively homosexual. Woman who were bisexual were, of course, at greater risk. This was discussed in a study of 117 lesbians conducted at the University of Iowa (Johnson & Palermo, 1992). It was also mentioned in the study that 80% of lesbians reported having had heterosexual intercourse, thus lesbians were more likely to have even greater risk of health concerns than those who were exclusively heterosexual.

Results from 186 self-identified women in Toronto who completed surveys were compared to Canada's General Health Survey and The 1986 Health Promotion Survey. The comparisons found that lesbians drank more, used caffeine more, and were not very knowledgeable about healthy diets. Lesbians also had a high incidence of mental health problems (Moran, 1996).

Sexual Transmitted Diseases

A clear relationship between the sexual behavior of homosexuals and sexuality transmitted diseases (STDs) had been established in the 20th century (Collier, 1987). Fluker and Cross (1981) reported that homosexuals accounted for a large and disproportionate percentage of STDs cases. They have long flooded hospitals with STD related conditions; these findings have been confirmed in a longitudinal study (Fluker, 1976).

Homosexuals reported significantly more STDs than the general population (Cameron, Proctor & Coburn, 1985). In comparison, 75% of male homosexuals

reported a lifetime incidents of STDs, 40% for the last year of study, while the general population had a 16.9% lifetime incident of STDs, 1.6 for the last year of study (Laumann, et al., 1994). In an editorial of one independent study of over 4,000 gay men, 78% admitted having at least one STD as indicated on the survey (Handsfield, 1981). In The Spada Report, two-thirds of the respondents had reported STDs (Spada, 1979).

Homosexual activity subsequently accounted for high rates of attendance to STD clinics. This was found in a very large random sample among 18,876 men and women ages 16-59 living in England. The researchers stated that their results were consistent with other studies in Europe and the United States (Johnson, et al., 1992).

In the U.S., the groups at the highest risk for developing AIDS are homosexuals and bisexuals. It was estimated that over half of homosexual men in some urban areas were infected with the AIDS virus. As discussed previously, the incidence of apparently heterosexual transmission of AIDS in the US was rather low; approximately 10% of the total AIDS cases (Huether & McCance, 1996). (See also Chapter 2: AIDS Risk).

Homosexual men had an increased risk of viral and even nonviral infections. These included gonorrhea, syphilis, and human papillomavirus (HPV) infections and many others (Hansfield & Schwebke, 1990).

Compared to heterosexual men, homosexuals were significantly more likely to have gonorrhea, syphilis, and anal warts than the general population (Judson, Penley, Robinson, & Smith, 1980). Holly, et al. (1989) in their study, found that

condylomata, or anal warts which is caused by HPV affected between 30-40% of homosexual men. In a longitudinal medical study, HPV and anal cancers were increasing among homosexuals (Surawicz, 1995). Anal HPV, the type most common among homosexually active men, usually incurs surgery to remove uncomfortable warts that tend to surface within the anal canal. This is an invasive surgery with no guarnetee the warts won't return. Life long worry and obsessive thoughts can proceed such surgeries as there is the the uncertainty that uncomfortable warts could, at any time return, or that there is the possibility other problems such as a risk of cancer since HPV is also a known cause of anal cancers as it is cervical cancers.

Homosexual men were discovered to have a much higher incidence of syphilis and gonorrhea (CDC STD Fact sheet, 1979; Darrow, Barret, & Jay, 1981; Fluker, 1983; Owen, 1980). Even after several years of decrease, the numbers of cases of gonorrhea continued to increase (deWit, et al., 1993). Since gonorrhea, and other STDs for that matter, may be asymptomatic, many more go untreated and therefore the rates were even likely higher (Berger, 1977). At the time of this writing, men who had homosexual sex developed a drug-resistant strain of gonorrhea (Palmer, 2006).

A high transmission of viral hepatitis A (HAV), hepatitis B (HBV) and hepatitis C (HCV) was common among homosexual men. In a comparison study, HAV antibodies (Anti-HA) were found in 30% of homosexual males verses 12% of heterosexual males (Corey & Holmes, 1980).

Cross-sectional studies have proven that HBV among homosexuals is due to

their risk practicing sexual behaviors, that is: active oral-anal sex, receptive and insertive anal intercourse, multiple partnerships, and the duration of homosexual practice itself (Kingsley, et al., 1990; See also Chapter 9: Sexuality). In male homosexuals, the seropositivity rates of HBV was said to be as high as 80%. At least 43% of a sample of 102 cases of HBV in Seattle in 1980, were gay men (Hansfield, 1981).

HBV can lead to death in some and may be a cause of liver cancers in others (Coleman, Waugh & Dayton, 1977; McCance & Whether, 1994). In liver biopsies of 25 homosexuals with abnormal liver-function tests, 56% of these proved to have chronic active hepatitis or active cirrhosis (Ellis, et al., 1979). When samples of serum of 2,523 inner-city emergency patients were tested, it was discovered that 21% of homosexual patents were infected with HCV (Kelen et al., 1992).

Research reported in the New England Journal of Medicine revealed that a high rate of herpes simplex virus (HSV) coupled with gastrointestinal symptoms was found among homosexual men (Goodell, et al., 1983).

Gastrointestinal symptoms were found to be high among gays and often associated with STDs (Rompalo, 1990). Enteric bacterial pathogens called shigellosis, giardiasis, amebiasis, infestations, and threadworms, which affect intestines and cause complications, are sexually transmitted were particularly high in prevalence among homosexual men (Fluker, 1983; Quinn 1986; Smith & Singer, 1994). Perianal carcinomas and anal warts also occurred more frequently among homosexuals (Holly, et al., 1989).

Chlamydia, often asymptomatic, was reported to affect between 5-15% of

homosexual men in the study by Quinn (1989). Of men attending a STD clinic in Houston, a significantly higher frequency of urinary excretion of human cytomegalovirus (HCMV) was found in random samples of homosexual men: 18% compared to 4% of heterosexual men (Grenberg, et al., 1984). HCMV was also found high among homosexuals in samples of semen and seminal fluid (Bigger, et al., 1983; Mintz, et al., 1983).

Homosexuals were exposed more to ectoparasites such as pubic lice and crabs. One study reported that 69% of male homosexuals reported a history of these ectoparasites (Billstein, 1989). A history of scabies was also reported in 22% of homosexuals in the study by Jay and Young (1979).

These high rates of STDs appeared to be consistent, over time, among homosexuals. In an earlier large scale study by the Kinsey Institute, it was discovered that over two-thirds of the male homosexual respondents had at some time contracted a STD as a result of a homosexual contact (Bell & Weinberg, 1978). Interviews with 150 gay men revealed that over half of the sample had contracted either syphilis or gonorrhea at least once (Goode & Troiden, 1980).

A series of interviews with gay youth found that they had an above average number of partners per year and that close to half of them reported a history of STDs (Remafedi, 1987b).

Lesbians were also found to be at risk for STDs. They experience all types of vaginal infections. Oral-genital methods common to lesbians, have put them at risk for herpes. Since heterosexual contact is also common among lesbian (80% of the lesbians reported heterosexual contact in the past) they are then at a dual risk for

STDs (Johnson & Palermo, 1984). It has been found that lesbians who report heterosexual histories are more likely to report a history of gonorrhea or syphilis (Ernst & Housts, 1984)

While it is clear that homosexuals have a higher rate and risk for STDs, the fear of contracting STDs was rated more important by heterosexuals than homosexuals, in a study by Leigh (1989).

It is often argued that the high rates of STDs reported among gays is not representative of homosexuals in general since the samples were drawn from STD medical clinics. However, among 4,212 respondents not sampled in STD clinics, "reported frequent infections with many of the same sexually transmitted diseases often seen in private medical clinics, public VD clinics, and gay health centers" (Darrow, Barrett, Jay, & Young, 1981, p. 1004)

Suicide

Earlier studies have showed a correlation between homosexuality and suicidal behavior (Whitlock & Broadhurst, 1969). One popular study found that more homosexuals than heterosexuals attempted suicide (Saghir & Robins, 1971). A systematic study of 57 homosexual woman and 43 single heterosexual controls, it was found that 23% of the homosexuals attempted suicide compared to 5% of the heterosexual controls (Saghir, Robins, Walbran, & Gentry, 1970).

When homosexual and non-homosexual women in prisons were matched and compared, the homosexual women reported significantly more suicidal attempts (Climent et al., 1977). In another study, 18% of the gay men compared to 3% of the heterosexual men attempted suicide at least once, and 25% and 10% for the women,

respectively (Bell & Weinberg, 1978).

The Department of Health and Human Services (DHHS) had reported that over one-third of suicides were committed by gays. This was cited as making them at least 2 to 3 times more likely to commit suicide than others. Forty percent of a study's adult homosexual subgroup indicated suicidal ideation. To add to this finding, they stated that "increase receptive anal sex behavior may in itself be considered a form of avoidant coping or suicidal behavior" (Ostrow, Beltran, & Joseph, 1994, p. 550).

Another study of 52 gay college men found that 55% reported a history of suicidal ideation (Scheider, Farberow, & Kruks, 1989). A review of 3 large, well-designed studies found that gay men and lesbians attempted suicide 2 to 7 times more often than heterosexual comparison groups (Saunders & Valente, 1987). Although attempts, or ideas of suicide, did not necessarily mean completion of suicide, it did increase the risk factors however; therefore, the conclusion being that homosexuals were more at risk for suicide completion.

Gay Youth and Suicide

Studies about youth who have attempted suicide have revealed that a disproportionately high number are homosexual (D'Augelli & Hershberger, 1993; Hendin, 1992; Prenzlauer, Drescher, & Winchel, 1992; Rich, Fowler, Young, & Blenkush, 1986). Gibson (1986) concluded that gay and bisexual youth are 3 times more likely to attempt suicide than heterosexual youth. The average age of a first suicide attempt was 15 years of age, with most commits between the ages of 16-21. The Pediatrics Department at the University of Minnesota found that nearly 30% of

gay adolescents had attempted suicide. Another study in New York City found that 34% of bisexual youth had attempted suicide, and nearly all had contemplated it. Findings from other studies were remarkably similar (Tielman, Carballo, & Hendricks, 1991).

A study revealed that out of 137 gay and bisexual males (ages 14-21) from the Upper Midwest and Pacific Northwest, 41 reported suicide attempts. Almost half of them reported multiple attempts. The study also added that attempters had more feminine gender roles and adopted a gay identity at an early age (Remafedi, Farrow, & Deisher, 1991). This debunked the theory that early outings create better adjustments.

A sample of 221 self-identified gay, lesbian, and bisexual youths by use of the Adolescent Health Questionnaire found that their scores were significantly associated with suicidal ideation and attempts: 40% had attempted suicide and 26% had seriously considered it (Proctor & Groze, 1994). Of 194 gay and lesbian youth (under age 21), 42% attempted suicide (D'Augelli & Hershberger, 1993). In a study of 138 gay-identified adolescents (ages 14-19), 39% had attempted suicide, and of those who had attempted, over half had more than one attempt (Rotheram-Borus, Hunter, & Rosario, 1994).

Mortality

A gay journalist wrote, "So where do the gay men go?...It's going to be interesting when our generation hits retirement age...assuming we haven't died of AIDS" (Biemiller, 1991, p. 29). As Satinover (1996) had pointed out, there was an approximately 5 to 10-year decrease in the life expectancy of homosexuals and

AIDS further shortened the life span of gay men by an even greater margin.

In a content-analysis study of over 6,000 obituaries (from 1986 through 1993), it was found that the homosexuals' life span, even apart from AIDS and with a long-term partner, was significantly shorter than that of heterosexual married men in general. The average life span of gays is in the mid-40s, if AIDS failed to intervene and in the late 30's-to-early-40's, if it did not. The study also reported that 163 lesbians registered a medium age of death at 44. The lesbians exhibited high rates of violent death and cancers as compared to women in general. In literature, up until the time of the published study, it was consistently found that old homosexuals appeared to be proportionately less numerous than non-homosexuals. AIDS, however, was stated to reduce the homosexual's life span by only 10%, thus the morality of homosexuals, apart from AIDS, held a much grimmer force (Cameron, Playfair, & Wellum, 1994).

Summary

Life, health, and mortality are of unique characteristics amongst homosexuals. Art imitates life. Medias such as art, sociolinguistics, and non-verbal communications can directly point to the gay men as some findings has shown. Gay youth are associated with an array of problem, with suicide as being one most serious. The aging process amongst gays has been found to uniqucly despairing and unlike heterosexual aging. The homosexual life has an array of other problems such as self-discrimations, low self-worth, and emotional conflicts. Healthcare related problems are hallmark to the homosexual, not just AIDS, but other STDs and related

problems. Morality rates for homosexuals are much higher than among heterosexuals as are the rates of suicide for both adult homosexual and homosexual youth.

Sexual Abuse and Offending

Rape, incest, and other traumatic experiences of lesbians

Over half of lesbians compared to heterosexual women, were raped before the age of 15 according to a study by Gundlaugh and Riess (1967), and subsequently, rape victims reported significantly more lesbian experiences (Belcastro, 1982). When 40 lesbians were compared to 40 heterosexual women in a clinical setting it was found that the lesbians differed significantly from the heterosexuals in that they reported greater abusiveness (Swanson, et al., 1972).

It was found that lesbians' experiences and lifestyles were related to earlier incestuous experiences (Cameron & Cameron, 1995; Cohen, 1983; Finch, 1967; Forward & Buck, 1978; Gagnon, 1965; Meiselman, 1978; Peretti & Banks, 1984; Simari & Baskin, 1982; Yorukoglu & Kemp, 1964), therefore lesbianism was considered "an effort to find a mode of sexuality that would be less conflict arousing than heterosexuality and to escape the chronically masochistic lives they had been living" (Meiselman, 1978, p. 254).

Forward (1978) noted that female victims of heterosexual incest may resort to homosexuality as a way to escape anxiety and sexual dysfunctions that heterosexual incest has caused. Further, and in conjunction with the pervious studies cited, it has been confirmed that some girls who have been sexually molested were more likely to become lesbians. Questionnaires and interviews of 48 lesbians and 30

heterosexual women revealed that out of 17 women molested in childhood by a relative or close family friend, 16 became lesbian (Gundlach, 1977).

In terms of mother-daughter incest, Goodwin and DiVasto (1979) recognized that the relationship between incest and homosexuality in such that the presence of overt homosexuality in both the mother and the daughter was a clue which facilitated the identification of incest cases.

A case illustration of a lesbian, clearly validated quantitative data of family incest. For example, the case of Sue, by Cates (1987):

> Sue reported attempts by two of her older brothers to molest her sexually. She noted that her father was an alcoholic but nothing said of her mother. Her lesbian identity was said to arise in later stages of adolescence, whereas she became involved with an older adolescent female. It was stated that clinically, she had a need for acceptance. She obviously could not trust her brothers or father for that matter and subsequently, she generalized these feeling of men. This is why she sought comfort in other women. (p. 361)

Molestation

Approximately 35% of pedophiles were reported to be homosexually identified, and since a small proportion of the society was said to be homosexual; this made for a disproportional large representation (Freud & Watson, 1992). This has been confirmed in several reports:

Freund, Heasmen, Racansky, and Glancy (1984) in a sample of 457

molesters in Canada, found that 36% were homosexual. In another study it was also found that a third of those who reported having been sexually molested were homosexually molested (Cameron, Proctor, Coburn, & Forde, 1986). Erickson, Wallbek, and Sely (1988) in their sample of 229 molesters in Minnesota, found that 28% were homosexual. Because of these findings the researchers concluded that pedophilia is proportionally a far greater problem among homosexuals than among heterosexuals.

In review of 75 years of English literature, it was found that a third of the male factors implicated in various forms of child sexual molestation practiced homosexuality. The study concluded that it is likely that those who practiced homosexual acts were at least 12 times more apt to molest a child sexually (Cameron, 1985).

Family dynamics of homosexual sexual abuse

Homosexual offenders' childhoods have been found to be characterized by poorer relationships with parents, coming from broken homes. Their prepuberal sex play was also found to be frequent and homosexual: "The frequency of homosexual contacts exceeded that of...other groups...attracted to children" (Lester, 1975, p. 82, describing the findings of Gebhard, et al., 1965).

Of the homosexual men from the data collected by the Kinsey Institute from 1938 to 1963, close to one quarter who were molested said the perpetuator was a relative or someone in charge of them (Gebhard & Johnson, 1979).

Simari's and Baskin's (1982) study of homosexual incest found that the respondents reported high percentages of fathers who were inadequate as parents.

They also reported high rates of father absenteeism. What was interesting was that incest in the extended family context, "was invariably reported as being positive in nature by homosexual identified individuals" (p. 342). Nuclear family incest was reported as being positive when the participants were about the same age as in brother-brother incest.

Sexual abuse by fathers and other family figures was found to be quite common in the backgrounds of male homosexuals (Biller & Solomon, 1986). While the reports of incest between mothers and sons was rare, "there [were] many father/son [incestuousness] relationships," according to Aytch (1980, p. 414). In that same discussion a panelist discussed a study that she had conducted on incest and found that 25% of the males had been homosexually sodomized either by their own fathers, or by another male.

Homosexual Teachers and Students

Although same-sex molestation was likely committed by relatives, same-sex molestations by other specific contacts (e.g. teachers, coaches) originating in institutions, was also very likely. In a review of molestation involving teacher-students, a great proportion involved homosexual interactions (Cameron, 1985). These incidents confirmed findings that approximately up to one-third of all molestations were of a homosexual nature (Timnick, 1985). It is no wonder why the Boy Scouts have banned gays from their ranks.

Hechinger and Hechinger (1978) surveyed school principles about teacher-student sexual contact and discovered that 35% of these reports involved homosexual activity. Of 199 cases of teacher-student sexual contact, 59 male

teachers had abused male students which equaled a one-third incidence rate (Rubin, 1988).

As discovered, disproportionately more incest and molestation by homosexuals have been reported and was a significant basis for homosexuality. This held true in a probability survey of 4,340 men and women, whereas 30% reportedly were homosexually molested (Cameron, 1986). It was also found that 35% of respondents were homosexually molested in a random survey of 3,132 men and women (Siegal, 1987). In a study of neuropsychology and pedophilia, fewer heterosexual pedophiles admitted to erotic preferences for minors than homosexual pedophiles (Hucker et al., 1986).

Summary

In summary, there is a strong disproportionate association between sexual abuse and homosexuality. About one-third of the reports of molestation, by the populace, have involved homosexuality. Between one-fifth and one-third of those who have been caught and/or convicted practiced homosexuality and one-fifth to one-third of surveyed gays admitted to child molestation. The conclusion being that the homosexual population was responsible for 20% to 40% of child molestation.

Ultimately, homosexual child molestation cases outnumbered heterosexual cases by 11 to 1. This was the case given the general population's count of homosexuals verses heterosexuals as it related to reported molestations. The researchers concluded, "This suggests that the resulting proportion of true pedophiles among persons with a homosexual erotic development is greater than in persons who develop heterosexually" (Freund & Watson, 1992, p. 34).

Silverman et al. (1973) validated earlier theory that homosexuality is a defense against incestuous attachment. He found in patients that incestuous stimuli increased homosexual wishes and those wishes were the motivating wishes in the homosexual behavior.

Outcomes and the Effects of Molestation

Females and males who experience molestation subsequently are prone to homosexuality. Not only are homosexuals disproportional the perpetuator of sexual molestation (more so for males), often they themselves have been molested and/or involved in, or interested in, same-sex incest. In a sample of 117 men, 16% reported having been molested before the age of 17, and 95% of their perpetuators were males. Twelve percentage of these men admitted to being interested in having sex with boys aged 13 to 15, while over 10% reported having had sex with boys between the ages of 13 to 15 (Bagley, Wood, & Young, 1994).

In a random sample of over 5,000 adults in the US, incest was disproportionally reported by gays, lesbians, and bisexuals. Twelve percent of the gay men verses 0.8% of the heterosexual men had brother-brother incest. Also, significant differences were reported as 50% of the gay men reported same-sex incest, and 69% of same-sex incest was with other relatives. Thirty-three percent of the lesbians, who were only 3% of the sample reported same-sex incest and 17% had same-sex sexual experiences with other relatives (Cameron & Cameron, 1995).

In a literature review (1973-1981), it was found that homosexual incest was mostly underreported and understudied. The author's findings supported that, "participants manifested serious psychopathology which was partially attributed to

the dynamics and impact of the homosexual incestuous syndrome...it appears that homosexual incest has a powerful and long lasting impact" (Kaslow, Haupt, Arce, & Werblowsky, 1981, p. 192).

A seminal study of 54 male homosexuals chosen from a wide variety of gay social networks revealed that all of the cases of incest, were homosexual in nature. The study also found that 29 lesbians reported a high rate of incest (not all homosexual in nature), and concluded, "What was surprising was the high incidence of incest reported in both populations [lesbians and gays] given the small sample size" (Simari & Baskin, 1982, p. 335). As with other findings, this study found, in terms of family dimensions, that the respondents reported a high percentage of inadequate fathering. There was also high rates of father absenteeism. What was disturbing was that incest in the extended family context "was invariably reported as being positive in nature by homosexual identified individuals" (p. 342); nuclear family incest was reported as being positive when the participants were about the same age as in brother-brother incest.

Boys victimized by an older man were found to be over 4 times more likely to be currently engaged in homosexual activity as were nonvictims. Close to half the male respondents studied, who had experienced childhood molestation by an older man, were in involved in homosexual activity in the previous year of the study (Finkelhor, 1984). Consistently, the quantitative data proved that adolescent gays report a considerably high rate of sexual abuse (Doll et al., 1992).

Another study about the sexual victimization of boys was conducted whereas samples were randomly drawn from routine questioning at a medical (non-mental

health) clinic. Both, the study group, and the control group, were demographically similar. The study group (those who had been molested) identified themselves as currently homosexual nearly 7 times as often and bisexual as nearly 6 times as often as the control group (those who had not been molested) (Johnson & Shrier, 1985). In a study of gay-identified adolescents attending social services in New York City, 22% reported childhood sexual abuse (Martin & Hetrick, 1988).

High rates of sexual abuse are common among young gay male prostitutes. Up to 68% where found in a sample produced by Coleman (1989). In a supplemental sample taken of London street workers there was found to be a greater preponderance of homosexuality and earlier child sexual abuse. Sixteen out of 25 said they were exclusively or predominately attracted to other males. Nine out of the 25 reported child sexual abuse in early childhood (under age 14) (West, 1993).

Consistently, over the 20th century, studies have shown that many prehomosexual boys had been seduced by older men, thus supporting this as a causative factor leading toward homosexuality (Calder, 1956; Caprio, 1955; Gagnon & Simon, 1967; Mundorff, 1972; Wolfson & Gross, 1953).

The effects of same-sex incest

Same-sex incest, by review of the literature and collected case histories, indicates that there is more prevalence of same-sex incest than most people believe. Father-son incest presents particular complicated consequences, not only is the son likely to become gay, he is likely to become a later perpetrator (This makes sense as one-third is found on both sides of the continuum). He may also experience homicidal or suicidal ideation, and present self-destructive behaviors (Kaplan &

Sadock, 1991).

In an extensive review of the literature on father-son incest, Williams (1988) concluded that, "The impact of [homosexual] incest upon the son often results in severe pathology during the period of sexual contact or subsequently" (P. 176). Both short-term and long-term negative effects were reported in the review of studies about homosexually molested subjects. Effects such as homosexuality, sexual dissatisfaction, promiscuity, and increased risk of revictimization were found (Beitchman, et al., 1991).

Homosexual sexual abuse is very confusing to a youngster. A family therapist from Long Beach, California shared what one male client said when confronted by the effects of being molested by an older male, "I was afraid that I must be gay, because otherwise why would this guy pick on me" (Engel, 1990, p. 83). As discussed earlier, clinical research has concluded that childhood molestation can result in homosexuality among woman, also.

As one would imagine, homosexual incest does indeed cause serious psychopathology. This has been reported consistently in several scientific studies (Dixon, 1978; Kaslow, et al., 1981; Medlicott, 1967; Meiselman, 1978; Raybin, 1962; Reichenthal, 1979; Rinehart, 1961).

Summary

It was found that lesbians' experiences and lifestyles were related to earlier molestations, incestuous experiences, and rape. Same-sex incest, by review of the literature and collected case histories, indicates that there is a high prevalence of same-sex incest. Although same-sex molestation was likely committed by relatives,

same-sex molestations by other specific contacts (e.g. teachers, coaches) originating in institutions, was also very likely. Females and males who experience molestation subsequently are prone to homosexuality. Homosexual incest does indeed cause serious psychopathology with effects such as, sexual dissatisfaction, promiscuity, and increased risk of revictimization. Most of the male street workers were found to be homosexual identified.

Gender Identity

Gender, roles and child-play identity

Kaplan and Sadock (1991) maintained that, in both sexes, homosexuality was likely to develop in one-third to two-thirds of gender identity disorder cases. This conclusion was based on many years of study. Men who were found to be effeminate had had more homosexual experiences before the age of 12. After their first homosexual encounter they were found to then be effeminate, more sexually active, and engaging in more cross-dressing behaviors (Holemon & Winokur, 1965).

Rekers (1995) who edited of a 500-page comprehensive text on childhood psychosexual development, cited that gender nonconformity in childhood was probably the single most common observable factor associated with homosexuality. He also noted that early homosexual molestation often contributed to the development of homosexuality.

It has been documented that gay men are typically more feminine and less masculine when matched with male heterosexual counterparts (Hooberman, 1979). The consistent reports of 3 studies showed that an emotionally distant relationship of a father and his son related to the son's atypical characteristics, i.e. effeminacy and

childhood gender identity (Freund & Blanchard, 1983). Homosexual men perceived themselves as psychologically more distance from their fathers than their heterosexual counterparts (Mallen, 1983).

It was found that fathers of homosexuals were more hostile and less dominate than fathers of heterosexuals and hence less desirable identification models (Sipova & Brzek, 1983). Barclay and Cusumano (1967) found that when a boy was absent of his father, his gender-identity became confused and when this takes place during the formative years, it will point to a homosexual orientation. These conclusions certainly corresponded with the findings by Bieber et. al. (1962) (See also Chapter 12: Familial Patterns).

Green and Money (1966) found that effeminate boys were more likely to become homosexual. Later reports from a 10-year follow-up of 16 boys with early effeminate behavior, found that 10 of them developed homosexuality, 1 transvestitism, and 1 transsexualism (Zuger, 1978). Zuger (1984), in another long term follow-up study with 55 effeminate boys, discovered that only 3 of them reported heterosexuality at the time of follow-up. Zuger (1984) discussed other reports: Money and Russo (100% homosexual outcome), Backwin (86% homosexual outcome), Lebovitz (63% homosexual outcome), and Whitman (97% homosexual outcome). In cross-cultural analysis, early cross-gender was found to be an intrinsic characteristic of male homosexuals (Westfall, 1975).

When a boy becomes self-allocated to female-roles, it is logical that without intervention, he will continue those roles consistently. As Chasseguet-Smirgel (1976) has said, "too much access to femininity can lead to 'psychic death' for a

boy." (p. 349). A longitudinal outcome found that such a boy when he reached adulthood, indeed, took on a nonparaphilic homosexual gender status (Money & Russo, 1979).

Resoundenly, boys who were feminine in early childhood or adolescence and experienced gender-identity disorders are more likely to become gay. This was also found also in follow-up studies (Green, 1985,1987; Zucker & Bradley, 1995). Internalized psychopathology exist in a higher percentage among those boys with gender-identity problems (Zucker & Bradley, 1995). Early intervention is therefore appropriate to help the boy restore masculine identity, as stated by Newman (1976).

Gay men recall playing more often with girls as children than heterosexual men (Grellert, 1982). In a large scale study, it has been found that far fewer homosexual than heterosexual men report having enjoyed typical boy's activities (e.g., baseball, football) "very much". Twice as many homosexual as heterosexual men reported having enjoyed solitary activities such as drawing, music, and reading. Homosexual boys participated less in team sports (Lewis & Schoenfeldt, 1973). Homosexual men preferred robust sports less than heterosexual men, as found by O'Connor (1964).

A comparison study of nonclinical samples of homosexual and heterosexuals, both male and females who were productive members of the community stated, "our findings indicate that the homosexual orientation develops very early in life and that the prehomosexual child displays behavioral characteristics that are more typical of the opposite sex than his own biologic sex" (Saghir & Robins, 1971).

A study has confirmed that gay mens' interests are more artistic and they scored differently from heterosexual men on masculinity scales. Gay mens' interests were less realistic than heterosexual mens'. This was found in a comparison of 63 gay men with 60 heterosexual men by Chung and Harmon, (1994).

More homosexual men than heterosexual men reported dressing in girl's clothes and presented female characteristics in childhood. They felt less masculine about themselves and were generally more passive. The study concluded that,

> Boys who sense themselves to be unlike other boys in terms of their playtime interests and the degree to which they are 'masculine' are more likely to feel sexually different from other boys, whether this feeling first occurs during childhood...or in adolescence. Such boys are more likely to experience homosexual arousal...such boys have more extensive involvement in homosexual activities in adolescence. In adolescence, gender nonconformity tends to produce a sense of alienation from one's peers. (Bell, Weinberg, & Hammersmith, 1981, p. 76-77)

Consistently, homosexual men reported less masculinity and therefore had lower self-esteem compared to heterosexual men. This held true because when masculine scores increased, so did self-esteem scores as discovered by Carlson and Stever (1985). The results of psychometric assessments showed that heterosexual men rated more highly on masculinity scores (Bernard & Epstein, 1978) and homosexuals rated more highly on femininity scales (Hooberman, 1979).

Confirming this, in another study, significant difference were found between heterosexual and homosexual men on feminine scales and heterosexual and homosexual women on bipolar masculine-feminine scales. In conclusion to the findings, the homosexual men were found to measure more feminine, while homosexual women measured more masculine (Storms, 1980). This study also supported that, on comparison scales in homosexual and heterosexual men, homosexual men are more likely to accept cross-preference sexual feeling than heterosexual men. Conversely, heterosexual men will not think about cross-preference sexual feelings, compared to the homosexual men. Thus, a shift in sexual preference is more likely in homosexual men than in heterosexual men: one-third found in homosexual men, whereas none were reported in heterosexual men (Storms, 1980).

A comparison study of 17 male homosexuals and 17 male heterosexuals was build on the methodology that the samples were nonclinical, both reported sexual orientation exclusivity respectively, and that each group was comparable in many ways prior to the investigation. On investigation, however it was discovered that the homosexuals fit more of a "sissy" profile, that is, they had negative feelings about their place in the world of males. They had negative feelings about their bodies. They felt their physiques were more like a girl's. They were often frail and reported having a strong fear of physical injury in contact sports. Over 75% of them reported persistent terror of fighting other boys during their juvenile and adolescent development (Friedman & Stern, 1980).

Data gathered on the Klein Sexual Orientation Grid found that homosexual

men differ significantly from heterosexual men on gender-typical behavior and feminine sex-role measures, both in childhood and in adulthood (Snyder, Weinrich, & Pillard, 1994). Gay men personally admitted that they have a different male self-identity than heterosexual men (Weinberg, 1978).

Studies confirmed that lesbians were found to be more masculine and less feminine than their female heterosexual counterparts (Oberstone & Sukoneck, 1976). Among lesbians, a masculine trend of sex-role identification has been consistently discovered (Gough & Heilbrun, 1965; Heilbrun & Thompson, 1977; Spence, Helmreich, & Stapp, 1975; Thomson, Scwartz, McCandless, & Edwards, 1973).

Heterosexual women were more likely to recall having had female stereotypic (gender conforming) experiences as children, whereas lesbians often recall a childhood characterized by male-stereotypic (gender non-conforming) experiences. With 80% accuracy in the classification of individual cases, 4 recollected attributes of lesbians were significant: imaged self as a male character, wished to become a mother, preference for boy's games, and was considered a tomboy as a child (Phillips & Over, 1995). This supported earlier findings that lesbians were more involved in rough and tumble sports than heterosexual women (Saghir & Robins, 1973).

Zucker and Bradley (1995) found that of the 24 girls in their sample, nearly 77% of them had mothers with histories of depression, and all of the mothers were depressed during their daughters' infant or toddler years. The authors concluded, "Thus, during the hypothesized sensitive period for gender-identity development, the

mothers of the girls in our sample were quite vulnerable from a psychiatric point of view," The authors continued:

> [O]ne consequence of this vulnerability was that the girls had difficulty in forming an emotional connection to their mothers. In some instances, it seemed to us that a girl either failed to identify with her mother, or disidentified from her mother because she perceived her mother as weak, incompetent, or helpless. In fact, many of the mothers devalued their own efficacy and regarded the female gender role with disdain...In smaller numbers of cases, it seemed that the daughter's "significant medical illness" or difficult temperament during infancy had impaired her relationship with her mother...Six of the mothers had a history of severe and chronic sexual abuse of an incestuous nature. The femininity of these mothers had always been clouded by their experience, which rendered them quite wary about men and masculinity and created substantial dysfunction in their sexual lives. In terms of psychosocial transmission, the message to the daughters seemed to be that being female was unsafe. The mothers had a great deal of difficulty in installing in their daughters a sense of pride and confidence about being female. (Zucker & Bradley, 1995)

Kennedy and Davis (1993) reported that lesbians can choose several different

roles. The lesbian community often prides their "butch-femme" idiosyncrasies. They use the term "dyking" when a "butch" (a more masculine sex-role women) gets together sexually with the "femme" (more feminine sex-role woman). As far as the butch-femme theory goes, a lesbian reported that butch-femme roles were not a mock of heterosexual relationships, but rather political and "a conspicuous flag of rebellion...an intimate exploration of women's sexuality" (Nestle, 1992) (See also Chapter 9: Sexuality)

Childhood peer relationships

The extrafamiliar experiences of homosexuals have long been described as less adjusted than their heterosexual counterparts. Isolation from same-sex peers is often noted (Robinson, 1994) and homosexuals have reported greater alienation than their heterosexual counterparts (Greenberg, 1973). Additionally, a sense of estrangement and uncertainty about their gender, is often reported. This gives support to why homosexuals seek same-sex contact with others as an attempt to boycott the earlier experienced estrangement from same-sex peers, as pointed out by Hatter (1970). Prehomosexual boys lack same gender interactions such as boy talk, which therefore inhibited them from cohesion with other boys and subsequently opposite sexual adaptations were affected (Gagnon & Simon, 1973).

Remafedi's (1987a) review of the literature found that several studies comparing heterosexuals with homosexuals found that the homosexual more often recalled their childhood as likely to contain feelings of being different from peers, more interest in atypical gender activity, and greater sexual interests. Prehomosexual boys are more likely to be loners than their heterosexual

counterparts (Hadden, 1967; Snortum, et al., 1969; Stephan, 1973) and are more likely to spend nonromantic time with girls, which is not characteristic of heterosexual males (Saghir & Robins, 1973). Frieman and Stern (1980) discovered that the prehomosexual boy was more likely to fear heterosexual boys.

A large study confirmed that homosexuals differ significantly from their heterosexual counterparts in what they report about relationships with peers while growing up. More homosexual men than heterosexual men, in both grade school and high school, felt "left out" and did not usually "pal around" with other boys. They also "felt quite different" from their heterosexual male peers. Those that reported feeling "sexually different" were more likely to become homosexual adults. They were also less interested in sports and had feminine traits (Bell, Weinberg, & Hammmersmith, 1981). The authors concluded "...that prehomosexual boys [were] likely to be less socially involved with male peers than are preheterosexual boys. We also found that the homosexual men recall having a larger portion a female friends while growing up" (p. 85) and "during adolescence a sense of alienation from peers for gender-related reasons as well as an emerging sense of sexual difference [were] a common part of the process of developing an adult homosexual orientation" (p. 89).

In the same study, the female homosexuals also differed from their heterosexual counterparts. They too reported a greater feeling of alienation from their peers. They were more "masculine", isolated more from other girls, and played typical boys games. The researchers concluded that, "[t]he lesbian respondents more often described themselves as lonely, unhappy, and alienated while growing up" (p.

163).

Summary

Studies throughout the 20th century have shown that homosexuality was likely to develop in one-third to two-thirds of gender identity disorder cases. Several studies comparing heterosexuals with homosexuals found that the homosexual more often recalled their childhood as likely to contain feelings of being different from peers, more interest in atypical gender activity, and greater sexual interests. Gender nonconformity in childhood was probably the single most common observable factor associated with homosexuality.

Intimate Relationships

In an interview in Omni magazine, famous sex therapist, Dr. Helen Singer Kaplan was asked, "Are there differences between male and female homosexuality?" of which she replied,

> Yes. The male homosexual is moved by a strong erotic attachment to other men, and his heterosexual drive is impaired. The female homosexual is motivated more by anger at males than by a strong erotic drive toward other females. Many, but not all, female homosexuals are so hostile or ambivalent toward males that they are turned off by them. Very often, when they resolve their anger at males and their envy of women who have a man taking care of them, homosexual women are free to feel erotic towards males. (D. Klein, August 1981, p. 92)

Several studies have found that homosexuals have less monogamous relationships and that their partner's sexual exclusivity was not an important factor in the relationship. Duffy and Rusbult (1985, 1986) found in their studies that, compared to heterosexual men, homosexual men reported a shorter level of duration in their longest relationship. Less heterosexual men had open relationships (when either one or both partners are sexually non-exclusive) compared to their homosexual counterparts. According to Harry (1984), the vast majority of gay relationships were characterized by sexual nonexclusiveness.

Despite acquired education about the correlation of homosexuality and AIDS, in the majority of gay partnerships, the HIV status was usually unknown. Both partners knew of each other's HIV status in only 26% of cases of those partners who participate in anal intercourse within the last month of the study (Dawson, et al., 1994).

In a magazine sex poll of 2,571 readers, a higher percentage of heterosexuals men, compared to gay men, were happy in their relationships and worried less about being able to love or finding someone to love (Radakovich, 1994).

In the study, The Male Couple, by two homosexuals, one a psychologist and the other a psychiatrist, found that of the 156 couples studied, only 7 had maintained sexual fidelity. Those couples that had maintained a relationship for more then 5 years were unable to maintain sexual fidelity. Although the study found that close to a third of the sample lived together longer than 10 years, they found that, "The majority of couples...and all the couples together longer than 5 years, were not continuously sexually exclusive with each other" (McWhirter & Mattison, 1984, p.

285). As Kurdek and Schmitt (1985, 1986) had found, while some gay relationships may seem to last, when a gay couple lives together for longer periods of time, their relationship eventually becomes open.

Saghir and Robins (1973) found that 75% of homosexual men over the age of 40 experienced no relationship that lasted more than 1 year. Only 8% of the homosexual men and 7% of the homosexual women ever had relationships that lasted more than 3 years

The Gay Report, included findings from a large study of 5,000 gay men and woman who frankly discussed details about themselves and their relationships in both open-ended and closed-end questioning. The study's participants were recruited mostly from gay homophile organizations. The authors concluded that, "...for gay men, the process of forming a couple and staying together is by no means the same as it is for a man and a women, married or not" (Jay & Young, 1979, p. 339). The research found that the average length of homosexual relationships was about 2 years. The study also found similarities and differences between gays and lesbians. While lesbians out numbered the gays in terms of having an emotional involvement in their relationships, both are usually emotionally uninvolved during sex. It was found that 86% of the lesbians felt that emotional uninvolved in a relationship was important, while less than half of the gay men felt that it was important in a relationship. But when having sex, only 56% of the lesbians include emotional involvement, while 13% of the gay men include emotional involvement (Jay & Young, 1979).

Like The Gay Report, in The Spada Report the respondents surveyed were

given the opportunity to lavishly reveal their unconventional sexuality and relationships. The survey was completed by over 1,000 gays represented from every state. Although more than half said that they had a lover, 74% of the men who had lovers stated that they, their lover, or both engaged in sex outside the relationship. One respondent stated, "If anything, having sex with others [made] our love for each other stronger" (p. 190). Another stated that, "those who impose monogamy must be so terribly unsure of themselves as persons of value", he furthered this by saying, "..sexually or otherwise, do not generate from a closed unit" (Spada, 1979, p. 190). These findings and others, made it clear that the attitudes of monogamy in gay relationships was diametrically opposite of heterosexuals' in general.

Harry (1984) found that while 50% of gay couples said they were involved in a relationship at any given time when studied that did not mean that they were committed or monogamous. Henslin and Sagarin (1978) made this conclusion, "Many [gay] couples who stay together for a long time become roommates bound chiefly by companionship and domestic ties, ceasing to be bed partners and finding sex outside the relationship" (p. 229).

A study conducted in Los Angeles during the late 1980s, found that homosexuals averaged over 20 partners a year (Linn, 1989). This was a large percentage considering the already prevalent risk of homosexual sex (See also Chapters 2 and 5). Another study in Boston, also during the late 1980s, found that 77% of over 400 male subjects had had more then 10 partners the pervious 5 years before the study (Seage et al., 1992). Other studies confirmed that homosexual relationships were based on non-monogamy (Blumstein & Schwartz, 1983).

Berger (1990) in a sample of 92 gay couples reported that 96.4% of them described their relationship as “monogamous”. Even still, for many homosexuals, monogamony did not necessitate sexual exclusivity. Further, not all of the couples in that study responded to that item. Wonder why? Additionally, if such a high percentage of the couples were in deed truly "monogamous", then why did half the sample report that they practiced, “safer sex” (sex with protection, e.g. with condom) on a regular basis? If “monogamy” were so high as claimed, then it would seem that this item would correspondently be lower since higher monogamous scores are associated with lower protected sex scores. If 50% of the couples had protected sex on a regular basis, and 96.4% were considered monogamous, then trust and true monogamony certainly were not highlights of the relationship!

The fact of the matter is that studies consistency showed that most gays, during the 20th century did not even desire or want monogamy. This was the case with over half of the homosexuals in marginal tabulation of data collected by the Kinsey Institute between the years of 1936-1963 (Gebhard & Johnson, 1979).

Ambiguity

Homosexual males and females alternate roles during homosexual activity. There are usually no strict masculine or feminine roles according to Saghir and Robins (1971). This showed that the homosexual identify is confused.

Krestan and Bepko (1992) found that lesbians experience more fusion or embeddedness within their primary relationships. It occurred more frequent and in greater intensity the more committed the relationship was. The researchers,

discovering this, also found that each lesbian partner had no real good sense about herself. At the same time, there was a problem of competition in the lesbian relationship. The problem occurred when one partner began to feel that she became lost in her partner, a demonstration of embeddedness (Lindenbaum, 1992).

Dutch researchers, Deenen, Gijis, and van Naerssen (1994) conducted a study of 320 men in gay relationships. It was mentioned that the Dutch have traditionally been quite liberal concerning their views about homosexual behavior. As far back as 1968, over two-thirds of the Dutch were said to tolerate homosexual behavior. "They should be free to lives their own lives!", the majority exclaimed. Along those lines, homosexuality was nearly 100% tolerated in that country during the latter half of the 20th century. In the United States, however especially during the 1960s, there was little tolerance for homosexuality. Hoffman (1968) in a study of San Francisco gays found gay relationships to be pathological in nature, that is, they were unstable and multiple. He explained it was that way only because homosexuality was condemned in American society. He said for that reason, it was impossible for gays to maintain close intimate relationships.

The Dutch study found that factors predicting relationship satisfaction, sexual satisfaction, sexual frequency, and sexual encounters differed according to relationship duration and the age of respondents. Physical intimacy and emotional exclusivity were found to be lower in the gay relationships of longer duration. "As relationships last, partners may notice that a high level of sexual contact is not necessary for relationship continuation" (p. 429).

The study went on to note that after 6 years in a relationship, the percentage

of men having sex with someone other than their partners was 62%. They found that older gays reported the most sexual partners. The researchers however did not discuss these factors as being pathological, in fact they claimed, "Gay men value the emotional aspects of their relationships above sexual satisfaction" (p. 429).

When hearing this, one would tend to question findings that have linked homosexuality to high prevalence of multiple partners. However, when the study is discussed logically, it can be concluded that longer relationships do report less sexual contact in the relationship and find more emotional aspects: The latter holds true - simply because the longer that one is in a relationship the more emotional dependency exist. This only makes sense. The earlier holds true also, and why wouldn't it? Almost two-third of those in gay relationships of longer duration reported having sex outside the relationship! Obviously, they would report sexual contact in the relationship as less importance - simply because they got it elsewhere!

Another Dutch study found homosexuals "valued emotional relationships", and the longer they were in the relationship, the more “open” they got. Also worth mentioning was that when sex habits of Dutch men were studied in the mist of the AIDS epidemic, the researchers stated, "Our data on the level of sexual activity resemble those available for the San Francisco Bay area in 1970" (Eddesen et al., 1984, p. 291). However, as discussed earlier, Hoffman (1968) saw that the problems of gays in San Francisco was related to social stigmas. Since the Dutch society was so much more conducive to homosexual acceptance in the 1980s than in the

1960s/70s in the United States, then why the same problematic sexual activity resemblance?

Bias against older prospective partners was seen as epidemic within the gay male culture (Steinmen, 1991). Interestingly, this bias came from older gays themselves. The younger gays sought older partners for sexual encounters (perhaps to fulfill earlier missing fathering), but usually not for friends. Steinmen (1991), quoting Harry and DuVall, found that "a majority of [gay] men 18-24 years old reported preferring older partners, but that 'above age 25 this choice sharply decline[d]...[above age 34] there occur[ed] a sharp increase in choosing someone younger and the percentage so choosing seem[ed] to stabilize at 50%' amongst all older men" (p. 180). Thus, the younger sought the older (to find daddy), then varied appetites with the aging process (to nurture narcissist needs), and finally, the older sought the younger (to hold on to youthfulness).

Summary

By these findings, it was clear to see that homosexual relationships were instable and full of ambiguity during the 20th century. Even when a gay couple lived together for a long period of time, the relationship became open. By these findings, fidelity was not a value for homosexual couples. Individuals within homosexual dyads were often confused about their personal role within the relationship. The aging processes were also a detriment to the homosexual relationship. Finally, homosexual realtionships were found to be ambiguous at best, and were indeed unlike heterosexual relationships, along several lines.

Sexuality

Studies showing homosexual sexuality as being deviant and estranged in comparison to heterosexual sexuality have been consistent. While gay men tended to be hypersexual, lesbians experienced sexual fluidity. That is, in addition to homosexual behavior, lesbians also reported intermediate or transitional heterosexual behavior. A good example of lesbian sexual fluidity is that of Ellen Degeneres's ex-lover, Anne Heche. The lesbian was also composed more in emotional dependency. It has also been found that lesbians were more often the initiator of sex than heterosexual women (Warczok, 1988).

Even though lesbians were found to be less sexually promisous than gay men in general, they were found to be more sexually experienced than a large group of women who reported not being lesbian (Goode & Haber, 1977). It is not uncommon to find an onset of homosexuality in women in which they often revert back to a heterosexual life style, at some point. These examples are usually preceded by an extended heterosexual life style (Kernberg, 1995). Homosexual women also tend to be sexualized earlier (prior to age 19) than heterosexuals and for that matter, prior to age 19, they described their sexual orientation as predominantly heterosexual (Bell, Weinberg, & Hamersmith, 1981).

Homosexual men where found to be more preoccupied with sex earlier than their heterosexual counterparts (Saghir & Robins,1973). Gay men maintained both interest and activity in sex as they grow older (Pope & Schultz, 1991).

Content-analysis has confirmed that there was a strong association between erotic body parts piercing with homosexuality as well as sadomasochism, bondage,

and fetishism (Buhrich, 1983). According to the sex research of Masters and Johnson (1979) gays and lesbians performed fallatio and cunnilingus (oral-genital) and oral-anal more. Lesbians used dildos more than heterosexual women. The homosexuals when observed in their sexual acts, where found to be goal orientated - they spent far less time in total-body (not penetrating) stimulation than the heterosexual couples. Bell and Weinberg (1978) found that lesbians are more apt to engage in frequent masturbation and threesomes.

A survey of over 12,000 homosexuals in 8 European countries found striking similarities appearing in the sexual behaviors of gay men, whereas the majority had multiple partners and participated frequently in anal intercourse (Bochow, et al., 1994). Gay men were also found to engage more in anonymous sex. A study, by way of telephone interviews with 141 male respondents, found that gay men were more likely to have engaged in anonymous sex during the 3 months before the interview (Roffman, Gillmore, Gilchrist, Mathias, & Krueger, 1990)

A study conducted by Newmeyer (1992) found that gay men were more enthusiastic about anal sex, group sex, and and use of dildos. Homosexual men and women were also more into masturbation than heterosexual men and women.

It is not just sexual practices where homosexuals differed from heterosexuals; homosexuals differed from heterosexuality along various measures in sexuality. For example, gay men and lesbians rated more highly in sexual conquest and to used sex as a realease of tension as found by Leigh (1989).

It was been found that the frequency of sexual involvement is less, while emotional dependency is high (an unbalance) in lesbian coupleship compared to

heterosexual coupleships. In the study by Loulon (1988), 43% of lesbian respondents who were studied had been sexually abstinent for a year or more. It has been discovered however, that lesbians do out rate heterosexual women in terms of their response to sexual stimuli. For example, lesbians rate higher to stimuli than heterosexual women in: seeing the partner unclothed in intimate situations, viewing photographs of nudes, and reading sexual literature (Warczok, 1988).

Again, it should be reiterated that lesbians have been more sexually traumatized than other women, so perhaps this could contribute to her sex fears (responses to sexual stimuli but not actual sex) and her sexual deviations (use of artificial sex organs).

A wave of qualitative and quantitative data revealed that gay men engage in egregious sexuality. For example, unusual sexual practices were found to be frequent among homosexual men while rare among heterosexual men (Collier, 1987). As reported in The Gay Report well over half of the men partipated in group sex frequently, while the remainder participated in it 1 or more times. One-quarter admitted to the frequency of threesomes of 1 or more times (Jay & Young, 1979). Another study, found that, "The clear majority of respondents (78%) said they had engaged in group sex at least once; more than one-quarter...said they had done so more than 6 times - a considerably higher percentage than a comparable group of heterosexuals" (Goode & Troiden, 1980).

The Spada Report allowed gays to speak frankly about how they viewed themselves and their sexuality. Because of its descriptive design and its large distribution, it added greatly to the quantitative data about gay sexuality. One

respondent reported that he felt the survey was "...a chance to be totally truthful" (Spada, 1979, p. 88). The survey was completed by over 1,000 gays represented every state in the United States. Much like The Gay Report, the respondents lavishly revealed their unconventional sexuality. Like the other reports on gay male sexuality, more of the men reported enjoying one-night stands, reached organism more by masturbation, engaged in anal sex, and other unconventional practices.

In a magazine poll of 2,571 readers in 1994, consistent with other findings, more gay men then heterosexual men participated in anal sex, three-ways and groups sex, and dominance and submission encounters (Radakovich, 1994).

In 1994, an Advocate survey of 1,300 gay readers discovered that close to half had engaged in 3-way sex in the last 5 years of the study; one quarter reported to have found sex partners in public parks or restrooms, 15% at roadside rest areas, and another quarter had sex involving 4 or more partners. Anal sex was highly reported; 58% of the men receiving anal intercourse allowed their partner to ejaculate in them without a condom. One-third reported having more than 100 sex partners in their lifetime (The Advocate, August 23, 1994, pp. 16-24).

It was no secret that gay men indulged themselves more in unconventional sex habits compared to heterosexual men as discovered by Lowery and Williams (1981). De Cecco (1981), during that time was a prominent researcher on the topic of homosexuality and the editor of The Journal of Homosexuality, a leading academic journal on homosexuality. He also contributed to gay-specific magazines such as The Advocate. In one article, he noted that a large element of the gay

culture was rooted in the experience of multiple and often transitory encounters which, "the emotional bound [of the homosexuals] consist[ed] of fantasy, unexpected excitement, [and] the tinge of possible disappointments.... (p. 20). DeCecco, who was also a psychology professor at San Francisco State University was quoted as saying that homosexuality was a behavior and not a condition, and something that some people can and do change, just as they sometimes change other tastes and personality traits (reported in USA Today, January 1, 1990, p. 4D).

DeCecco also served as an editorial board member of PAIDIKA: Journal of Pedophilia. This journal, by the way, carried advertisements for the National Association for Men and Boy Love (NAMBLA). According to DeCecco, "man - boy and woman - girl sexual relations ... are not inherently wrong and can be a responsible choice, under particular circumstances" (San Francisco Examiner, October 22, 1993, itailized emphasis added).

The Hite Report, like The Spada Report, although dismissed as a rigid scientific study, allowed gays to speak frankly about how they viewed themselves, thus adding quantitative weight to the literature. One gay male respondent wrote, "I'm in love with my lover, but I'm also in love with all men. I'd had sex with several hundred men in my life, and don't intend to stop now." Another male respondent wrote, "I've had sex with over 2,000 men... I love group sex and going to the baths. I would be bored with monogamy" (Examples of quotes from The Hite Report on Male Sexuality, 1981).

As far as sexual fluidity, homosexuality has also shown evidence of this. Self-reported gay men and lesbians showed variance on sexuality and experience

when measured on a continuum, as found by Bell and Weinberg (1978): 65% self-identified homosexual men and 84% of homosexual women reported heterosexual intercourse. Of homosexual women interviewed, 70% said their first sexual experience was with a man, (Paczensky, 1984 as cited by Warczok, 1988). Another study found that 43% of homosexual men had more than once engaged in heterosexual intercourse (Dannecker & Reiche, 1974 as cited by Warczok, 1988). Finally, seeing an attractive women "intensively" excited 13% of a sample of self-identified homosexual men as reported by Warczok (1988, p. 181).

As mentioned previously, it was clear that on comparisons of cross-preference scales among homosexual and heterosexual men, that homosexual men were more likely to accept cross-preference sexual feelings than heterosexual men. That is, the heterosexual men didn't report thinking about sex with the same gender; but, the homosexual men, would on occasion think about women, sexually. Thus, a shift in sexual preference was likely in homosexual men, but not in heterosexual men: one-third found in homosexual men, none reported in heterosexual men (Storms, 1980). Whereas the opposite direction was the case, was when heterosexual men were raped (Goyer & Eddleman,1984).

Other studies of "gay-identified" respondents showed that they usually do not report their sexual histories as exclusively same-gender oriented. For example, in a study of 61 "gay-identified" males, only 39% defined their history as exclusively same-gender oriented (D'Augelli, 1992). It was also discovered that sexual orientation is established (developed) later for women than for men (Henderson, 1984). This points to sexual orientation as being a developmental issue

rather than a biological issue.

The Kinsey Institute conducted large-scale studies over the century to help provide a closer look at the sexuality of homosexuals comparative to heterosexuals. Over the years since their publication, The Kinsey Institute studies, namely, Kinsey, Pomeroy, and Marin (1948), Bell and Weinberg (1978), and Bell, Weinberg, and Hammersmith (1981), provided much discussion on homosexuals' sexuality. All used large sample sizes as these research projects were highly funded. These studies have been cited much in the literature (because of their large scale and publication distributions) however, much of their findings have been taken out of context. For example, Kinsey et al. (1948) concluded that since they found more people practicing or who have practiced homosexuality at one time or another, than expected, then it must have been a natural variation of sexuality. Because of their conclusions, "growing numbers of people, including clinicians, came to disagree with the long-held view that homosexual persons were necessarily less well adjusted than were their heterosexual counterparts" (Bell & Weinberg, 1978, p. 196). Thus, Bell and Weinberg coined the term, "the new view", which was then implanted, since homosexuality had always been viewed as pathological.

Despite the social and political correctness in their's and others discussions of the findings, the results, nevertheless, pointed to several major significant differences between homosexuals and heterosexuals, especially as it related to sexuality. Recent studies still points in that same direction. This is in line with the analogy that North is always North and South is always South, and it is that way no matter how one discusses it.

One study, not conducted in the US, found that there were 3 major dimensions of sexual behavior of homosexually active men:

1. Most of their activity had an anal focus.
2. Oral sex. The researchers noted that condom use during oral sex had not been incorporated into this pattern of behavior.
3. "Brachioproctic ("fist-fucking") activity, unprotected anal intercourse, and other high-risk activities while avoiding condom use and kissing" (Ross & Rosser, 1991, p. 611).

Dr. Charles Silverstein was a pivotal influence on the psychiatric Nomenclature Committee when the American Psychiatric Association made its decision to depatholize homosexuality as a listed disorder. Although he argued that homosexuality was normal, he developed illustrated books entitled: The Joy of Gay Sex (Silverstein & White, 1977) and The New Joy of Gay Sex with co-author Picano, 1993. These types of books, namely Anal Pleasure and Health by Jack Morin, illustrated how to perform anal intercourse and other sadomasochistic sex and suggested that anal sex could be part of a "healthy relationship". These books have been praised by the gay community. In a book review of Anal Pleasure and Health, in The Journal of Homosexuality (Vol. 8., # 2), Wendell Ricketts exclaimed, "...[Anal Pleasure and Health] is a book about...letting go of patterns that have kept us from getting as much out of sex as we deserve."

Silverstein's books contained these types of subheadings: (Please note that the actual content in theses books are to graphic in both language and illustration to be shared in narrative): Bondage (illustrations shown on how to practice those acts);

Bottoms-up (on how to perform anal sex); Daddy-Son fantasies ("sugar-daddy" fantasies, suggested as part of a healthy sex life); Dangerous sex Doggy-style (how to penetrate another man from behind); Fisting (how to insert fists in the anus of another); F--K buddies (encourages casual sex, especially anal intercourse); Rimming (oral licking the anus of another); Sadomasochism (S&M); SCAT (sex play with feces); Sex with animals (bestiality); Sit on my face (oral-anal); Tearooms and Backrooms (sex in public places, usually brief anonymous encounters); Three ways; Orgies; Water sports (sex play with urine).

These sexual phenomenas were said to be of "value" within the gay community. Many of the topics of sexuality will be discussed below as it relates to the prevalence of use among homosexuals. The real amiss was that these acts were encouraged by advocates such as Dr. Silverstein, despite the medical reports about their risk and dangers. These books were not even considered pornographic and were made available in local mainstream bookstore to persons of any age. In fact, the APA even lists Silverstein's book in their, "Selected Bibliography of Lesbian, Gay, and Bisexual Concerns in Psychology: An Affirmative Perspective", found on their website (American Psychological Association, 2007).

These areas will be discussed below in detail as it related to findings on the prevalence of, and risk of homosexual sex, as mentioned in the research literature. For example, the Kinsey studies findings, along with several others, will be presented according to certain aspects. This is done to present a more detailed, widened, in-depth look at the sexuality of homosexuals:

Promiscuity

Hoffman (1987) wrote that, "Sexual promiscuity is one of the most striking, distinguishing features of the gay life in America" (p. 45). Quadland (1987) stated that promiscuity has always had a connotation of perversity, immorality, or psychopathology. Studies consistently throughout the 20th century have noted promiscuity to be a major characteristic of homosexuality:

> Nonpromiscuity in the gay world...must be regarded as a mixed blessing. To view each [gay] respondent as an isolated actor free to actualize his destiny in a world of unlimited options would be misleading. The homosexual who chooses not to engage in promiscuous sex also chooses a number of less desirable accompaniments. Nonpromiscuous sex is related to less frequent sex, although having a lover is correlated with more frequent sex. The least promiscuous respondents were somewhat (although not strikingly) less likely to have had sex 3 times a week or more during the past 6 months than were the most promiscuous respondents (37% opposed to 56%). They were also more than twice as likely to say that masturbation was their most important sexual outlet (60% opposed to 26%) (Goode & Troiden, 1980, p. 54).

"Homosexual men are rarely faithful in their relationships..." according to Saghir and Robins (1971, p. 505). Promiscuity and multiple partnership in the gay lifestyle is very commonly reported (Kelly, Sikkema, & Winett, 1995). Gay men are

more inclined to have multiple sexual partners (Rotheram-Borus & Gwadz, 1993) and they have long been reported as having a very large number of sexual partners compared to heterosexual men (Bell & Weinberg, 1978). The Multicenter AIDS Cohort Study of nearly 5,000 homosexual men found that a significant majority of those men (69-83%) reported having 50 or more lifetime partners (Kaslow, et al., 1987).

John Rechy, a well known gay writer reported that he has been with over 7,000 men, and reported that, "Thousands of sex encounters are not rare in the gay world" (In Goode & Troiden, 1980, p. 58). The results from Goode and Troiden's study revealed that, "The number of partners with whom our respondents admitted having engaged in sex was, by heterosexual standards, prodigious" (p. 52). One respondent said he had engaged in sex with over 10,000 men. Only 35% said that they had had sexual intercourse with under 100 men; slightly more than that (42%) said that they had had sex with between 100 and 499 men; and 23% admitted to having had 500 or more partners. In contrast, a National Opinion Research Center (NORC) found that although the majority of the general non-homosexual adult population have had sexual intercourse since age 18, only 1.2 partners were reported during the year preceding the survey and nearly 7.2 partners since age 18 (Smith, 1991). Although the argument that heterosexuals are also promiscuous can be supported, it cannot be supported that it is in proportion to homosexuality.

During the early years of the AIDS epidemic, the Centers for Disease Control reported that gays with AIDS, at that time, had over 1,100 sexual partners in their lifetime (Pryor & Reeder, 1993). A counter-argument however is that those

reports were from the mouths of high-risk gays and not representative of all gays. However, when samples of both heterosexuals and homosexuals (both having AIDS) were compared, the homosexuals had a median of 1,160 lifetime partners, compared to a medium of 41 for heterosexuals (Guinan, 1984). Much earlier, before AIDS, it was reported that male homosexuals had a scorecard of a 1,000 partners and the majority, at least 100 partners (Masters & Johnson, 1979).

Promiscuity is the expectation for most gays, while the exception for most heterosexuals. As stated previously, in the study, The Male Couple it was found that of the 156 couples studied, only 7 had maintained sexual fidelity. Those couples that had maintained a relationship for more than 5 years were unable to maintain sexual fidelity (McWhirter & Mattison, 1984).

In a study of 30 gay men in a sexual compulsive support group, it was estimated that they experienced 2,000 different sexual encounters over their lifetime verses 500 for the non-gay control group. Despite their awareness of AIDS, these gays stated that they would like to average 14 sexual experiences per month. Even after "successfully completing" the group (goal to reduce sexual compulsivity), these men still reported at least 3 different sexual partner per month. This equaled the control group's report at the beginning of the study. Three different partners a month was still very risky given the implications of gay sex (Fluker, 1983).

According to the findings by the Journal of The International Association of Physicians and AIDS Care (October 1994), monogamy did not always mean a completely exclusive sexual relationship. Davies, Hickson, Weatherburn, and Hunt (1993) claimed that 56% of gay relationships were open and results were

astronomical in partner switching. It was also stated, in that same study, that gays averaged 70 partners per year. In comparison, the average for heterosexual man was estimated at 11 partners (Masters & Johnson, 1979).

Bell and Weinberg (1978) reported that over 40% percent of male homosexuals estimated having sex with 500 or more partners and 28% with 1,000 partners or more. Over 70% of these said that half their partners were men whom they only had sex with once. Ultimately, gay relationships seldom lasted more than 2 years with partners discussing having several dozen partners a year (Pollak, 1985).

In another study of over 1,000 homosexuals, only 2% were monogamous (defined as 10 or fewer lifetime partners) (Bell, Weinberg, & Hammersmith, 1981), compared with data on heterosexuals who report 83% monogamy (defined as 100% faithful) (Michael, et al., 1994). Compared to heterosexuals, homosexuals rated less, on the average, the number of lifetime partners of 50% and 4% respectively; that's a ratio of 41:1. The number of partners in the last 12 months of the study found 8% for homosexuals compared to 1.2 for heterosexuals, a ratio of 7:1 (Michael, et al., 1994).

In a study of gay men in San Francisco only 73 of 508 of them reported being monogamous (McKusick, et al., 1990). Gays often blame their promiscuity on society not accepting them as normal. However, the latter study was conducted in San Francisco, a very gay tolerant city. In fact, in San Francisco, same-sex unions were even acknowledged way before the turn of the 21st century.

High promiscuity rates are not just common among American homosexuals as the research has shown. It appeared be consistent in various cultures as found

within the research. The rates of multiple partnerships was found to be higher among certain groups of gay-identified men, for example a study of Asian and Pacific Islanders, found that 95% reported multiple same-sex sexual partners during the previous 5 years; during the previous 3 months, 27% reported having unprotected sex (Choi, et al., 1995). Gay-identified Thai men reported having a higher number of total sex partners than other non-gay identified Thai men (Beyrer, et al., 1995).

Another group who are traditionally known to be sexually promiscuous are heterosexual male college students. However, even they where found to be less promiscuous than gay men. A study of heterosexual-identified male college students revealed that only 13% had more than 1 partner in the previous month of the study, while the remainder had either none (30%) or 1 (56%). This finding suggested that while a smaller percentage of male college students may be promiscuous, the majority were not (Butcher, Manning, & O'Neal, 1991) .

It is very clear that gays want sex and they want it as frequently as possible. They actually complain when they are unable to have frequent encounters. This was discovered in a large scale study of gays by the Kinsey Institute. Two-third of the gay respondents complained that they could not find sexual contacts frequently enough. Woman respondents also complained of such (Bell & Weinberg, 1978). This is surprising since the sample was taken from San Francisco, the nation's most tolerant and abundent city of homosexuals.

In an interview in Omni magazine, famous sex therapist, Dr. Helen Singer Kaplan was asked why the homosexual male was unable to satifiy his sex drive by

the male-to-male pair bonding, like heterosexual bonding. She replied that, "[When] such males start talking to each other and knowing each other, their sexual experience is ruined" (D. Klein, August 1981, p. 92).

As mentioned earlier, lesbians have been found to have much sexual fluidity. For one, they report earlier sexualization, and are more likely to be molested or sexually traumatized than others. Second, they report incidents of heterosexuality at some point in their lives. The phenomenon which found that lesbians were less sexual related to earlier traumatization which was overly characteristic of those who have been traumatized. As stated earlier, even though lesbians have been found to be less sexual, per say, than gay men, they were found to be more sexually experienced than a large group of women who reported not being lesbian (Goode & Haber, 1977).

Health risk

Homosexuals were found to be at particular risk of infectious diseases and other related health issues because of their sexual practices (Fluker, 1983). It had been reported that homosexuals who practice fellatio occasionally were found to be absent of a gag reflex or to have it considerably reduced (Gioscia, 1950). Those who received anal intercourse often acquired acute and chronic pruritis ani (anal itching or sensations) (MacAlpine, 1953).

Homosexual men have been reported to expose themselves more to biological hazards more so than the general population. For example, common activities such as fisting, SCAT play, and S&M expose them to blood and open wounds. It was found that they also exposed themselves to different bodies through

orgies, and multiple partnering. They frequently reported being in socially disruptive sexual activities (e.g. martial infidelity, knowingly infecting someone else, etc.g) (Cameron, Cameron, & Proctor, 1989).

The effects of the homosexual's sexual behaviors have been traumatic to their health, for example, they have been reported to have a disproportional rate of anal fissures, rectosigmoid tears, penile edema, and hemorrhoids (Owen, 1985). A lethal skin cancer, Kaposi's sarcoma, was found to be disproportionately related to homosexuals (Lancet, 1981 cited by West 1983). Another study found that 75% of homosexual men were carrying intestinal pathogens which led to intestinal diseases (Quinn, 1986).

Anal intercourse as we learned was found to be highly practiced and favored among homosexuals, despite its risks. According to Dr. Gerald M. Feigen, M.D., the erect penis is generally between 15 cm to 17 cm long with a base diameter of approximately 5 cm. The anus is only 1.5 to 3 cm long and its muscular tone permits comfortable distention of only 2 to 3 cm. Therefore anal intercourse could very easily cause damage to the upper rectum and rupture the peritoneum. Continued stretching and displacement of the anal leads to problems in control of gas and feces. Anal intercourse is in fact unnatural, while the vagina has natural lubrication and wide openings, the anal canal is small and dry, thus facilitating injury if sexually penetrated (Ketterer, 1983). The vagina wall is relatively tenacious and cleaner than the rectum. It is also naturally lubricated. In terms of unprotected intercourse, vaginal sex is safer than anal sex, because with anal sex there is a greater possibility for feces to enter into the insertive partner's bloodstream

(Satinover, 1996). Even with a condom, anal intercourse is just too dangerous a practice (US Surgeon General's Report, 1991). Anal penetration puts the anal sphincter muscle at risk, causing chronic incontinence or urgency of defecation (Miles, Allen-Mersh, & Wastell, 1993). Finally, the anus is intended for a one way direction. It is stimulated to open by pressures from the inside, this is necessary for waste to come out. The anus is not designed for sexual penetration, but rather for waste (feces) elimination.

Due to immense amounts of anal sex, gay men were found to have a disproportionate incidence of acute rectal trauma as well as of rectal incontinence which is the inability or difficulty to control the passing of feces (Miles, Allen-Mersh, & Wastell, 1993). They also have been known to have a disproportionate incidence of anal cancers (Fenger, 1991).

Induced Immune Dysregulation (non-AIDS related) can be brought about by male homosexual contact. In male homosexual sex, even apart from AIDS, exchange of sperm antibodies alone are most likely responsible for marked suppression of the immune system (Mavligit, 1984). Even in the absence of symptoms, homosexuals have been found to evidence immune dysfunction (Greenberg, et al., 1984). Seminal fluid test done on homosexuals have been found positive of cytomegalovirus which have been related to immunosuppression. In fact, of 84 cultures studied, only 18 showed no antibody against the cytomegalovirus. Immunosuppression has many long-term consequences, for example Kaposi's sarcoma is related to immune suppression (Bigger, et al., 1983).

Lesbians were harder to identify in terms of physical problems, as they have

generally failed to seek traditional healthcare (Trippet & Bain, 1992). In fact, lesbians were known to seek alternative pseudo-health care from other lesbian friends rather than from professional health care providers (Saunders, Tupac, & MacCulloch, 1988). As this is the case, it is likely that many lesbians have faced several medical difficulties unknown to society. This, however, has not been a generality for heterosexual women. Lesbians do, however represent a greater percentage of hysterectomies (Johnson, Smith, & Guenther, 1987). Because lesbians have been more apt for violence, they were more at risk for physical and emotional destruction (See also Chapter 3: Violence).

Even when homosexuals practiced sexual monogamy (which decrease AIDS risk) they were at higher risk, than the general population, for non-AIDS conditions, such as those just previously discussed (e.g. anus problems, Induced Immune Dysregulation, etc.).

Anal Intercourse

As already mentioned throughout this report, anal sex is most preferred by homosexually active men, as found by both qualitative and quantitative research. To reiterate, according to Dr. Gerald M. Feigen, M.D anal intercourse could very easily cause damage to the upper rectum and rupture the peritoneum. Continued stretching and displacement of the anus leads to gastrointestinal problems.

Male homosexuals engage more frequently in anal sex than heterosexuals and have frequent incidents of anal intercourse often with multiple partners. In the study, Sex in America, it was found that these episodes are 13 times more frequent than heterosexuals (Michael, et al., 1994). In the study of over 1,000 gay couples,

only 94 said they performed insertive anal intercourse “less frequency” or “never”, however half of the 94 had admitted to having performed it (Harry, 1984). In an earlier study of over 5,000, only 9% said they never practiced insertive anal sex. Thirteen percent said they never practiced recipient anal sex. Sixty percent of those practicing anal sex said they felt very positive about having another man ejaculation inside them. The researchers concluded, "Reading the responses to the questionnaire, it is clear that there are innumerable [gay] men who find nothing but delight in anal intercourse..." (Jay & Young, 1979, p. 464). Three-fourths of the male homosexuals from collective data from the Kinsey Institutes between 1938-1968 admitted that they would allow others to climax in their anuses (Gebhard & Johnson, 1979).

By these findings, it was clear to conclude that more gay men enjoy anal sex than not. In The Spada Report, three-quarters of the respondents said that they enjoyed anal sex. "Anal intercourse was frequently mentioned as the most intimate act between men, the sexual activity holding the most emotional impact (Spada, 1979, p. 92), and "Many [gay] men see anal intercourse as a spiritual bonding between men" (p. 93). Another study confirmed that "There is a high level of anal eroticism among [gay couples]" (McWhirter & Mattison, 1984, p. 279).

The Multicenter AIDS cohort Study of nearly 5,000 homosexual men found that over 80% of these men had engaged in receptive anal intercourse with other men in the previous 2 years of the study (Kaslow, 1987). In a multicenter AIDS Cohort study in Pittsburgh, of a sample of 43 HIV-a converters, 91% reported receptive anal intercourse (Kingsley, 1990). In another Multicenter comparison of

601 gay men, one fourth had engaged in 1 or more episodes of unprotected anal sex and more than 23% engaged in 23 or more episodes. Over 80%, consistently reported in the 3 cities studied, admitted to incidents of protected anal intercourse. The numbers were likely to have been even higher as men were said to be resistant to admit their participation in anal intercourse (Doll, et al., 1991).

A study in Los Angeles reported episodes of anal sex in the 4 weeks before the survey to be 6 times more frequent among homosexual men than among the heterosexual men studied at the same time (Kanouse, Berry & Gorman, 1991a). Although physically possible, heterosexuals generally do not participate in anal sex. Anal intercourse reported by heterosexual men and women is low, a far cry from the level reported by homosexual men (Wellings, et al, 1990).

Anal intercourse among gay men was found to be an international phenomena. In a sample of 502 men from England, one-third attempted to receiving passive anal intercourse, and 19% had had unprotected passive anal intercourse (Dawson, Fitzpatrick, McLean, Hart, & Boulton, 1991). In the Men's Survey 91 in Canada, 62% of the 500 respondents admitted participated in anal intercourse in the 3 months prior to the survey completion (Myers, Godin, Calzavara, Lambert, & Locker, 1993). In a earlier study of urban Mexican males, some 90% preferred anal intercourse (Carrier, 1971). Although anal sex was considered dangerous, even with use of a condom (US Surgeon General's Report, 1991), it remained a favored activity in the gay lifestyle (Doll et al., 1991).

Dr. Charles Silverstein argued that homosexuality is normal, and as stated earlier, developed illustrated and instructive books such as The Joy of Gay Sex with

co-author White (1977) and The New Joy of Gay Sex with co-author Picano (1993). These kinds of books, namely Anal Pleasure and Health by Jack Morin, illustrated how to perform anal intercourse and suggested that anal sex could be part of a so called, healthy relationship. These books have been praised by the gay community. In a book review of Anal Pleasure and Health, in The Journal of Homosexuality (Vol. 8., # 2), Wendell Ricketts exclaims. "...[Anal Pleasure and Health] is a book about...letting go of patterns that have kept us from getting as much out of sex as we deserve."

Given the onset of the AIDS epidemic in the 1980's, one would think that behaviors, such as anal sex, which contributed to AIDS-risk would decrease. It did, however it went back on the rise and stayed that way. Even when risk reduction measures had been taken, gays did not want to give up on anal sex. Research found that most gays were very educated and knew of the risks. When gay physicians were surveyed, they certainly reported decreasing their own high-risk behaviors since the onset of the AIDS epidemic. However, in the gay physician's sample, 16% increased unproceted insertive anal sex, and 31% made no changes after the onset of the AIDS epidemic (Klein, et al., 1987). This is shocking not only that they were doctors and were highly educated, but given the fact that this was well past the onset of the AIDS epidemic. (See also Chapter 2: AIDS Risk).

Oral-Genital

Homosexuals were reported to engage in more oral-genital contact, compared to heterosexuals. The Bell and Weinberg (1978) study found that there was a high incidence of fallatio among gay men, and cunnilgings among lesbians.

Oral sex among heterosexuals was not as high as the incidences found among homosexuals as it was found, in one particular study that about 55% of homosexual men compared to 26% of heterosexual men and women had engaged in oral-genital sex (Kanouse, Berry, & Gorman, 1991b).

In The Spada Report, 90% of gay men reported receiving fellatio and 88% enjoyed giving it; 77% enjoyed having another man ejaculate in his mouth. In a sample of 61 gay-identified college males, 69% admitted to having experienced oral sex (D'Augelli, 1992). When white non-delinquent gay men in the Kinsey studies between 1938-1963 were asked how often others put their mouths on their organs, only 5% said "none" often (Gebhard & Johnson, 1979). In the Canadian Men's Survey 91, 85.2% reported practicing insertive fellatio and 81.7% receptive fellatio in the 3 months prior to the study (Myers, Godin, Calzavara, Lambert, & Locker, 1993).

Analingus

Analingus (oral-anal), also known as rimming, was also found to be very popular among gays. In a study of 156 gay couples, 42% admitted to either performing analingus or receiving it. “Diaries concerning sexual behavior kept by homosexual men showed that the acquisition of hepatitis A virus infection was correlated with frequent oral-anal contact”, according to Corey and Holmes (1980, p. 435). The act of analingus was unmatched in comparison to heterosexual couples, who also have the same ability to do so (McWhirter & Mattison, 1984). When white non-delinquent gay men in the Kinsey studies between 1938-1963 were asked how often others rimmed them, 20% said "much" often (Gebhard & Johnson, 1979). In

the Canadian Men's Survey 91, 33.7% reported practicing insertive analingus, and 40% receptive analingus in the 3 months prior to the study (Myers, Godin, Calzavara, Lambert, & Locker, 1993).

Fetishism

A fetish is a perversion, in specific to a fixation related to libinal activity. According to Freud, sexual perversions stem from failure of the normal heterosexual development. Fetish behavior is a correlate of underlying psychopathology (Diamond & Karlen, 1980). Foot fetishism (feet of other men as primary sex object) has been especially associated to male homosexuals' sexuality. Organizations such as The Foot Fraternity have been established to meet their needs. In a study of these organizations, by Weinberg, Williams, and Calhan (1995) only 4 respondents were self-identified as heterosexual. As children, 53% of the respondents reported having fewer friends then other children their age. Much of the fetish behavior accompanied masturbation fantasy. Many of the respondents were introduced to and/or reinforced to the foot fetish by sexual experience with their fathers' or other males' feet/footwear. One-fifth of the respondents who supplied explanations for their fetish made reference to being aroused by observations of their fathers' feet/footwear or some direct sensual experience they recollected involving their father or other male adults in their life. One respondent wrote, "At [age] 6 or 7, I had my stocking feet worshipped by a 30 year-old uncle. He would massage my feet and either masturbate on them or sodomize me. I began finding men in their socking feet sexually exciting" (p. 22).

In The Gay Report, about one-fourth of the men indicated that foot fetishism

had played a part in their sexual interactions at least once. Close to one half of the study's participants admitted to fetishes of jock straps and underwear, while close to three fourths were into boots, leathers, and other clothings (Jay & Young, 1979). Genitals also took a fetish nature; the authors found that "Gay men have an overwhelming positive feeling about male genitals, their own and others" (p. 447). Gillespie (1964b) said that for some homosexual men, they could not be inaccurately described as penis fetishists.

Sadomasochism (S&M), Bondage and Discipline (B&D) and humiliation.

Homosexuals were found to expose themselves more to sadomasochist behaviors. This was discovered in a random sample of adults in 5 metropolitan areas (Cameron, Cameron, & Proctor, 1995). In an earlier study of sadomasochism, only 34% of heterosexuals respondents reported having acquaintances with sadomasochist interests compared to 87% of homosexual respondents (Spengler,1977).

In The Gay Report, in terms of S&M frequency, over one-third of the gays admitted to S&M practice, 1 or more times. Close to another third admitted to the practice of Discipline and Bondage (D&B), one or more times, while 22% admitted to the use of humiliation (Jay & Young, 1979).

Spada (1979) reported that 16% of his sample admitted to S&M activity and 12% admitted to B&D. One respondent wrote, "I really love the masochis[t]...I think of him as a father figure. I like to be cussed out and criticized....then I like to be stripped, spanked, and [penetrated]- but always hugged and loved in the end" (p. 128).

Gay sadomasochists during the 1970's have had an easy time making sadomasochist contact due to the enormous amounts of gay leather bars, baths, clubs, and the like during that time (Lee, 1979). Gays in sadomasochist relationships viewed them as a "fulfilling game" according to Kamel (1980). Kamel found that gay sadomasochists evolved from the gay subculture whereas some men became disenchanted because they could not find partners were masculine enough for them. These men became depressed and therefore entered the sadomasochistic subculture, referred to as the "second coming out" (p. 187). Kamel did not see the heterosexual sadomasochistic in this way, in fact he stated "the difference between homosexual and heterosexual sadomasochists are so great that they should be viewed as distinct entities" (p. 187).

Sadomasochistic behavior and the correlation with homosexuality was also found in a longitudinal context analysis study by Innala and Ernulf (1992). The term, "leathersex" was often used by gays. In depth, it really was a euphemism for S&M and other unconventional activities. An association had also been dedicated to gay S&M, titled, National Leather Association (NLA). A gay psychotherapist had stated that S&M was a style of "erotic play" which could be part of a "healthy expression of [Homo]sexuality" (Baldwin, 1993, p. 16). Baldwin advanced S&M to his patients. He referred his style as the, "advancement of kinky people" (p. 16). He did not see it as aggressive and pathological but rather as, "Sensuality and Mutuality (S&M)" (p. 40).

Rinella (1994), while advocating for gay S&M behavior stated,

The leather scene is famous (notorious?) for its focus on paddling,

whipping, cock and ball, and tit torture, and the infliction of pain in general.

> Because of that, how to handle the resulting pain is an often-asked question. The most obvious way, of course, is to avoid it. But avoiding pain denies us the satisfaction we're [meaning himself and other gays particularly] looking for. Pain holds a certain attraction, so we allow it in our lives. (p. 153)

During the 1990's, the homosexual S&M community celebrated that the American Psychiatric Association's Diagnostic and Statistical Manual IV (DSM-IV) had changed its clinical diagnostic language about sadomasochism. The DSM-IV was changed to state that the sadomasochistic behavior was only a diagnosable disorder if it "cause[d] significant distress or impairment". The APA denied, however that they meant to depatholize the behavior (Satinover, 1996).

SCAT and Waterports

Commonly found, mostly among gays and not heterosexuals, was SCAT: the use of feces and defecation in sex play. In The Gay Report, 4% of the gays admittedly used defecation in sexual encounters (Jay & Young, 1979).

More common among gays was a sex game referred to as "watersports" or "golden showers" acts of which one or a group of participants, urinate on another or others. Actual establishments in the gay community have been set up to facilitate this action. In The Gay Report, gays described how exciting this practice was for them, many said they enjoyed the warm feeling of being urinated on, while others discussed how they enjoyed doing it. The study found that 22% of the study's

participants admitted to use of this practice (Jay & Young, 1979). Nineteen percent of the respondents in The Spada Report admitted to watersports (Sapda, 1979). One respondent wrote, "That soft, warm liquid feels nice" (p. 128). In Kinsey's data (1938-1963), close to 15% admitted to some frequency of urination in sexual encounters (Gebhard & Johnson, 1979)

A gay social scientist, Mains (1980) in writing his master's thesis, discussed gay sexuality. In discussing one scene, he wrote, "...within seconds, a dozen or so [gay] men have been drawn from the shadows of the room to the perimeter of [a] tub. All of them ready to [urinate]. Before them a man writhes in expectant passion [to be urinated on]" (p. 107).

Fisting

Despite its severe health risk (emergency colostomies, bowel rupture and even death), "fisting" or "handballing", an act of which participants place an entire fist and even a forearm the rectum of another "is usually a [male] homosexual activity (Shook, Whittle, & Rose, 1985, p. 319). Several organizations (gay or S&M in nature) were described as such: The Fist-Fuckers of America (FFA), Total Ass Involvement League (TAIL), Mid-America Fist in Action (MAFIA), and Red Hankies of San Diego. The latter, hosts a “fist-fest” each June in California.

Jay and Young (1979) found that 13% of gay respondents admitted to the use of fisting. The authors concluded that "[fisting] is experienced regularly by 1 out of every 20 of the respondents to the survey" (p. 566). One respondent reported, "..[fisting] seems to me to be the most intimate, caring, and yes, loving sex experience that I've enjoyed..." (p. 566).

The Spada Report found that 15% of their respondents admitted to active fisting (Spada, 1979). The qualitative data reported in The Spada Report was too graphic and therefore not included in this report.

"[Fisting] takes a lot of work and a lot of caring", as discussed in Mains (1984, p. 130). Mains stated that the physical act of fisting required a disconnectedness of the mind. Accordingly, mental control made it possible. In order to relax the sphincter muscles to be fisted, he stated that physiology is vital - "The mind must also learn to take control...so that it can be disconnected..." (p. 130). The respondents in The Spada Report also stated that mind control (e.g. to think beyond the pain) was reported necessary in order to complete fisting activity.

When Shook, Whittle, and Rose (1985) interviewed gay sources, knowledgeable of fisting they said that it is almost exclusively a gay behavior which coincided with other S&M and unconventional actives, such as the use of cockrings (devices applied to the base of the penis and undersides of the scrotum which have a tourquet like action which dams blood flow for the goal to prolong erections).

Some gay bars even catered to people interested in fist insertion. Enemas and rectally administered drugs and alcohol were often used as a preparatory to fisting. As stated previously, psychological, cognitive distortion, abuse of amyl nitrite, and fantasy were used to help enable participation.

The Gay Men's Health Crisis (GMHC), a popular New York-based AIDS health education organization, published pamphlets which suggested that fisting with latex gloves on was safe as long as individuals "don't insert the fist past the length of the glove". The GMHC also said that "SCAT" and "Watersports" were "fine" as

long as one did not get body fluids "inside [their] body" (The Lambda Report, June 1994, p. 6). The GMHC also published the "Sexier Sex Handbook for Lesbians". In it, accompanied discussions about female fisting of both vagina and anus (The Lambda Report, April, 1995, p. 3).

Other unconventional sex practices

Gays have been cited for a variety of other unconventional sex practices. Bestiality (sex with animals) was reported by 13% of the respondents in The Gay Report. Eleven percent admitted to frequent use of enemas. One gay respondent wrote, "...I've used enemas since I was ten years old" (Jay & Young, 1979, p. 564).

Unusual sexual acts were described by respondents in The Spada Report, but they were "viewed by most gay men as fun, not brutality" (Spada, 1979, p. 127). When asked if they engaged in unusual sexual activities, close to one-third answered, "yes" (p. 127).

In a study of gay couples, a general use of a wide assortment of sex paraphania were described. Dildos and rubber penis were popular as were cock rings. S&M equipment was also characteristic for some gay couples. These materials however were not described as general use among heterosexual couples (McWhirter & Mattison, 1984). One-third of The Spada Report's respondents admitted to use of sex toys, such as cockrings and dildos (Spada, 1979).

There was the increasing popularity of "blood sports," a pathology involving cutting and piercing that was previously quarantined within the S&M community, but spread outward as part of gay sexual experimentation. According to the San Francisco Examiner, participation in blood sports had gone beyond piercing of body

parts. It involved someone using a scalpel to cut an intricate design in a partner's skin, and drawing blood through whipping in the middle of an erotic exchange. One advocate of this sort of activity called it an exchange of energy which had to do with trust.

Despite the risk of spreading AIDS and hepatitis, members of the gay and lesbian community defend the practice of blood sports, claiming that education would make it safe. Therefore, the AIDS Clearinghouse in Los Angeles printed brochures with tips on the best places on the body to flog to avoid internal damage and how to provide first aid in case a cut went too deep. It said that whips should be cleaned with alcohol in between uses, and gloves and antibacterial cleansing agents were a must. Mentors were said to be available and made it known that several groups offered demonstrations and courses (Heterodoxy, October 1994).

Fantasies

Compared to heterosexuals, fantasies for homosexuals tended to take more extremes and were more characterized by voyeurism. When The Gay Report questioned men about their fantasies, the authors found that, "...large penises, black men, incest, and group scenes (sometimes in combination) [were]...repeated themes..." (p. 629). Further they stated, "A large number of fantasies involve[d] dominance and submission, including rape, gang rape, sadism and masochism, bondage, and related acts (p. 631). Forced sex was also more characteristic of the homosexuals in the study by Masters and Johnson (1979).

Pornography

When homosexual and heterosexual men were compared on greater arousal

for pornography, homosexual men, relative to heterosexual men were found to be more likely, as a response to pornography, to have tried multiple coitus, passive and active oral-genital contact, and they reported higher masturbation frequency (Athanasiou & Shaver, 1970). Gay men reported a higher frequency usage of pornography than heterosexual men by ways of a wide assortment of: magazines, pictures, novels, and videotapes of which they shared with gay couples and in groups (McWhirter & Mattison, 1984). Fifty percentage of the men in The Spada Report admitted to using pornography during sex (Spada, 1979).

Magazines known of homosexuals are not like those of the mainstream. In almost every way they can be considered pornographic. In content-analysis of gay Dutch magazines between 1974 and 1983 it was discovered that these magazines were pornographic in nature and in a large sense, S&M. The researchers found, "The theme most frequently recurring in the 136 S&M pornographic stories was mental humiliation, in which the dominating partner abuses the submissive partner, or disparages him, or gives degrading orders (such as eating from a dog-pan)" (van Naerssen, et al., 1987, p. 112). "Fear disgust, and pain" (p. 116) were in the scenarios of half the pornographic stories reviewed. The same research group interviewed 16 homosexual men who, in reality, practiced S&M of which many of these characteristic were agreed upon by each of the practicing partners.

Voyeurism

Masters and Johnson (1979) found that fantasies were different among heterosexuals and homosexuals. Homosexual men reported more imagery, especially of the male body, primarily the genitals and buttocks.

The samples in the study by Price, Allensworth and Hillmans (1985) where more similar in background than samples in the Maters and Johnson (1979) study and they also found voyeurism traits higher in the fantasies of homosexuals. Both homosexual men and women fantasized about watching same-sex relationships while the heterosexuals fantasized more about being irresistible to the opposite sex.

Cruising

Cruising has always been one of the sexual hallmarks of homosexuality. Rich (1991) in his psychoanalytic work found that, for his patient, cruising was a pathological compulsion. In an in-depth psychoanalytical study on homosexual cruising, it was found that it was a complex ritual, typical in sexual manifestation. It was ritualistic in that "the regularity, the immutability, [left] no doubt of its compulsive nature and its origins in anality and aggression" according to Calef and Weinshel (1984, p. 47). As one subject was described: "He could not get the thought of cruising out of his mind. He was compelled both to think about it and do it", and "in contrast he often felt denigrated, depreciated and unloved at home" (p. 47). These findings however were not characteristic of heterosexual cruising. The homosexuals tended to cruise solo, while heterosexuals tended to cruise in groups. The heterosexual cruise aim was found to have a motive for socialization, first and primary, while the homosexuals' aim, purely sexual.

In a large-scale study of homosexuals, nearly all the gay men reported that during the previous year of the study they had cruised other men especially to look for a sexual encounter. It was found that cruising took place not only in vehicles, but in public places like bars, parks, reststops, adult book stores, and bathrooms. While

cruising was observed more with homosexual men than homosexual women, the women tended to cruise more in bars or private establishments known to them (Bell & Weinberg, 1978).

Public/Commercial sex

Unlike straight men, gay men have widely been marked for conducting sexual practices in common public places: restrooms "tearooms", parks, rest stops/truck stops, parking lots, bathhouses, and adult shops (Fumento, 1988; Humphreys, 1970; Rechy, 1977; Troiden, 1974; Weinberg & Williams, 1975;). In bathhouses, short term anonymous sex has been praised as a"desire to know and trust other men in a type of brotherhood". It was found that the popularity of these locales was found to be popular among homosexuals since they afforded the opportunity to exchange sex without obligation or commitment (Hatter, 1970).

In questioning over 5,000 homosexuals, close to 50% of the men said they practiced sex in public restrooms 1 or more times (Jay & Young, 1979). Reviewing case histories of gay men, it was found that sexuality became deformed, reduced to frenetic encounters in baths or back rooms. Lauritsen (1993) revealed,

> Sexual partners were not spoken to, or even seen, let alone confronted as complete human beings. Some gay men never learned to make love, but instead came to define their sexual identity in terms of a fragmentary repertoire of acts. It became morbid self-degradation. Some establishments provided a Theater of Depravity, in which the patrons derived erotic satisfaction from psychologically and physically

abusing each other. There were commercial sex clubs featuring rooms in which demented beings in bath tubs waited for others to come along and use them as toilets. A "Black Party" at a popular disco club provided, for entertainment, the spectacle of a young man mutilating himself and of a pig being murdered. Many had died long before that in terms of humanity and respect. The commercial sex milieu was extremely unhealthy psychologically. (pp. 190-191)

In another qualitative study, one gay himself, said,

In backrooms and bar rooms, in sex clubs, and in our own bedrooms we have let the fog of denial fall upon us...how many of you, when asked to have sex with Mr. Right at the moment, think of unsafe sex as OK, just this one time, him being so gorgeous and all. Can it be that the forces of hatred and bigotry have won out? Have we decided that we are not worthy of life? Fourteen years into this plague and still most new infections are among gay men. Have we gone from our right to be ourselves to the right to be murderers? (Norman, 1995, p. 1)

Commercial sex was much more popular in the homosexual world than the heterosexual world in the 20th century. Even when advertisements claimed, "non-physical contact", it did not prove to be true. In one study, massage advertisements were found to be nothing more than lies. For example, the masseur in one

advertisement was claimed to be young and nonsexual, but it turned out that he was much older and further, the masseur "[was] clearly into sex rather than massage..." (West, 1993, p. 88).

Gay baths

Dr. Styles, a gay ethnographical researcher, did a complete observation study of gay baths. He found that gay baths were institutions that provided a spa like atmosphere (e.g. jacuzzis, showers, pools, steam room, etc.) where for a nominal fee, gays could roam around nude or partially nude, and engage in sexual encounters with other men. Since, Styles was gay, he was able to get a complete insiders view. He found what he called the "relationship escalation", which was a hierarchy of relationships discovered at the baths: Number 1 on this hierarchy was "the negotiation of a sexual encounter", number 2 was the "sexual encounter itself", and number 3 was a "post coitum conversation". He concluded that, "the vast majority....never [went] beyond [number 2]" (Styles, 1979, p. 140).

One-third of the respondents in The Spada Report admitted to regular attendance to gay baths. One respondent sated that the gay baths "[were] a marvelous institution. Imagine, instant sex without any hassle..." (Sapda, 1979, p. 113). The Spada Report's qualitative data on reports of the baths only showed that they were purposefully for uninhibited, unprotected, and anonymous sexual encounters, for several hours at a time. One respondent reported having unprotected sex at the bath with up to 3 other men in a 6 hour period. Many respondents would report group sex in the baths. This study was conducted in the 1970s, however on the onset of the AIDS epidemic in the early 1980s, many gay baths closed as a

response, but shortly after the AIDS onset, they reopened relapsing back into the same patterns. Definitely not a thing of the past, gay baths are on the rise, bigger than ever (Tone, 2006).

Telephone and Cyber Sex

Telephone Sex

Once the elecrontic age hit the 20th Century, homosexuals took advantage of it to promote themselves for sexual activities. Telphone chat lines were very popular with the sexual content much like that of personal advertisements discussed earlier. While one researcher interviewed a sex line operator, interesting findings were reported in their exchange of dialogue. The operator interviewee explained, "We've got about 14 special lines, ranging from leather interest to mud and oil, PVC, construction workers, bikers....a rubber line, a master line, a slave line...". When asked, "Are these both heterosexual and heterosexual?", the interviewee replied, "They're all homosexual. We had heterosexual slave and master lines....but they proved rather unpopular."

The researcher further questioned, "So most of the kinky ones are homosexual?" The operator interviewee exclaimed, "Definitely yes." He validated that homosexual lines were the "general trend" in the spectrum of “electronic dating” (West, 1993, p. 183).

Cyber Sex

During the 20th century, personal web pages began to be formulated over personal computers (PC). These pages were set up to advertise for sex, or for others to get acquainted. All that was needed was a PC with simple applications such as

Windows 3.1. One web page, set up by a gay men, David Beals, described: "My hobbies...include computers....body piercing and sleeping. I'm only mildly psychotic, and the medication seem to be helping..." He offered viewers a chance to see his body piercings. He also offered information about a leather and uniform organizations. Although this is an anecdotal account, it served as a model for millions of gay interactions found over the cyber space during the 20th century and into the 21st century.

Although the century was absent of studies to compared homosexual to heterosexual cyber interactions, it served as an example of how homosexuals used the opportunity to exploit themselves. Beals mentioned that he learned about body piercing through the internet. He said that the body piercing, "hurt like hell", but then said, "it was love at first sight". The same author also shared examples of tattoos that he and other friends had engaged in. As stated earlier, content-analysis has confirmed that there is a strong association between erotic body piercing and homosexuality (Bulhrich, 1983).

Other examples available over the computer net were, "kinky leatherfags", "body modifications", and "tattooing, branding, and scarification page". Another web page by David MacKenzie of Hampton, Virginia, told viewers about the "Home Town Guys Videos". This was really a euphemism for pornographic explicit videos with fetish themes. On MacKenzie's home page he showed and told of 3 videos with men practicing with latex toys, titled "Dildo Dudes". He said the videos were "fantastic". One video showed a man anally intercoursing with a large dildo, while in another, a young man was masturbating while hiding his face. These are just

nuggets of the kinds of things that gay web pages offered it's users at the onset of the computer age in the 20th century. Today, it has evolved into a multi-billion dollar industry (InNewsWeekly, January 25, 2006). This begs the questions, however, if gays are so concerned about "community", then why does all this money goes towards electronic sex outlets?

Content-analyses of "In Search Of" (ISO) Sex

It has been suggested that personal advertisements from homosexuals are more frank and sex-goal orientated which was merely a refection of their culture (Laner & Kamel, 1977). This had since been tested and found to be true. A 5-year content-analysis was conducted from 10,292 random "In search of" (ISO) (personal) male advertisements in The Washingtonian (the heterosexual male sample) and The Advocate (the gay sample) (Reisman & Johnson, 1995). The readers of The Washingtonian were mostly upscale, urban, white heterosexual professionals. The demographics matched almost entirely with The Advocate readers accept in sexual orientation, whereas most readers, if not all of The Advocate were gay. Thus, these were good comparison groups to use in the research.

Content-analysis of advertisements has been known to be a good way to get reliable characteristics because the advertisements are paid for by the individuals and therefore indicative of what they really wanted. The Advocate was indeed representative as it reached a large percentage of white, upscale male homosexuals between the ages of 20-45.

Given the similar demographics of the 2 samples, it was hypothesized that

the outcome of both groups would then be similar or at least somewhat similar. They weren't, however. The following significant findings were reported: 86% of the Washingtonians sought time-bound relationships compared to 2% of the Advocates. Thirteen percent of the Washingtonians sought quick sex encounters verses 98% of the Advocates. The Advocate samples' focus was singular and clear - immediate, anonymous sex with the youngest aged males possible. None of the Washingtonians sought young girls at the earliest legal age of 18 years old verses 51% of Advocates, who sought boys at the earliest age possible, in fact, 15% of the Advocates actually sought young boys less than 18.

Forty-nine of the Washingtonians verses 3% of the Advocates solicited partners by their own non-sexual interest. Fifty percent of the Washingtonians sought partners by non-sexual characteristics verses 4% of the Advocates. Five percent of the Washingtonians verses 63% of the Advocates sought paid sex. Less then 1% of the Washingtonians sought forms of sadistic sexual behaviors with their partners verses 25% of the Advocates who did. Also found in the study was that 22% of the Advocates sought partners by their phallic size or other body parts; 15% of the Advocates actually cited their own phallic size, while the Washingtonians did not.

Other studies have also supported the fact that homosexuals wontedly seek out sex and sexual characteristics through their paid advertisements. In another content-analysis of over 1,000 paid advertisements in The Advocate, gays primarily sought out personal physical characteristics in their desired prospects as well as ads for commercial sex, such as escorts, nude models, and masseurs (Lumby, 1978).

Because these paid advertisements have been so consistently sexually explicit and numerous, The Advocate devoted a completely separate publication just for those advertisement and want-ads. If not, The Advocate would have to be considered a pornographic magazine. This had never been the case in any comparable magazine, such as The Washingtonian, which was read mostly by heterosexuals.

Youthful sexualism was also what was desired of gays seeking contacts in personal ads. In a content-analysis of personal ads in the National Singles Register (heterosexual sample) and personal ads from The Advocate (gay sample) it was found that "..among homosexuals, far more 'young adults' than members of other age categories advertised for companions, dates, or mates" (Laner, 1978, p. 498).

Another content-analysis of 800 personal column advertisements equally balanced between men and women, showed that the homosexuals were more concerned about sex, while the heterosexuals specified a broader range of characteristics (Deaux & Randel, 1984).

In longitudinal content-analysis of restroom graffiti conducted from 1972-1984, it was discovered that 83% of the bathroom graffiti had same-sex seeking content. Body traits were mostly sought. The highest percent of which sought sexual and masculinity traits (52% combined), with the penis trait was desired the highest. The messages were also concerned about sexual roles, e.g. who should be passive-submissive (44%), and who should be dominant (18%). Seeking personality was of the lowest percent (3%). Finally, not surprising, most wanted oral and anal sex (Innala & Ernulf, 1992) (See also Chapter 9: Sexuality).

Early Sexualization/Experiences

Studies have shown that homosexuals are more likely to have had their first sexual experience early in their lives (Athanasiou & Shaver, 1970). In collective data from the Kinsey Institute (1938 to1963) it was found that a major percentage of homosexual men said that they had their first post-pubertal sexual contact between the ages of 12-14 . In contrast, the major percentage of heterosexual men reported that their first post-pubertal sexual contact was between the ages of 17-19, only slightly younger were delinquent samples (Gebhard & Johnson, 1979).

Later, Rotheram-Borus and Gwadz (1993) found that gay men were more likely then heterosexual men to become sexually active at a younger age: 12.7 verses 15.7. Lesbians were also sexually active earlier than their heterosexual counterparts: 15.4 verses 16.2 (Rotheram-Borus & Gwadz, 1993). In a study of gay couples, it was reported that they usually had their first sexual experience at around age 5 or 6, most commonly with another male (McWhirter & Mattison, 1984). Many of The Spada Report's respondents also admitted to early sexualization (Spada, 1979). The author in his own words stated that, "In some cases, young men had either their first experience or their first meaningful experience with an adult" (Spada, 1979, p. 35).

It has also been reported that young boys and teens can be seduced into a homosexual lifestyle which has long been founded (Davies, et al., 1993) and as stated earlier, pedophilia is more common among homosexuals (Freund & Watson, 1992) (See also Chapter 6: Sexual Abuse).

Intergeneration ("Man-Boy Love")

The Wolfenden Report published in 1957, emphasized the need to protect boys from sexual attention of older men. However, despite the warning, during the 20th century there existed homosexual movements and rings, internationally, that supported and even advocated for adult-child same-gender sexuality. A gay Dutch organization, C.O.C., stated that the age of homosexual consent should be eliminated. In 1990 with their advocacy, the age of consent was moved to that of age 12 in Holland, but if parents objected, then the age of consent was moved to 15 (Stonewall Union Reports, 1991). One pro-gay editorial brutally put down and criticized the British House of Commons because they did not vote to lower the age of homosexual consent to 16. The House was accused of being "criminalizing , prejudicing, and unreasonable" (editor, The Statesman and Society, 1994).

A whole issue of the Journal of Homosexuality was dedicated to intergenerational (man-boy love) relationships (1990, vol. 20, no. 1-2). One contributing author wrote, "In recent years the general trend has been to label intergenerational intimacy [as] 'child sexual abuse'...[This] has fostered a one-sided, simplistic picture...Further research...would help us to understand the... possible benefits to intergenerational intimacy" (Jones, 1990 as cited in Satinover 1996, p. 62). In the same issue, Sandfort, Brongersma, and Van Naerssen (1990) argued that the social climate, at the time, made it difficult to study the relationships between man-boy love. They felt it was just another "diversity" (like homosexuality) in a wider repertoire. They did not feel that such relationships were necessarily pathological or that pedophilia carried a negative psychiatric connotation. This, of

course, is similar to arguments that were used to depatholize homosexuality in the early 1970's (more in Chapter 13, section, “The depathologization of Homosexuality”).

Despite its pathologies, D. J. West, a British psychiatrist who self-identified as gay, suggested that the sexual patronage of older gays to young boys could be "caring" and like "pseudo-parenting". He stated, "it is rightly pointed out [that] sexual patronage of an older man can sometimes provide wayward youngsters with an emotional and social security that they would not otherwise enjoy, much to their own benefit and that of society at large" (West, 1983, p. 225).

BLK, described as "The National Black Lesbian and Gay Newsmagazine" responding to the Michael Jackson child molestation allegations, was quoted as saying: "...And who among us can be sure that the emotion which prompted Michael Jackson to lie down with boys…was any less, any different than that which one drove Peter Pan to beseech Wendy to return to Never-Never Land?" (The Lambda Report, April 1995, p. 12).

During the 1980's some gay activist were in favor of sexualizing youth in a militant manner. Michael Swift's in his article "Speaking up for the homoerotic order," in The Gay Community News sated that,

> We shall sodomize your sons, emblems of your feeble masculinity, of your shallow dreams and vulgar lies. We shall seduce them in your schools, in your dormitories, in your gymnasiums, in your seminaries, in your youth group, in your movie theater bathrooms, in your houses of

> congress, wherever young men are with men together. Your sons shall become our minions and do our bidding. They shall be recast in our image. They will come to crave and adore us (The Gay Community News, Feb15-21, 1987).

The Defense for Children International, USA reported that there were child sex package tours offered in West Germany, the Netherlands, Japan, and the U.S.A.. The North American Man/Boy Love Association (NAMBLA), an association which believed that sex between an underage child and an adult could be beautiful and should be legalized, has been reported to steer adult men to Thailand. There, a "boy's home" tour was arranged, where the men could choose and pick up young boys for sex. Tours were set up where the men could go and negotiate prices for child prostitutes. They also gave direction on how others could manipulate local laws in order to use children for sexual gains (Hedberg, 1995).

NAMBLA also documented these locales in several third world countries where children could be molested free of legal consequences (Satinover, 1996). NAMBLA, at the time of the research, had over 1,000 members, most of which self-identified as homosexual. They once used an 11-year-old boy to write a monthly column for them with featured erotic stories and poems of which older men reported to enjoy (Shurmaitis, 1995). One adult male reader reported seducing and engaging in sex with a 7-year-old boy, with detail. The writer praised NAMBLA that they are available to support him in his behavior (The Lambda Report, Spring, 1996, p. 9).

NAMBLA was part of the International Lesbian and Gay Association (ILGA) until 1993 when it was expelled because of pressures from The United

Nations (The New York Times, Sept. 18, 1994; Frontiers , Oct 7, 1994). When ILGA expelled NAMBLA, other gay groups became outraged at ILGA, for example, the Munich homosexual group Society for Sexual Equality, criticized ILGA for refusing to stand up for sexual rights (The Lambda Report, Spring 1996, p. 9).

NAMBLA continued to find support from some homosexual publishers, however (The Lambda Report, November, 1993, p. 3). In fact, Alyson a gay book publisher, published "Gay Sex: A manual for men who love men" listed "suggestions" on how "to minimize the risk" for "men who are involved with partners under the legal age of content"-courtesy of NAMBLA (The Lambda Report, Spring 1996, p. 1). Noteworthy is the fact that Alyson was the publisher of "Daddy's Roommate", "Heather has Two Mommies" and "Daddy's Wedding", books aimed at young children to teach them that gay relationships and marriages were “normal”. Alyson also published, "Doing it for Daddy" which was a sex fiction book for lesbians who fantasized about daughter-father incest and for gays who were into male leather daddies (The Lambda Report, Oct 1995, p. 14).

The May 8, 1995, issue of The New Republic published a review of the movie titled, Chickenhawk. The movie's title was slang for pedophiles who hunt children for sex. The author downplayed the seriousness of NAMBLA, denying that the idea of mutual consent between boys as young as 12 and older men is necessarily unreasonable. They considered the age-of-consent laws to be, "plausible on the continuum of, say, a defense of children's legal autonomy." It was noted: 'There is some bravery in NAMBLA members keeping all their activities above board...After

all, it is still heresy to consider the possibility of the legitimacy of their feelings" (as cited by Satinover, 1996).

The gay magazine, The Advocate, at the time of study, averaged about 27% boy images per issue in which 97% of those were homosexual. When The Advocate was compared to The Washingtonian magazine with similar demographics as The Advocate accept in sexual orientation, the researchers stated, "Were heterosexual and homosexual male orientation alike, we should find similar Washingtonian rates of sexualized girls in print and pictures. The data finds Washingtonians without either the quantity or quality of sexualized or sadosexual 'teen' imagery which is typical of The Advocate treatment of boys" (Reisman & Johnson, 1995, p. A-22).

In the pro-gay climate of the late 20th century there was wide spread efforts toward the socialization of gay adolescents and even young children. In schools, the curriculum was rewritten to engage the gay influenced agenda. At the same time, however underage gay sex was found to be rampant. A survey of New York City's gay and bisexual youths found that, 80% were engaging in anal sex (Rotheram-Borus, et al, 1994) (See also Chapter 6: Sexual Abuse).

Prostitution

Homosexuals were known to often take a flight toward prostitution, usually in younger years, whether or not the aim was sexual or monetary. Homosexual behavior was found to be common among male prostitutes. Although male prostitutes were referred to as delinquent or transitory, homosexual sex was the primary behavior amongst them, whether gay-identified or not. This was confirmed in several studies (Allen, 1980; Ginsburg, 1967; Luckenbill, 1985).

As the research found, reciprocally was, of course, achieved between the prostitute and the patron. For the young prostitute male, an adult male patron provided for his lost father-son bond and gave him monetary exchange (also representative of fathering). For the patron, he gained affection from a pseudo-son and at the same time got a chance at a last ditch effort to hold on to lost youthfulness. Twenty-two percent of the gay respondents in The Spada Report admitted to having paid for sex (Spada, 1979).

Pathology is evidence as there is a correlation between sexual abuse, prostitution and homosexuality. Almost all male prostitutes were homosexually abused as children. In a study of male prostitutes in London, 17 of the boys who admitted to have been involved in child sexual abuse, only 1 incident of female violation was indicated. The study concluded, "...it is fairly evident that the majority, over 50%, of London street workers are gay or bisexual" (West, 1993, p. 143). The researcher noted that these numbers could possibly be higher since many males were resistant to acknowledging sexual abuse as well as being gay.
(See also Chapter 6: Sexual Abuse).

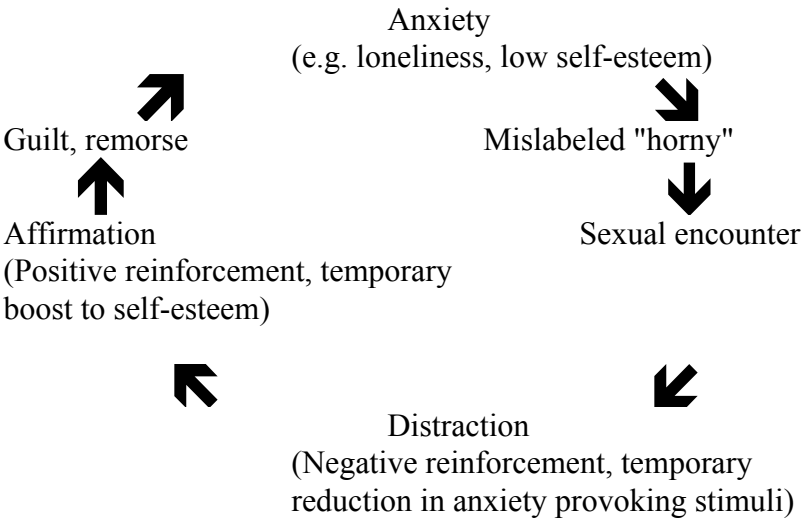
Sexual Addiction

Homosexuals have been known to have extreme difficulty controlling their sexual behaviors. A gay and lesbian addiction treatment center, known as The Pride Institute admitted that sexual addiction was a severe problem in the homosexual population. Over one-third of their male clients admit to experiencing sexual compulsive behaviors (Downton, 1995).

Dr. Jennifer P. Schneider, an expert in the field of sexual addictions provided

illustrations of sexual addictions among homosexuals and said that homosexuals represented a high proportion of the sexual addiction cases (Schneider, 1991; personal communication, October, 7, 1996).

Quadland (1987), at the time of study, treated homosexual men who presented themselves for therapy for problems related to poor sexual control. Although he, like many other researchers, claimed to be a gay advocate, he did not hide the fact that homosexuals had huge problems of sexual addiction. From his work, he described a specific cyclic pattern found in his clients:



In Quadland's study of his support group for sexually compulsive gays, it was found that the members had premorbitity of same-gender intimacy problems and anxieties. It was found that the support group provided a forum for developing intimacy which was said to help reduce anxiety in group members and inhibition regarding ongoing relationships. Once the group cohesion was established, their numbers of sexual partners decreased, from an average of 15 per month to 3 per

month (Quadland, 1985). Even after this alleged, "treatment success", 3 partners per month was still a high rate considering the risk associated with homosexual activity. The premorbity supported the fact that these men had same-gender inhibitions, thus more pathology, anxiety, and AIDS-risk issues. Therefore, compulsive sexuality for gays was more than just a sexuality issue, but rather a glance of underlying pathology in general.

Quadland and Shattls (1987) found that their clients reported having more sex than they wanted. They also reported feeling victimized by their frequent sexual activity in a variety of ways besides that of the obvious AIDS risk. Since higher risk behavior was associated with greater difficulty in controlling sexual activity (Joseph, Adib, Joseph, & Tal, 1991), then it was likely that gays in general would fit the patterns found in Quadland's samples because homosexuality was also associated with high levels of sexuality, anxiety, AIDS and high AIDS risks. Difficulty in controlling sexual behavior was also strongly associated with having more sex partners and sex occasions (Exner, Meyer-Bahlburg, & Ehrhardt, 1992). Again, gay men in general, fit those descriptions.

Sexual dysfunction

In the research findings, there were some significant sexual dysfunctional problems among gay men in comparison to heterosexual men. Retarded ejaculation was found to be the case, more frequently among gay men in the study by McWhirter and Mattison (1980). Conversely, premature ejaculation was less common in heterosexual men than gay men. The reasons according to the researchers for this was that "the major difference between heterosexual and

heterosexual persons is that sexual activity with another man is less goal-directed and more focused on…pleasure..." (McWhirter & Mattison, 1984, p. 283). This finding has also been noted by Masters and Johnson (1979). This falls in line with the earlier findings that homosexual men were less romantic and more sex goal orienated than their heterosexual counterparts (Athanasiou & Shaver, 1970).

Lesbian Sex

Contrary to the "butch-fmme" theories, lesbians are usually reported to be androgynous during sex. Participation in mutual manual stimulation and cunnilingus were often common in lesbian sex. Lesbians reported enjoying masturbation as close to one-third admitted to practice it several times weekly (Jay & Young, 1979).

As discussed earlier, lesbians report more sexual fluidity. As Jay and Young (1979) found, lesbians do have sex with more than one partner over their life spans. Surprisingly, in the same study, over one-third of the lesbians reported having tried 3-way sex (Jay & Young, 1979).

When the CDC conducted a study of 498 lesbians in The San Fransico Bay area, 81% reported having sex with a man during the past 3 years of the study and 10% reported engaging in unprotected sex during the past 3 years. Fifteen percent reported body piercing, cutting, and whipping behaviors with either male or female partners. Given these factors and that 10.5% admitted to IV drug use, lesbians were found to be 6 times more apt to be HIV positive and over 10 times more apt to shoot drugs than women in general (Lemp et al., 1995) (see also Chapter 2: AIDS Risk).

Since lesbians are more emotionally attached to their partners than their gay

counterparts, its easier to see the lesbian pathology in terms of the unique dynamics of their relationships. For gay men, it is clearly the sexuality that stands out; for the lesbians, it is more ambiguous than that. An imbalance of power within the lesbian relationship has been found. In a study of a lesbians, a sizable minority said that one partner had greater influence than the other (Caldwell & Peplau, 1992). Although power distribution in heterosexual couples shift some, in reference to gender, the lesbian dyad was unparalleled to heterosexual couples since the male in heterosexual relationships usually takes on the majority of the power in most cases (Bernard, 1972). In chapter 3: Violence, it was found that it is common for lesbians to shift from dependency to independence thus creating a cycle of violence within their dyads (Renzetti, 1992).

The lesbian has a poor self-image. Because in having sex with another women, the lesbian finds her partner's body as like her own, which in turn is an attempt to gain greater acceptance of her disowned body (Mara, 1983).

Caldwell and Pepuau (1992) found that when role-reversible does occur in lesbian relationships it takes on more of the mother-daughter dyad, however this still demonstrates an imbalance of power and may even suggest a power struggle and ambivalence within the relationship. To validate earlier clinical findings it was found that, "a love relationship between two woman has a potential to evoke certain aspects of mother-daughter intimacy" (Lindenbaum, 1992, p. 86). The authors furtherly quoted Nancy Chodorow who found that, "a [lesbian] sexual relationship with a women reproduces the early situations more completely and is more completely a return to the mother, than is a sexual relationship with a man" (p. 87).

The author concluded that,

> What emerges as powerfully, albeit often unconsciously, in the lesbian relationship is a profound desire for and concomitant fear of the primal experience of psychic and bodily oneness. Ultimately, the lesbian couples re-creation of primal intimacy gives rise to the excruciating terror of primal loss. Thus, the couple finds itself in a tremendous dilemma: how can the women fulfill their original desire to merge, and simultaneously subdue the terror it arouses? This dilemma is at the root of the difficulty that many lesbians couples have in sustaining their relationships. (p. 87)

When lesbians were gathered together, the pathology became clearer. For example, at the "Womyn's Festival" in Michigan, where thousands of lesbians gathered, glorification of S&M was present and, "the atmosphere at the festival was charged with sexuality"(The Lambda Report, July 1995, p. 5).

Sexual fluidity

Not only are homosexuals noted for gender identification confusion but also confusion about their own sexual preferences. It was discussed previously, a shift in sexual preference (cross-over) is more likely in homosexuals than in heterosexuals: one-third found in homosexual men, none reported in heterosexual men (Storms, 1980). However, there is the exception in cases of rape in

heterosexual men.

In The Spada Report, 17% of the gay-identify respondents said that they have sex with a women and 128 of the respondents said they "use to have sex with a women" (Spada, 1979). These findings therefore supported the earlier clinical theories about crossing-over, proposed by Feldman (1956). Ultimately, homosexual exclusivity is a specious term. Gillespie (1964a) claimed that some homosexual activity was spurious and were defenses of essential heterosexuality. Freud (1905) pointed out that a single individual is very liable to show both kinds of behavior (homosexual and heterosexual) at different times or simultaneously.

Worth noting is the fact that cross-over (homosexual to heterosexual) has been reported in earlier studies of treatment with various outcome rates (Clippinger, 1974; James, 1978; Socarides, 1979, pp. 261-263; see also Chapter 14: Amerolieation and Treatment Outcomes).

Studies of heterosexual women have also revealed shifts toward lesbianism in mid life (Fleishman, 1993) and from lesbian to heterosexual (Katz, 1993). Otto Kernberg, a famous psychoanalyst of the 20th century, mentioned women, whom therapists found have an elective orientation: "a late onset homosexuality that usually is preceded by an extended heterosexual life style and that may revert to a heterosexual life style" (Kernberg, 2002, p. 16). Thus, like men, women report that their sexual orientation had changed (cross-over) within their developmental

process. A great percentage of lesbians report heterosexuality at some point in their lives (Bridges & Croteau, 1994; Einhorn & Polgar, 1994). Thus, the sexuality of lesbians is not fixed but rather, fluid. This does not support a biological explanation of sexual orientation, but rather a developmental process of homosexuality.

Finaly, lesbians are more concentrated in cross-sex relationships to a greater degree than gay men (Leigh, 1989).

Summary

The overwhelmingly majority of gay men were found to have multiple partners, and participate frequently in anal intercourse and other unconventional sexual behaviors. Lesbians were found to be more characterized by cross-sex behaviors. Lesbians were found to be more sexually experienced than a large group of women who reported not being lesbian. There are clearly marked differences found in the sexual behavior patterns commonly practiced by homosexual couples and married heterosexual couples. That is, homosexuals tended to have a more anomalous sex life in several aspects. In keeping in line with the discussion on sexuality, for example, lesbians frequently engaged in masturbation with their partners, more so than heterosexuals, and almost all gay men reported receiving fallatio, performing anal intercourse, and receiving anal intercourse. Finally, cross-over (homosexual to heterosexual) has been reported in earlier intervention studies with various outcomes.

Psychological Maladjustment studies

The outcomes of research using psychological tests showed an emerging trend which correlated homosexuality to high neuroticism (van den Aardweg, 1985). Several significant differences in psychological maladjustment between heterosexuals and homosexuals have been found. A review of earlier studies have been cited as follows by Lester (1975) and by others:

The Minnesota Multiphasic Personality Inventory (MMPI)

Loney (1971) administrated the MMPI to homosexual males in the community and heterosexual controls and found that the F scale scores of the homosexuals were greater than those of the heterosexuals. The F scale score is a deviant, or rare response scale. This meant that the homosexuals answered items which are rarely endorsed by most stable people.

Manosevitz (1971) compared nonclinical samples of homosexuals and heterosexuals and found the homosexuals to have high D, Pd, Mf, Pa, Pt, Sc, and Si scores, that is they were more depressed, sociopathic deviant, feminine, paranoid, anxious, schizophrenic, and had lower social skills (respectively). Cubitt and Gendreau (1972) compared homosexual and heterosexual prisoners and found the homosexuals to have higher Hs, D, Hy, Mf, and Pa scores to indicate histrionic (theatrical), and somatic pathologies (physical complaints).

Braaten and Darling (1965) compared males seen at a college counseling center and found the overt homosexuals differed from the covert homosexuals (in whom homosexual impulses were found only in dreams and fantasies) on the Pd scale (the coverts had lower scores) and Si scale (the overts had lower scores). Compared to heterosexuals, the Mf (femininity) scale differentiated the groups with the homosexuals obtaining higher scores.

Doidge and Holtzman (1960) rated Air Force trainees for the degree of homosexuality and found that the homosexuals obtained higher F, Hy (hysteria), Pd, Mf, Pt, Sc, Hs, D, and Si scores. On a forced choice scale adopted from the Taylor Manifest Anxiety Scale, the homosexuals obtained higher scores. They also had more food aversions and took longer in a word association test to respond to homosexual homonyms, but they did not differ in identification of the sex of drawings of human figures.

Oliver and Mosher (1968) compared homosexuals and heterosexuals in a reformatory. The heterosexuals were older, more educated, and better behaved than the homosexual inserters ("bottoms") but did not differ form the homosexual insertees ("tops"). There were no differences in age at first conviction, number of previous convictions, or months served. On the MMPI, the insertees had higher scores than the heterosexuals on Hs, Hy, Pd, Mf, and Pt. The insertors had higher scores on F, Hs, D, Hy, and Sc, along with high uniform T-scores. The researchers concluded,

Although the particular scales the differentiate homosexuals and

heterosexuals differ from study to study, it is found consistently the homosexuals obtain higher scores. The data suggest greater maladjustment on the part of homosexuals (p. 101, emphasis added).

The MMPI Mf (Masculinity/Feminity) Scale

Lester (1975) found that 5 out of 7 studies had reported that homosexuals obtained higher Mf scores, meaning they were more feminine compared to heterosexual controls. Friberg (1967) found that homosexuals scored higher Hsx (homoerotic) scores in a sample of psychiatric patients. Friberg found that Mf and Hsx scores were not associated and that the homosexuals obtained higher scores on both scales than psychiatric patients involved in other sexual deviations.

Lester (1975) after his review concluded that, "In general, it appears that homosexuals do obtain higher femininity scores than heterosexuals" (p. 102).

California Psychological Inventory (CPI)

Other studies also supported differences between homosexuals and non-homosexual controls. Compared with heterosexuals men (sample size of 66), gay men (sample size of 60) score lower on the California Psychological Inventory scales Wb (self of well-being) and Sc (self-control), but higher on Scale 5 (sensitivity) (Hiatt & Hargrave, 1994).

The Personality Factor Questionnaire (16PF)

In a community sample, Evans (1970) compared male homosexuals and heterosexuals on the 16 PF and found differences on 9 scales: the homosexuals were less emotionally stable, conscientious, and controlled, and more tense, tender-

minded, suspicious, imaginative, apprehensive, and self-sufficient. Evans felt that the homosexuals resembled normals more than they resembled anxiety neurotics, and he felt that the homosexuals were mildly neurotic.

In a forensic sample, Cattell and Moroney (1962) found no differences in the profiles of uncharged and charged homosexual males. They felt that the profiles of the homosexuals resembled the profiles of the neurotics more than the profiles of psychotics, psychopaths, or psychosomatic persons. They especially resembled the profiles of the anxiety and obsessional neurotics. Compared to the neurotic profile, the homosexual profiles were more extraverted and lower in guilt, suggesting that there were more acting out of neurosis. As compared to nonsexual offenders, the homosexuals had lower emotional stability, and higher suspiciousness.

Cubitt and Gendreau (1972) using a forensic sample, found differences on 3 scales. They concluded that the homosexuals had less emotional stability, were less experimenting, and were more shrewd. After reviewing these studies, Lester (1975) concluded that, "Again, although differences are not consistent, the trends are for greater maladjustment or neurosis in the homosexual" (p. 103).

Gough's Adjective Checklist

Evans (1971) compared homosexuals and heterosexuals in the community on the Gough Adjective Checklist. The homosexuals scored: less self-confident, less need for achievement, less dominant, less endurance, less need for order, more succorant, more need for abasement, and more counseling readiness. They checked more unfavorable adjectives, but fewer personal adjectives. The groups did not differ on the number of favorable adjectives checked: self-control, lability,

intraception, nurturance, affiliation, heterosexuality, exhibitionism, autonomy, aggression, change, and deference. On the masculine-feminine scale, the homosexuals scored as more feminine. Evans concluded that homosexuals were more neurotic.

Other Tests

Hooker (1957) compared small convience samples of male homosexuals and heterosexuals and independent judges found no differences in overall adjustments on Rorschach protocols. The judges could not distinguish the homosexuals from the heterosexuals. Although no differences in overall adjustment were found on Thematic Apperception Test (TAT) protocols (taps into subject's unconscious to get repressed motives, etc.) , it was easy to distinguish the 2 groups from these protocols.

Grygier (1958) compared male neurotics on the Dynamic Personality Inventory. The homosexuals scored higher on passivity and need for comfort/support, feminine narcissism, and feminine identification and lower on masculine identification.

Thompson, et al. (1971) compared male and female homosexuals and heterosexuals in the community and found no differences in their rating of themselves on the Semantic Differential. On the Gough Adjective Checklist, the male homosexuals rated themselves as less self-confident than the male heterosexuals. More of the homosexuals had been in or were presently in psychotherapy more so than the heterosexuals, but this variable did not effect the

results. The researchers suggested that the increased incidence of psychotherapy in the homosexuals was a reflection of family or social pressures rather than greater maladjustment.

Siegelman (1972) administered the Scheier and Cattell's Neuroticism Scale Questionnaire to samples of homosexuals and heterosexuals in the community. For the total sample, the homosexuals were more tender-minded, more submissive, more anxious, and had a higher total score. When he matched the groups for age and their responses to the Marlow-Crowne Social Desirability Scale, the same pattern of results was obtained. Siegelman compared respondents with low femininity scores and found that the homosexuals were more tender-minded than the heterosexuals.

Siegelman also administered parts of other scales, and in general, the homosexuals were more neurotic, and less well-adjusted. Siegelman also compared those homosexuals who belonged to a homosexual organization and those who did not, and found that those in the organization to be more depressed, more submissive, and to have a higher total score on the Neuroticism Scale Questionnaire.

Mosberg et al. (1969) compared male homosexuals and heterosexuals in the armed forces and found significant differences in self-concept. The homosexuals had stronger feelings of physical and social inadequacy. Kendrick and Clarke (1967) compared homosexual psychiatric patients with nonpsychiatric heterosexuals and found differences on both the Semantic Differential and Geroge Kelly's REP Grid in their self-concept. On the whole, the homosexuals had less favorable attitudes toward themselves, but they also had less favorable attitudes to other concepts, such as justice, sex, and being normal.

Summary

The outcomes of research using formal, well controlled, and validated psychological tests showed an emerging trend which correlated homosexuality to high neuroticism. After presenting the findings of various psychological testings comparing homosexuals and heterosexuals, Lester (1975) concluded that, "homosexuals do seem to be less well-adjusted than heterosexuals" (p. 108, emphasis added).

Mental Health/Psychiatric Disorders

The Council on Scientific Affairs stated that there are "unique mental health concerns faced by [the homosexual] population" (p. 8). During the latter 20th century pro-gay advocates have been very defensive when it came to topic of homosexuality and mental illness and felt that many scientific works were "often more subtle in…homophobia and bias in assuming homosexuals are 'sicker', if not ill, just by being homosexual" (Cabaj, 1988, p. 14).

The argument that homosexuals, like their heterosexual counterparts, have bouts with mental illness holds strong for pro-gay practioninonaires and advocates. While they agree that gays and lesbians display higher rates of drug and alcohol abuse and are at higher suicidal risk, they argue that victimization and non-acceptance of homosexuality leads to those ends. Contrary to this, however, in a study by Hershberger and D'Augelli (1995) it was found that victimization's do not directly relate to suicide of gays and lesbians. A causal link between stressors and negative outcome of gays and lesbians was only suggestive and not scientifically found (Savin-Williams, 1994).

It was found that the notion of the gay community as being caring and supportive was hard to take serious and that in many cases the dynamics of the gay community itself had produced the depression and desperation that often contributed to unsafe sex (Gold, 1995). In a systematic non-clinical study, when individual

disorders were compared, there was a trend for homosexual woman to have more psychiatric disorders. It was found that the risk of having a psychiatric disorder and interpersonal conflict seemed to be greater for the homosexual than for the single heterosexual (Saghir, Robins, Walbran, & Gentry,1970, p. 153).

When clinical features of female homosexual patients were compared with heterosexual patients, significance differences were found. Lesbian patients were found to be like lesbians in general; they had increased paternal abusiveness and alcoholism, indifference toward men, increased drug abuse, and more suicide behavior. In contrast to heterosexual patients, lesbian patients had significantly more alcoholic problems and abusive fathers (Swanson, et al., 1972) (See also Chapter 4: Substance Abuse).

A Columbia University study presented data that correlated demographics, psychopathology, and medication. It was found that homosexually sexually active patients had greater psychopathology. About 62% of these patients reported sex with multiple partners (AIDS Weekly, p. 15).

The mental health of homosexuals is consequential. Socarides (1968) stated,

> Approximately half of the patients who engage in homosexual practices have a concomitant schizophrenia, paranoia, are latent or pseudo neurotic schizophrenic, or are in the throes of a manic-depressive reactions. The other half, when neurotic may be of the obsession or, occasionally the phobic type. They may suffer from character disorders, psychopathic personality or some variety of

addiction. (p. 90)

Mental illness for anyone, gay or straight, has been stigmatized and many efforts have been taken to try to eliminate it. However, if stressors are not the means to the negative outcomes of gays and lesbians then suggesting pathology is logical, and not homophobia, as some have suggested. The following will review homosexuality in the context of mental illness and psychiatric diagnosable disorders found in the 20th century.

Results from the National Lesbian Health Care Survey (US) and surveys from Canada

The National Lesbian Health Care Survey (NLHCS), conducted from 1984-1985, presented the largest mental health information on a sample of 1,925 lesbians from all 50 states and was considered the most comprehensive study, at the time. It reported that despite the fact that lesbians were socially connected and had support systems, they reported significant problems. Over half of the sample thought about suicide at some time, and 18% had attempted suicide. Of the lesbians, 41% had been raped or sexually attacked at least once in their lives; the overwhelming majority had been violated by a male. In terms of incest, 19% of the lesbians were involved in incest while growing up. Alcohol abuse was rampant among lesbians, with 30% drinking alcohol more then once a week (see also Chapter 4: Substance Abuse).

Much of the sample, close to 73%, had received counseling: Half for depression and related symptoms, 31% for anxiety and fears, and 21% for loneliness. The percentage of lesbians in a primary relationship was similar to the

percentage of married woman in the census data. Although more than half of the sample was in a lesbian relationship, 53% said a lover had abused them (see also Chapter 3: Violence). When the lesbians were asked about their most common concern, the majority of them reported concerns with money, not the problems mentioned earlier (Bradford, Ryan, & Rothblum,1994).

The results from 186 self-identified women in Toronto who completed surveys were compared to Canada's General health Survey and The 1986 Health Promotion Survey. The final analysis was that lesbians drank more and had a high incidence of mental health problems (Moran, 1996).

Anxiety

There is clear evidence that mental health patients with anxiety disturbances such as obsessive-compulsive disorders do have homosexual conflicts or repressed homosexual desires (Lester, 1975). Vetter cited by Lester (1975) found that obsessive-compulsive neurotics gave more of Wheeler's Rorschach signs of homosexuality than the undifferentiated neurotics did.

According to van den Aardweg (1986) homosexuals represented a structure that was not different from obsessive-compulsives; the homosexual wish was said to be an obsession like the perfectionist compulsion of the obsessive-compulsive. The author noted that the homosexual observed in the gay bar displayed a nervous gaze and painfully examined every newcomer. The homosexual preoccupation could not be compared with heterosexuality, as it was often done; when whole heterosexual men look at every woman in the street, their feelings are far less obsessive, for the homosexual there is was a painful compulsion to look and this pain was found to be

caused by inferiority complaints as if the individual was in trance.

As with depression, whether nor not a homosexual man was HIV positive or not, he still reported significantly higher lifetime rates of anxiety disorder (Atkinson, et al., 1988).

Depression

Saghir & Robins (1971) found that more homosexuals reported depression than non-homosexuals. Vincke's (1994) study of Belgium gays, found that low social supports arguably led to depression and low levels of "gay self-acceptance" [A term that was used in the literature to say that gays would have better mental health if they accepted their homosexuality as a positive quality]. Along these lines, it was argued that this, combined with societal acceptance of homosexuality, would ultimately lead to positive fulfillment in the gays' life. They argued that if missing one or both of those things, then gays were likely to suffer with mental disturbances, such as depression. However, the study failed to find out whether or not self-acceptance was truly based on societal support, specifically.

Pillard (1988) found that bipolar depression (including bipolar I, II, and cyclothymic types) occurred significantly more in his sample of 51 homosexual men compared to 50 heterosexual men.

It was discovered that positive social network interactions do help ameliorate stress but positive socialization can also be experienced as psychologically disturbing. This held true in a sample of HIV-positive gay males. Even with positive socialization, depression was found. One could argue that AIDS itself could have caused these findings (Siegal et al., 1994); however, it was found that,

> few, if any studies before the AIDS epidemic suggest that male homosexuals may on an average have higher levels of depression than male heterosexuals. However, several samples of homosexual and bisexual men in HIV studies suggest that depression and anxiety are high in these populations and that their psychiatric morbidity began before the AIDS epidemic. (Weinrich et al., 1995, p. 55)

A study by Cazzullo, et al. (1990) did find that there was a higher psychopathological risk for those with asymptomatic HIV seropositivty in their homosexual sample, but they concluded that the "major risk for HIV infection consists of subjects whose personal histories contain clear indications of psychopathological traits" (p. 290). Therfore, not only the HIV seropositive individuals, but the andedcentant risk individuals, showed psychopathololology.

HIV/AIDS was not the primary source of depression for homosexuals, contrary to arguments, which said that homosexuals are depressed because of issues like HIV infections. Homosexuals with or without HIV infection report significantly higher rates of major depression (Atkinson, et. al., 1988). When a comparison study of 28 HIV-positive asymptomatic homosexual men and 68 HIV-negative homosexual men was conducted, the 2 groups did not differ significantly in levels of depression at the baseline and follow-up of the study (Jadresic et al., 1994).

A study of HIV non-infected homosexual African-American woman showed that they were just as distressed as HIV infected African-American men

(Cochran & Mays, 1994). Although race and gender could be an arqument here, it was also found that both homosexual men and women reported distress levels in excess to those previously reported in studies of African-Americans and whites, and males and females.

Nurius (1983) studied the relationship among depressive measures and sexual orientation, as well as other variables. Homosexuals rated higher on scales of depression compared to heterosexuals. Although the study found "unmistakable, statistically significant relationship between depression and sexual orientation" (p. 133), the researcher would not support it as an explanation of psychopathology, stating that, "...sexual orientation can be expected to make a significant but very small contribution to the explanation of variance in these problem areas..." (p. 132). There is a contradiction here. How can something such as depression be scientifically significant and yet be small? This points to the fact that when studies do find pathologies, their discussions turn politically correct and point to homosexuality as normative.

Ultimately, homosexuals are just as depressed, with or without AIDS, and other factors, regardless of social stigma, which begs the question: "What leads to this unprecedented distress?"

Dual Diagnosis (Substance Disorders and Mental Disorders)

Several studies which show a correlation between substance abuse and mentally ill homosexuals have been cited by Lester (1975). For example, both alcoholics and hysterics gave some of the Wheeler's signs from the Rorschach test that were indicative of homosexuality, although not as often as overt homosexuals

(Reitzell, 1949).

Norman (1948) found that paranoid schizophrenics had significantly more homosexual experiences than catatonic schizophrenics and alcoholics, but he judged the alcoholics and paranoid schizophrenics to have had more unconscious homosexual impulses than the catatonic schizophrenics. Ericksen (1951) found that both paranoid schizophrenics and alcoholics showed more perceptual defense to homosexual stimuli as compared to other psychiatric patients.

An investigation was conducted on the extent to which psychiatric diagnoses of antisocial personality, alcoholism, depression, and homosexuality in male and female narcotic addicts predicted recurrence of drug and alcohol dependence during a 5 year follow-up after discharge from the National Institute of Mental Health (NIMH) Clinical Research Center in Lexington, Kentucky. Of the 187 subjects followed, 23% black males and 18% white males reported homosexuality, and 24% black females and 22% white females reported homosexuality (Croughan, Miller, Matar, & Whitman, 1982).

Data from The Epidemiological Catchment Area Survey and from studies in New York and Milwaukee indicated a very high rate of alcoholism and drug abuse amongst homosexual psychiatric patients (Auerbach, 1994).

Comorbidity of mental disorders of drug and alcoholism has been found in 29% of those homosexuals with a mental disorder, at the time of the study. They all had a lifetime prevalence of an addictive disorder, 37% of those with an alcohol disorder and 53% with a drug disorder (Kurth, 1993).

A study conducted at the Medical College of Wisconsin revealed that

homosexual activity was self-reported amongst 22% of the male patient population. Among sexually active men and women, half had 2 or more partners and half used alcohol. Psychiatric symptoms that influenced risk behavior included: poor impulse control, hypersexuality, poor judgment, and medication noncompliance (AIDS Weekly, March 7, 1994, p. 14) (See also Chapter 4: Substance Abuse).

Eating disorders

Gay men were found to be closer to heterosexual woman in body dissatisfaction and more vulnerable to eating disorders, while lesbians and heterosexual men shared lower vulnerability (Siever, 1988).

In a non-clinical study of 250 college students (53 lesbians, 59 gay males, 62 heterosexual women, and 63 heterosexual men) it was found that the gay men and heterosexual woman were dissatisfied with their bodies and were vulnerable to eating disorders. As an explanation, gay men and heterosexual women shared emphasis on physical attractiveness. It was also found that lesbians and heterosexual men are less concerned with their own physical attractiveness and therefore less dissatisfied with their bodies and therefore less vulnerable to eating disorders (Siever, 1994). Earlier studies also supported Siever's findings. Herzog, Norman, Gordon, & Pepose (1984) supported the hypothesis that gay men were at higher risk, and lesbians at lower risk for bulimia nervosa compared to their heterosexual counterparts.

In clinical studies of eating disorders it was found that one-third of the samples were gay (Robinson & Holden, 1986; Schneider & Agra, 1987). In a

eating disorders group it was also confirmed that one-third of the sample were reportedly gay (Herzog, Bradburn, & Newman, 1990). A study's sample of 50 gay men revealed that they are more likely to binge eat and lacked control over their eating than heterosexual men (Schneider, O'Leary, & Jenkins, 1995).

A clinical study of men diagnosed with bulimia nervosa found that 82% considered themselves gay-identified. Even those identified as heterosexual, indicated scores toward homosexual tendencies in both stimulation and feelings (Fichter & Hoffman, 1990).

In a non-clinical sample, after comparing heterosexual and gay college men, it was concluded that gay men were significantly more likely to report past or current binge eating at the time of the study. The study also noted that some of the gay mens' self-identification leaned toward effeminacy (Yager, Kurtzman, Landsverk, & Weismeier, 1988).

Gay men were also found to be less likely than heterosexual men to have a high positive body image (Berscheid, Walster & Bornstedt, 1973). Gay men rated physical appearance as being significantly more central to their well-being, however they perceived less satisfaction with their bodies in terms of masculine physique, when compared to heterosexual men, thus supporting the notion that gay men are dissatisfied with their body image (Silberstein et al., 1989).

Lesbians were found to be less invested in conventional means of attractiveness (Brown, 1987). Lesbians placed more emphasis on physical strength as a physical characteristic (Striegel-Moore, Tucker & Hsu, 1990).

A New York psychotherapist compared sexual compulsivity to eating

disorders and found that they were both anxiety-based disorders. He made the connection that if a person was feeling anxious and went to the refrigerator then it was done to reduce anxiety the same way sexual compulsives used sex (Downton, 1995).

Finally, by way of this synthesis, it is clear to see that homosexual men represent a higher disproportionate rate of eating disorders compared to heterosexuals.

Personality Disorders

In a study on the prevalence of personality disorders (PDs) of 100 HIV-positive and 52 HIV-negative homosexual men it was revealed that 19% in both groups were diagnosed with a PD (Johnson et al., 1995). This findings did not support the hypothesis that those with HIV were more likely to be diagnosed with a PD, since the same percentage of PDs occurred in both groups.

It was found that individuals with Borderline Personality Disorder (BPD) were usually painfully uncertain of themselves, their self-image, sexual orientation, life goals, and, values (Comer, 1992). These factors were consistently found amongst homosexuals. Homosexuality, which was found to be correlated with BPD, is uncommon among straight men (Silverstein, 1988).

The sexual histories of 80 psychiatric patients who met the criteria for BPD, revealed that homosexuality was 10 times more common among the men and 6 times more common among the women with BPD than the general population, or in the depressed control group (Zubenko, George, Soloff, & Schulz, 1987).

Turner, Pielman and Orwin (1974) concluded that their study "indicated that there [were] significant personality differences between homosexuals who [were] referred for treatment [the study group] and those who live in society without seeking professional help [the control group]" (p. 448). Differences were found in only 4 out of 16 variables, however. Not really a large margin along individual variables. What was found was that the nontreatment group reported being more relaxed and self-assured. The study did not compare their sample with a non-homosexual control group, so it is hard to get a true comparison in terms of sexual orientation.

Psychotic disorders

When psychotherapists were asked to evaluate heterosexual and homosexuals, they reported that the homosexuals were often more psychotic (Ellis, 1959). Further, Ellis (1965) found that "Schizophrenics [were] not able to cope with the world successfully, and [were] particularly unable to achieve good heterosexual relationships in…society; and therefore they frequently, though of course not always, turn[ed] to homosexuality" (p. 81-82). In quantitative support of this, a study which was discussed by (Lester, 1975), found that when 6 patients developing schizophrenia were compared with 6 controls, the preschizophrenics gave more homosexual signs on the Rorschach Test. There was also an association between homosexuality and paranoia. The author concluded that,

> Several studies have found that those with paranoid delusions are more overtly homosexual than those without paranoid delusions, that they have more homosexual preoccupation

than those without paranoid delusions, that they are judged by psychiatrists

> to have more latent homosexual impulses than those without paranoid delusions, and that they have more unconscious homosexual wishes... and the majority of the studies show that paranoid patients resemble overt homosexuals....than they resemble nonparanoid patients. (Lester, 1975, pp. 89-90)

Lester (1975) cited findings from Scott and Lyman's (1968), proposed interactional analysis, which provided an interesting narrative:

> The individual who has repressed homosexual impulses might have fears for his masculinity. This may lead to behavior categorized as 'strange' and which would make people suspicious of him. This in turn may reinforce his concerns about the reactions of others toward him. The behavior of his peers gives him a basis for his paranoid delusions. Similarly, the overt homosexual is often in a heterosexual environment which, for him, is stressful and would lead to heightened suspiciousness by him of the thoughts and reactions of others toward him. He will tend to interpret events in a paranoid fashion and adopt strategies of disavowing and concealing his deviance. This may make him appear “odd” to his peers and so, as in the case of the repressed homosexual, a

vicious circle is set up. (p. 90)

There are many negative affects related to psychosis and homosexuality. In a review of 53 cases of male genital self-mutilation published in 1979, feelings of homosexual wishes were common in both the psychotic (87%) and non-psychotic patients (Fisch, 1987).

Summary

To conclude this section on homosexuality and mental illness, a final analysis by Lester (1975) is appropriate which stated that "there is clear tentative evidence that patients with some disturbances...do have homosexual conflict or repressed homosexual desires" (p 93). We can not blame homophobia and bias in assuming homosexuals are ill, just by being homosexual. The statistics of studies in the 20th century reveal homosexuals to be disportionally higher in representation of mental health problems. Clinical studies of eating disorders have shown that one-third of the samples represented gay men. Gay men are also overrepresented among the cases of Boderline Personality Disorders which is uncommon among heterosexual men. Results from the National Lesbian Health Care Survey (US) and surveys from Canada revealed that lesbians have unique mental health problems including alcohol abuse, which is unparalle to their female heterosexual counterparts.

The "Depathologization of homosexuality":

Although homosexual pathology has proven to hold weight by way of 20th century literature, it is published past the redefinition of homosexuality which has gone from being known as a pathology (a medical model) to an acceptable behavior (a socio-political, cultural model). The etiology of this stemmed from homosexual movements, including many professional, who argued that that there was no proof that homosexuality was pathological. The American Psychiatric Association normalized homosexuality in 2 steps: first they removed (from its list of disorders) homosexuality that was “ego-syntonic” comfortable and acceptable to the individual, leaving only “ego-dystonic” - unwanted - homosexuality as a disorder; later, it removed "ego-dystonic” homosexuality as well.

The psychohistory of the depathologization of homosexuality began most likely in 1969, when gays and police got into riots as a result of an earlier police bust of a small gay tavern in New York City, named Stonewall. This coupled with the verge the Sexual Revolution, in the absence of AIDS, and the arguments that homosexual was nonpathological, the mental health community was asked to help free homosexuals from social sigma. The Institute of Mental Health (NIMH) established a task force on homosexuality and appointed psychologist Evelyn Hooker as the chair to see what they could come up with.

Evelyn Hooker presented her research findings at an APA conference in Chicago in 1957. Her study consisted of a small non-clinical samples (provided

from the gay organization known at the times as The Mattachine Society) who were issued a standard personality test (MMPI). After the test was administered, the results were then judged by a panel who was not allowed to identify the participants. As a result, they could not match homosexuals sample from heterosexual samples. Thus, Hooker concluded that homosexuality was not indicative of psychopathology

The problem with Hooker's (1957) conclusion was that the MMPI, was not intended to measure comprehensive psychopathological differences between two groups in reference to sexual orientation. It merely was intended to give clues about a patient's personality characteristics. Further, early use of the MMPI was not meant to measure homosexual's characteristics in totality. Even subsequent research with a scale to detect homoerotic inversion had been unable to differentiate a homosexual from a heterosexual (Wong, 1984 as mentioned in Craig, 1987; Oberstione & Sukoneck, 1989). Additionally, it was not surprising that gays and lesbians were not any less intelligent or had lower academic performances than the general population (Braaten & Darling, 1965; Vilhotti, 1958), that too, did not tell tale psychopathology, necessarily. Freud noted this as well as he was impressed with Leonardo da Vinci's genius (Freud, 1910).

Hooker's findings only justified the conclusion that homosexuality, in and of itself, did not necessarily mean personality or social maladjustment in those samples.

A person could be pathological and still appear to function well in society. This, Freud discussed many years earlier, and therefore was not a landmark conclusion. Hooker's conclusions certainly did not support her discussions intellegically. For the same matter, pedophiles and serial killers, for example have adjusted very well in society and can score well on functional scales. (For a more further critique of the Hooker study, refer to Fine & Bieber, 1973).

Despite the findings of Hooker's (1957) and others', we did learn, however that maladjustment on several psychological test did however show some significant differences between heterosexuals and homosexuals, favoring the heterosexuals (refer to Chapter 10: Psychological Maladjustment Studies). Finally, it has been cited, however, that Evelyn Hooker received the American Psychological Association's Award for Distinguished Contribution to Psychology in the Public Interest, "For demonstrating that homosexuality is within the normal range of human behavior and is not pathological" (APA, 1992, abstract). It would indeed seem proper that she be recognized for contribuations in public (that is, spocial –polical) interest rather than scientific interests. The APA continues to follow this suit, that is shielding the facts about pathology and using politics instead of science. They also do an excellent job at hiding their own political motives from their general dues paying members (O'Donohue & Dyslin, 2005).

The NIMH's Task Force on Homosexuality Final Report and Background paper (1972) purposely disagreed with years of theory, research and therapy that had found homosexuality to be pathological, perverse, and neurotic. This of course, was also done in the absence of AIDS, and subsequent research.

Several studies after the Hooker (1957) study maintained a motive to support the notions that homosexuality was not at all pathological in nature. Those studies were used by gay social activists in assisting toward the political removal of homosexuality from the American Psychiatric Association's Diagnostic and Statistical Manual (DSM). This was done however for political reasons such as to avoid further stigma of gays and to avoid menaces such as the 1969 Stonewall riots in New York City. It was not based on scientific evidence, nor popular in professional and public opinion (Socarides, 1978b; 1992).

Finally, there had not been international agreement with the total removal of homosexuality as a disorder, as it had been maintained (post-1973), as a mental diagnosis by the World Health Organizations 9th revision (1980) of the International Classification of Diseases (ICD-9) (Sadock & Kaplan, 1991).

It is clear that the removal of homosexuality from the DSM was based solely a political and pragmatically measures, however "the larger theoretical and conceptual issue of the necessity for separating the whole process of diagnose of pathology from psychodynamic understanding [should have been] be clarified as well" (Mitchell, 1978, p. 262), but was not given the opportunity. A swift aggressive gay caucus pushed the removal of homosexuality as a classified diagnosable disorder (in the DSM, that is), merely for socio-political reasons alone.

The general population certainly did not have a say it the depatholization process which took place by the APA, however it was greatly affected. Many were shocked and appalled. The general population basically felt that homosexuality was unnatural. The fact has held true in varies public polls. According to the General Social Survey by The National Opinion Research Center in 1977, 67% of those questioned said that sex between two adults of the same sex was always wrong. A Newsweek poll revealed that in July 1983, 58% of respondents said homosexuality should not be considered an acceptable alternative lifestyle. Later in 1991, the National Opinion Research Center reported, 71% of respondents said gay sex was always wrong. These datas were retrieved 4 years, 10 years, and over 20 years, respectively, after the removal of homosexuality as a pathology from the DSM.

The fact was that many health and mental health professionals felt that same sex contact was pathological. For example, when surveyed, over half the practicionairs questioned, felt that homosexuality was unnatural and unacceptable (Ediason and Ranall, 1991; Randell, 1989). As late as 1992, the majority of psychiatrists from 34 countries viewed homosexuality as pathological and psychiatrists from 125 professional organizations said that their general feeling was that homosexuality was a mental illness (Psychiatric News, September 3, 1993). However, majorities such as these were called such names as "homophobic" and "heterosexist".

Dr. Richard C. Pillard, at the time of study, was a professor of psychiatry, who later in his career put his efforts into the study of biology and homosexuality.

In 1988, in his article in Psychiatric Annals (supported in part by a grant from the NIMH) discussed The Family Study of Sexual Orientation (FSSO) planned in 1978. Pillard (1988) said the FSSO was planned to,

> Answer three interrelated questions. First was whether a homosexual orientation is significantly familial. The second was to investigate certain personality traits hypothesized to be associated with homosexuality, and finally to see if the pattern of mental disorders differed between gay and heterosexual individuals. (p. 52)

Please note that this was 5 years past the removal of homosexuality from the DSM. So, the question remained: Why was the FSSO planned in 1978 to investigate issues of which the NIMH had already allegedly found to support the removal of homosexuality from the DSM in 1973?

In a step strikingly reminiscent of what occurred in the 1970s with respect to homosexuality, the 1994 edition of the DSM (DSM-IV) had quietly altered its long-standing definitions of all the "paraphilias" (sexual perversions). In the 1994 edition, in order for an individual to be considered to have a paraphilia--these included: sadomasochism, voyeurism, exhibitionism, and among others, pedophilia--the DSM required that in addition to having or having acting on impulses, the person's "fantasies, sexual urges or behaviors" must "cause clinically significant distress or impairment in social, occupational or other important areas of functioning." In other words, a man who routinely and compulsively has sex with children, and does so without the pangs of conscience and without impairing his

functioning otherwise, is not necessarily a pedophile and in need of treatment. Only the man who suffers because of his impulses is a pedophile requiring treatment.

The committee responsible for this change claimed that their intent was not to "normalize" the paraphilias, but to give diagnosticians greater latitude in making the diagnosis. Nonetheless, that will certainly be its effect, as it was with respect to homosexuality, now transexualism and sadomasochism, and mostly likely the future being pedophilia. Race Bannon, coordinator of the "DSM Project" for a major sadomasochistic organization, noted that "For the first time, the leather S&M fetish community's style of sexuality is no longer considered necessarily pathological...The new DSM-IV language means that we will no longer be considered sick unless our erotic play causes 'clinically significant distress or impairment.' " Bannon praised, "kinky-friendly psychotherapeutic professionals" who lobbied for the changed criteria.

Gay activism has long made known its objections to the pathologizing of any form of sexual freedom, as was clearly the case in homosexuality.

Does social stigmatization account for the maladjustment of homosexuals?

A study by Ross (1990) was conducted to measure life events and psychological adjustments of homosexuals. Eighty gay-identified men were recruited from the gay media. A large percentage of the sample were recruited from gay social organizations and from AIDS/STD clinics. They completed the General Health Questionnaire and the Gay Affect and Life Events Scale (GALES). The study yielded some interesting findings. For example, the highest correlation with

psychological adjustment were obtained for HIV-disease-related events. Emotional distress and life changes were found to be closely related. The best predictors of total psychological adjustment was related to the relationship with lovers and AIDS-related concerns. Thus, the psychiatric adjustment of gays in this study, by correlation, found that they were depressed by their own health and relationships and some events in their life (e.g. moving, work, lifestyle, etc.).

The study by Ross (1990) was certainly unable to relate the findings to societal stigma. But nevertheless, the author, in his discussion wrote, "It can be concluded from these data that stigmatization of homosexual men does have consequences for mental health [as another has theorized]." (p. 411). Stigma, however was not even one of the variables measured within the study. At best, this may have been a perceptional conclusion (that is, gays may have felt they are maladjusted because of stigma, or some researchers may have assumed it), but at any rate, it was not scientifically based. The fact of the matter is that stigma for any individual may have consequences. It may have more psychological consequences if one has a gross perception. It is irrational to internalized stigma in a negative way. We certainly know this to be true as cognitive restructuring is a way of preventing this as discussed by Albert Ellis (1965).

The study did show that life events were associated with maladjustment. But, it is not surprising that a groups' emotional disturbances were closely related to there life changes. It is not society's fault that the homosexuals' life events (e.g., poor health, sexual acting out, risk-taking) caused them maladjustment. The fact is that anyone having these life events would certainly be maladjusted, heterosexual,

homosexual, or otherwise.

Instead of blaming society for the psychological maladjustment of homosexuals, perhaps they should focus on changing irrational perceptions as is applicable to cognitive intervention since it is more probable that certain psychiatric maladjustments found in homosexuals are based within their own intrinsic factors.

Cornett (1995) revealed that many pro-gay advocates argue that society has caused the homosexuals' problems; that negative societal values toward homosexuals produce their difficulties. It should however be noted that stigma and homophobia certainly do add some stress in the lives of the homosexual (Kleis & Lock, 1995), however, empirical studies have failed to show that severe consequences such as, mental distress, or suicidal ideation results from this (Hershberger, Scott, & D'Augelli, 1995). The question remained, why did 40% of gay adolescents report suicidal behaviors?

Many gay-advocate researchers of the 20th century did not deny that gays were psychologically maladjusted. For example, Savin-Williams (1994) admited that gay youth were associated with school problems, run away behaviors, substance abusers problems, prostitution, and suicide. But he explained that it was caused mostly by parental verbal and physical abuse. He did say that this was, "suggestive", and acknowledged that "...a causal link between these stressors and outcomes has not been scientifically established..." (p. 261). Overall, however it seemed that by the end of the 20th century, researchers wanted to discuss an extrinsic societal factor to explain the homosexual pathology, despite the fact that no scientific evidence could point in that direction.

The social maladjustment of homosexuality associated with AIDS had also not been supported, thus an argument to state that AIDS caused homosexual maladaptivity was void. In fact, it was suspected that regardless of HIV serostatus, psychiatric morbidity rates in gays were relatively high (Auerbach, 1994). Atkinson, et al. (1988) found that gay men with or without the HIV virus had significantly higher lifetime rates of anxiety and depression. Thus, the first hypothesis that society caused homosexuals' their problems remained unsubstaniated. Therefore, this pathology went beyond and more deeper than societal and AIDS factors, which have been so commonly argued as causative. If stigma was as real as it was suggested, than why were gays more financially secure than their heterosexual counterparts? According to World (July 30, 1994) more than half of homosexual households earned in excess of $50,000 compared to the national average which was slightly over $32,000 at the time of the study. Almost two-thirds of homosexuals were college graduates in the 20th century and nearly half held professional and managerial jobs compared to 15.9, which was the national average, at the time of the study. In the Spada Report the minority of the gays said it was difficult to be gay and that was in the 1970s, when homosexuality was removed as a mental disorder, when there was the excitement of the sexual revolution, and no AIDS. So, begging the question, why was that?

Other gay advocates wrote that, "studies have found no differences in the psychological adjustment of lesbians and gay men from heterosexual women and men" (Rothblum, 1994, p. 214). However, this merely blinded the truth. The author did not discuss what she meant by "psychological adjustment" and her claim was based on review of reviews of selected earlier studies. When a synthesis is completed such as this, the Rothblum's statement is void. Nevertheless, Rothblum's discussion was given space in the American Psychological Association's, Journal of Consulting and Clinical Psychology. Pro-gay slants, such as Rothblum's became popular in the professional journals post-1973, and transforming them to be more pseudo-scientific than scientific. This is because more political, rather then scientific, discussions were rampant (Wellings, et al., 1990). In the Annual Review of Psychology, Betz and Fitzgerald (1993) noticed that the research on counseling gays and lesbians did indeed show a trend, that is, it moved from pathology to normalization of homosexuality.

The normalization of homosexuality followed a liberal potical agenda. Making sense as to why publications served to regard homosexuality as normal was the fact that the majority of publishers, and their respective organizations had liberal orientations. For example, when researchers invested the APA's flagship journal American Psychologist, 97% of the articles were judged to advance liberal themes (Prilleltensky, 1994). However, when medical journals are reviewed (despite some politically correct discussions and commentaries within some) the facts are bold that homosexuals are indeed less adjusted than their heterosexual counterparts.

Rothblum (1994) also felt that "history" had "pathologized homosexuality";

suggesting that pathology was just a label or perhaps a veracious attitude. However, she did not explain what evidence, over the years pointed to pathology in reality. At the same time, she discussed selected studies to base her commentary on.

On one hand, Rothblum claimed that the mental health of gays and lesbian were stable, than one the other, claimed "more research [was] needed", suggesting she was either not convinced or she hadn't synthesized the literature properly.

The pro-gay way of explaining the homosexuals' pathology is by the following paradoxical quotations, such as: "Well, its not classified as a disorder, anymore", and, if they do admit any pathology, they claim: "Well its diversity, or societal stigma which has caused it", "Society must change", or "accept it." Militant gays of the 70s, and 80s (ACT UP) used the "in your face strategy" and went as far as to say: "We are queer, we are here, get over it".

Finally, stating that homosexuality is a normal behavior only enabled its pathology, it did not take away from it, as so many would have liked. It's much like the relationship between the codependent and the alcoholic. They know the alcoholic is sick, but they love him and depend on him, thus they enable the behavior. Some go as far to say that those who contend that homosexuals are pathological are themselves sick.

Reponses from the American Psychological Association (APA) to the National Association for Research and Therapy of Homosexuality (NARTH)

In the APA Monitor (September, 1994), Mr. Clinton Anderson of the Office of Gay and Lesbian Concerns of The APA, stated that gays and lesbians "do not

differ on any kind of measure" from heterosexuals except sexual orientation, and that coming out of the closet "is positively correlated with mental health" (p. 39) . On September 27, 1994, The National Association for Research and Therapy of Homosexuality (NARTH) addressed a correspondence to Mr. Anderson, asking him to provide documentation, to support his claims (NARTH, personal communication, September 27, 1994).

On January 19, 1995, Mr. Anderson responded to NARTH on APA letterhead. To support his claims, he provided two references. The first was an edited text by Gonsiorek and Weinrich (1991): Homosexuality: Research implications for public policy and the second, by the Garnets and Kimmel's (1993) chapter in the book they edited titled, Psychological Perspectives on Lesbian and Gay Male Experiences. The following is therefore a review of these 2 references:

1. Psychological Perspectives on Lesbian and Gay Male Experiences (Garnets & Kimmel, 1993)

Overall, the text was a forum of lesbian and gay issues targeting the academic ranks. It added to a wave of literature discussing "human diversity". The editors, however discussed that the homosexuals' status was based on politics. For example, they provided the case where the minority status of gay law students in California Supreme Court was enabled solely because they identified themselves as a political group.

The book offered no real original data, other than their own interpretations of prior studies, rather it was a composition of so called, "thought provoking" chapters prewritten by partisan gay advocates such as, De Cecco, Troiden, Morin, and the

like. As mentioned previously, DeCecco once served, as an editorial board member of PAIDIKA: Journal of Pedophilia and Morin, is the author of Anal Pleasure and Health. In fact, it mentioned that royalties from the book went to the Society for the Psychological Study of Lesbian and Gay Issues, which is a division of the APA. The organization, of course which Mr. Anderson represented. Thus, the contributors were of a select group with a particular interest.

The book's gist was on,

> …critical issues reflecting the contemporary relevance of each section.. discussed. These are in turn, outing, the debate regarding choice verses no choice of sexual orientation, the effects of historical differences between older and younger generations of lesbian and gay men, homophobia and ant lesbian/antigay violence, racism in the gay and lesbian community, legal recognition of relationships, the impact of HIV/AIDS on adolescents and the aging process, and the health effects of coping with social oppression. (p. 12 of the preface).

Given this laundry list (and then reading chapter-by-chapter), it was clear to see that the consideration of pathology was bypassed with political issues. Ultimately, what Mr. Anderson offered NARTH was a text that only nullified his claims. It did not provide much in the way of proving that homosexuality was not pathological, in fact, it rather bypassed it and moved on to its own partisan agenda.

There were some arguments that the text offered. For one, they suggested

that the heterosexual family was not a good role model for gays and lesbian children: "Because families of lesbian and gay men typically are heterosexual, they [heterosexuals] do not provide useful role models for normal transitions" (p. 6), and other developments. So, here they suggest heterosexuality is not normal!

Another argument provided, gave support to the present study's findings that homosexuals' were confused in identity and were sexually fluid. The author stated that, "lesbian and gay men are diverse and the majority are not easily identifiable, most move in and out of gay and straight identities..." (p.7) and "lesbian and gay men raise the issue that...everyone is not 100% percent homosexual all the time..." (p. 7). Citing the Kinsey studies and others, they stated, "Many [homosexuals] report no same-gender sexual experiences until adulthood. Moreover, many bisexuals report moving from a same-gender sexual relationship to an other-gender sexual relationship and then back again, or vice visa" (P.8). "...some individuals appear to have flexibility in their sexual orientation or adopt one orientation after considerable experience with the other orientation in adulthood" (p. 9). The authors explain sexual orientation as very preplexing, for example one can have homosexual feelings and not be homosexual, while that same person could have heterosexual thought to facilitate a homosexual encounter.

The editors also stated that a biological origin explaining homosexuality is "controversial" (p. 9), and that "...the origins of sexual or are not well understood". The said that,

> ...today no more is known about the specific origins of sexual orientation than is known about the origins of other

characteristics such as expertise in ballet, chess, or the violin. The best conclusion is that a complex set of factors interact, varying from individual to individual, to produce lesbian and gay adults. (p. 34)

The authors, probably because of this, shifted their focus on political issues, rather then constitutional ones. Simply, if their discussion stayed political it would, comfortably, stay the status quo, i.e. as stated earlier, the editors, discussed that the homosexuals' status was based on political bases. Much of this strategy had pioneered into the buzz statement, "politically correctness", which by that time had become a household word.

Further, the authors found that the gay and lesbian identity was rather a process or formation which was dependent upon socialization. Their premise was that if the environment was more positive for gays and lesbians, then their process would be better.

The editors stated that, "[T]he gay male and lesbian identity requires individuals to reconcile their own uniqueness with society's template..." (p. 12). Cross-culturally they added that homosexuality was not seen as favorable. For example, they stated that Asians viewed homosexuality as a threat to their beloved tradition of marriage and family. However, if homosexuality was so "natural", as it was suggestive throughout the text, then why does it demand favorable environmental factors? Furthermore, if homosexuality was so natural, as it is was suggested, then why does its origin demand biological proof? (see sections "Biology and Sexual Orientation" to follow).

Other questions remained as it related to their discussions. One sparked from the statement that: "Lesbians and gay men show great resilience in the face of social oppression. As individuals, they typically manage to form a positive sense of self and do not suffer from low self-esteem." (p. 12). However, the question sparked is: If homosexuals are so resilient, then why were there such large discussions about claims of social influences causative to homosexual distress and maladaptation? Further, the text stated: "The psychological study of lesbian and gay issues is an emerging field that has only begun to explore the ramifications of the social significance attributed to sexual orientation" (p. 34). Thus, this would suggest that such statements about society were premature and were unable to be substantiated. Additionally, to address the other issue, our findings did not support their statement, which suggested that gays and lesbians "do not suffer from low self-esteem" (p. 12), but rather the opposite was found.

Without identifying it, the authors support certain pathological traits of homosexuality, for example: "...gay men tend to use strategies that deny affective involvement in order to minimize the importance of sexual experiences with men" (p. 28). And in one earlier discussion they stated that, "....[homosexuals] create patterns of behavior, identity, and relationships that neither mirror nor duplicate heterosexual patterns" (p.25). This statement alone, nullifies the claim by Mr. Anderson.

Inconsistencies were also found in the text, for example, while advocating for gay parenting, they stated that, "Research is clearly needed on the uniqueness of lesbian and gay parenting" (p. 33). So, while they made claims, they did not have

the research data available to support them. However, this is the text, Mr. Anderson referred to as proof that stated that gays and lesbians "do not differ on any kind of measure" from heterosexuals except sexual orientation" (p. 39).

Now back to the issue claiming that homosexual is indeed nonpathological, the following was cited:".....psychological research has shifted from removing the stigma of pathology from lesbians and gay men to examining issues of implicit concern to them" (p. 35). Not only does this give support to this discussion about the political aspects, but confession that the psychological research shifted, rather than disprove homosexuality nonpathological. It only found that it shifted its focus. However, if you look away from what is in front of you, it does not mean it becomes absent. Finally, the classic argument was haphazardly used within the text that homosexism and homophobia were pervasive to homosexuality; again, said in the absent of any proof:

> Moreover, research has focused on the nature and impact of negative social attitudes toward lesbians and gay men and has documented the pervasive effects of heterosexist bias and homophobia within American society. (p. 35)

What research? It was not found in the 20th century when this was quoted! In addition, this contradicted earlier statements they had presented. By this small review, it was clear enough that Mr. Anderson's statement and documented citations never supported his or the APA's claims to NARTH.

2. Homosexuality: Research implications for public policy (Gonsiorek & Weinrich, 1991).

This text existed because 2 editors were "dissatisfied with their disciplines and wanted to response to the public policy debates on homosexuality" (p. 1 of the Preface). Over all, the text was intended to be a guide for, "public policy". Evelyn Hooker served as one of the advisors to the task force writing the text, along with John De Cecco and John Gagnon. The APA, as with the first text, was very accommodating to the project.

Like the Garnets and Kimmel (1993) text, this text offered no original data, rather a composition of "thought provoking" chapters prewritten by gay scholars and advocates. One chapter was written by Charles Silverstein, and as mentioned proir, was the co-author of The Joy of Gay Sex and The New Joy of Gay Sex.

Gay biology researcher Dr. Richard C. Pillard wrote another chapter. He discussed previous research conducted and the hypotheses which stated that homosexual men were more feminine and not more masculine than their heterosexual counterparts. He was unable to disregard the hypothesis. Reasons given were that, "Homosexual men's sexual behavior patterns may indeed be more "feminine...", and, in pencil-and-paper questionnaires of psychological interest and feelings, homosexual men did not score in the frequency of the heterosexual men but rather intermediate, thus not equal." Clearly, his discussion pointed to the fact that gay men differ from heterosexual men along the lines of feminine scores and psychological interests and feelings, which by the way merely refuted Mr. Anderson's previous comments that homosexuality did not differ from heterosexuality.

Dr. Pillard's discussion like many advocates remained confusing and at

times contradicting. One hand he said "..it is important to consider a hypothesis [about homosexuality] that perhaps...is part of a completely natural way of being…", then stated, "that being [homosexual can] sometimes be worse than...any other part of nature's plan."(p. 43). Pillard, of course was an advocate of biological explanations of homosexuality.

One editor, John C. Gonsiorek wrote a chapter titled The empirical basis for the dismiss of the illness model of homosexuality. Immediately in the chapter, Gonsiorek discussed politics. He discussed how "diagnostic [criteria] 'fashion' changes over time, especially in the manner in which psychiatric diagnosis is used as an agent of social control and conformity" (p. 115). Thus, in the absence of a diagnose (as it were post-1973) then "social stigma" would be lost and "conformity" would be replaced. Gonsiorek felt that homosexuality as a diagnosis was "simply another example of social control by mental health professionals" (p. 115). This type of discussion set the pace for the chapter.

The heart and soul of the chapter was based on his attempt to refute homosexuality as a sign of psychopathology, psychological maladjustment, or disturbance. In attempt, he reviewed the studies conducted by way of psychological tests. Gonsiorek criticizes those studies which found "significant differences suggestive of greater psychological disturbances in their homosexual samples" and stated that "they [were] by-products of the faulty sample and poor design" (p. 129). He conveniently provided these kinds of statements.

The studies which did not find or discuss significant differences between homosexual and heterosexual samples, however, he did not critize their

methodology and sampling. For example, he did not criticize the Kinsey, et al. (1948) study or the Hooker (1957) study. In fact, he stated, "...Hooker's seminal study...elicited a line of research for about 25 years. This research was so consistent in its lack of findings suggesting inherent psychopathology in homosexuality that researchers began moving on to other projects by the 1980s. Recent research has dropped off because the inherent pathology of homosexuality has been answered from a scientific point of view and has not been seen as requiring more research" (p. 132). This is not only an erroneous statement but also one that does a disservice to the research community (both past and present) and to the public of which he claimed to support.

As stated earlier, only studies which found and discussed homosexual pathology did, Gonsiorek quickly, state as "flawed". The fact of the matter, of which Gonsiorek didn't want to admit, is that practically all studies have some type of methodology flaws (even the ones he praised), that's just the nature of the research world. Because of the nature of homosexuals, we are limited to studying them, (e.g. nonrandomizing, small samples, etc.). Because of these limits of which many researchers have little control, there is not a reason to criticize many years of scientific inquiry. The baseline that homosexuality is pathological has been established and quite frankly seems intimidating to Gonsiorek and his fellow advocates who share the pages of this, so called, "public policy" text.

Unlike Gonsiorek (1991), at least Garnets and Kimmel (1993) discussed limitations of research studies that supported nonpathology. Pay close attention to their last statement in emphasis, however:

For example, Hooker's (1957) study showed that homosexual men cannot be distinguished from heterosexual controls on the basis of psychological tests, and Masters and Johnson's (1979) laboratory study showed that the homosexual men and homosexual women showed the same physiological sexual response as did heterosexual men and heterosexual women, respectively. In neither study was a representative sample used, yet both were convincing. (p. 5, emphasis added)

By review of the references (as reviewed above) which were cited By Mr. Anderson, it becomes clear to see that they do not support his claim in an empirical manner. Rather they too are claims based upon political rather then scientific motives, and at times, contradicting to each other.

Biology and Sexual Orientation

Although Bell, Weinberg, and Hammersmith (1981) concluded that, "The sexual preference of the exclusive homosexuals simply seemed to follow from a deep-seated predisposition that had emerged during childhood or adolescence" (p. 216), the 20th century will be famous for introducing the biological studies on the etiology of homosexuality.

Hypotheses which discuss a natural basis of homosexuality became very prominate, yet controverseral in the 20th century. Neuroscientist Simon LeVay (himself homosexual), tested the hypothesis that the brains of homosexual men possessed distinctive structural and functional attributes different from those of heterosexual mens' brains. He tested his hypothesis on the brains of gay men who

had died from AIDS. He did find that the nucleus called INAH-3 was much smaller on average in the homosexual men's brains than in comparison to heterosexual mens' brains, but were about the same size as the INAH-3 in women's brains (LeVay, 1991).

The results of LeVay's study provided support for the hypothesis that specific clusters of cells in the human brain have a great effect on sexual orientation on adults. In a critical review, however, it was stated that:

> ...the issue is far from closed. Ideally, the hypothesis that a small INAH-3 causes a homosexual orientation in males should be tested against alternatives, one of which is that homosexual activity causes a reduction in the size of INAH-3. And what behavioral interactions could have an effect on the size of selected brain cells. (Alcock, 1993, p. 118).

The study was unable to support a causal criteria for homosexuality as several open issues existed:

1. The study wasn't tested against alternative hypothesis to see what else could have had an effect on the brains.
2. He did not know what effect AIDS have had on the brains.
3. He was not clear about the sexual orientations of all the subjects.
4. The study has not been replicated, which is needed to substantiate its' findings

LeVay, also set the record straight stating that he did not find a biological basis for homosexuality.

Twin studies have also failed to prove that concordance in those cases prove

a biogenetic etiology because they report various degrees of sexualities (Kallman, 1952a, 1952b) and the development histories of twins was found to be uniquely different from other individuals (Rainer, et. al, 1960). Bailey and Pillard (1991) while studying the incidence of homosexuality in twins found a 52% concordance rate for identical twins; a 22% concordance rate for fraternal twins; a 9% concordance rate for non-twin brothers, and a 11% concordance rate for adopted brothers. Based on a higher concordance rate among identical twins they concluded, therefore that men were born homosexual. However, it could not be conclusive that genetics played a role in sexual orientation since a remaining high percentage of twins were not homosexual.

In a study on homosexual subjects, they were found to have lower amounts of testosterone in their bloodstream (Kolodny, et al., 1971). However, it is not suggestive to say that testosterone levels are causal of homosexuality because environmental factors do have an impact on testosterone levels. An interesting critique of the Kolodny et. al., 1960 study finds:

> ...decreased testosterone level could be a result of [homosexual behavior] rather than a cause and could be mediated through hypothalamic mechanisms- [others] have pointed out that the life style of persons with...homosexual activity could also be involved. Many subjects have said that while...patronizing gay bars, they frequently average less than four hours of sleep. Testosterone levels normally decrease during the day by some 30 percent, and the high early morning levels are presumably restored during sleep (cited in Socarides, 1989, p. 31-32).

Other activities such as the effects of substance use and other variables could

also be of consideration on the possibility of effecting testosterone levels.

In the early 1990s a team of researchers from the National Cancer Institute (NCI), including Dr. Dean Hamer, completed a study of the DNA of 40 separate pairs of homosexaul twin brothers which showed that 33 pairs shared 5 different patches of genetic material grouped around a particular area on the X chromosome (the mother or female chromosome). Although this was a significant finding, it was not validated and the NCI researchers could not say that their findings accounted for homosexuality in general and certainly could not be considered as causal. The study was severely flawed in that it had no control group and was not duplicated. (Hamer, Magnuson, & Hu, 1993).

While a deficit in androgens can diminish the sensitivity and reactivity of the sexual apparatus it does not necessary abolish heterosexual orientation. While there may be some physiological factors that may predispose toward androgenic deficits (thus in the case of males - gender deficits) and consequent homosexaul behavior, there is not one found that predetermines homosexuality. Dr. John Money, famous sex-genetic researcher concluded that, "sexual orientation is not under the direct governance of chromosomes and genes...[but]....it is influenced thereby, and is strongly dependent on postnatal socialization (Money, 1987, p. 384).

For a comprehensive critique of the biological studies refer to Byne and Parsons (1993) and Byne (1994).

Summary

This Synthesis of the literature from over 500 sources reveals that:

- Despite the knowledge of AIDS risk, homosexuals continue, time after time, to indulge in unsafe sex practices. Homosexuals represent the highest numbers of sexual transmitted diseases (STDs) cases.
- With or without protection, homosexual practice is just too dangerous a practice.
- Over one-third of gay men and lesbians are substance abusers.
- Forty percent of gay adolescents report suicidal histories.
- Lesbians generally do not seek healthcare, thus they are underreported in public health reports.
- Lesbians are at great risk, however, for AIDS, STDs, and other health concerns since their sexuality is characterized by sexual fluidity.
- The sexuality of homosexuals differs greatly, along several lines, from heterosexuals.
- Homosexuals are more sexually abused and have experience more early sexualization compared to heterosexuals.
- Consistent reports have shown that boys who have been seduced by men support a causal factor leading to homosexuality.
- Homosexuals are more likely to have evolved from a disturbed family of origin.
- Homosexuals are more likely to suffer from gender identify confusion.

- Homosexuals are more likely to have mental health concerns, such as eating disorders, personality disorders, paranoia, depression and anxiety.
- Homosexual relationships are more violent than heterosexual relationships.
- The lesbian relationship is based on an imbalance of power and dependency; the relationship is characterized by dysfunctional embeddeness and fusion.
- Gay relationships are not sexually exclusive and are emotionally destructive.
- Almost all male prostitutes were homosexually abused as children.
- Almost all gay men report involvement/fantasy in anal eroticism and other unconventional sexual behaviors.
- Homosexuality is not a fixed state, it is fluid, and can be changed.
- There is no biological evience to support a etiological arguments for homosexuality.
- Because homosexual behavior has been found among other species, it does not support a natural theory of its existence.
- By the end of the 20th century, researchers wanted to discuss an extrinsic societal factor to explain the homosexual pathology, despite the fact that no scientific evidence could point in that direction.
- Societial bias and discriminations do not, in and of themselves, cause homosexual maladaptivity.

- There is a distinct dichomony between homosexuals and

heterosexuals, favoring more positively toward heterosexuality.

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