

Preface

The Group for the Advancement of Psychiatry And Its Past Reports Relating To Homosexuality

Historical GAP Positions on Social Issues Related to This Monograph

The Group for the Advancement of Psychiatry (GAP) was founded shortly after World War II in 1946 by young psychiatrists just returned from the war and impatient with the traditionalism of the American Psychiatric Association at that time. GAP's intended purpose was to produce position statements on relevant and controversial psychiatric issues. GAP reports were concise, published soon after they were written, and widely respected and influential. Possibly because of the profound social changes that followed World War II, both the profession and the public were ready to accept revisions of traditional psychiatric attitudes and practices. This monograph, *Homosexuality and the Mental Health Professions: The Impact of Bias*, is in the tradition of a number of GAP publications dealing with bias, discrimination, and human sexuality.

GAP's formulated policy to discuss controversial psychosocial issues was announced in 1950, in the Committee on Social Issues' Report, *The Social Responsibility of Psychiatry, A Statement of Orientation* (The Group for the Advancement of Psychiatry, 1950b). In that report, the Committee noted that two factors had been influential in causing neglect of social problems by psychiatry: the role of prejudice in determining attitudes toward social problems and the sparse knowledge about the relationship between society and personality. In that pioneering document, the Committee on Social Issues emphasized the social responsibility of psychiatry. It made a number of suggestions for broadening the conceptual framework of psychiatry to include redefinition of the concept of mental illness, emphasizing those dynamic principles which pertain to the person's interaction with society . . . examination of the social factors which contribute to the causation of mental illness and also influence its course and outcome . . . consideration of the specific group psychological phenomena which are relevant, in a positive sense, to community mental health . . . the development of criteria for social action, relevant to the promotion of individual and community mental health [p. 5].

The *Psychiatric Aspects of School Desegregation* (The Group for the Advancement of Psychiatry, 1957), also produced by the Committee on Social Issues, addressed the issue of racial prejudice, around which there has been intense and ongoing conflict in American history. The following paragraph from the *School Desegregation Report* illustrates the way that GAP attempted to integrate psychosocial perceptions in the areas of both racial and sexual prejudice into individual and group psychodynamic theories:

On the deepest personal level, prejudices and their supporting myths can be understood as a means of maintaining feelings of self-esteem and security. In this sense they serve a defensive function. Many people of any race have acute doubts about their own worth, their adequacy in their sexual roles, and their acceptability as members of their groups. Turning attention to others' deficiencies permits one to remove the focus from fear and misgivings about oneself. Relief from intolerable feelings of self-contempt may be sought unconsciously by turning the hatred away from the despised part of oneself onto another person or group who, by the distortion of racial mythology, can represent the bad self. A down-graded minority, then, can become the source of a somewhat illusory security about oneself . . . the basis that "I am better than they are. . . ." But guilt feelings with associated anxiety are a frequent price for whatever psychological gains may come from such defensive dealing with inner conflicts. The use of the myth as a defense against insecurity, therefore, is self-defeating for it not only fails to reach a realistic solution of the original difficulty but also increases the original burden of guilt. The well-known vicious circle of anxiety, defense, increased anxiety, and increased defensiveness may then ensue [p. 167].

These two GAP monographs provide much of the framework within which this report is to be understood. Also important, however, have been GAP's previous discussions of human sexuality. In 1950, GAP published its first such report, *Psychiatrically Deviated Sex Offenders*, (The Group for the Advancement of Psychiatry, 1950a), written by the Committee on Forensic Psychiatry. The Committee's intent was to bring an end to the use of traditional stereotyping and unclear legal terms and to bring a fuller measure of psychiatric understanding of sexual behavior to the court system. It stated: The Committee cautions against the use of this appellation "psychopath" in the law on several grounds. There is still little agreement on the part of psychiatrists as to the precise meaning of the term. Furthermore, the term has no dynamic significance. The Committee believes that in statutes the use of technical psychiatric terms should be avoided whenever possible. Psychiatric knowledge and terminology are in a state of flux. Once having become a part of public law such a term obtains a fixity unresponsive to newer scientific knowledge and applications [p. 1].

Despite the Committee's recommendation, in the DSM-I (American Psychiatric Association, 1952), which was shortly to follow, homosexuality was conceptualized as a form of psychopathic deviance.

GAP continued to focus on clinical psychiatric issues in human sexuality in later reports, for example: 1) *Assessment of Sexual Function: A Guide to Interviewing* (The Group for the Advancement of Psychiatry, 1973), formulated by the Committee on Medical Education, 2) *Psychiatry and Sex Psychopath Legislation: The 30's to the 80's* (The Group for the Advancement of Psychiatry, 1977), formulated by the Committee on

Psychiatry and the Law; and 3) Crises of Adolescence: Teenage Pregnancy: Impact on Adolescent Development, formulated by the Committee on Adolescence (The Group for the Advancement of Psychiatry, 1986).

The earliest GAP publication to focus explicitly on sexual orientation was *Homosexuality with Particular Emphasis on This Problem in Governmental Agencies* (The Group for the Advancement of Psychiatry, 1955), formulated by the Committee on Cooperation with Governmental [Federal] Agencies. The Committee hoped that their scientific discussion of what they considered a frequently misunderstood condition might "result in a more effective appraisal and management of the practical problems that homosexuality creates in society in general and in Governmental agencies . . . in particular" (p. 1). The stated purpose of that report was "to define and describe homosexual behavior and homosexuality from a medical and social point of view in accordance with scientific principles" (p. 1). Consistent with prevailing psychiatric opinion of that time, the Committee responsible for the report identified homosexuality as a treatable illness, meaning that a person's homosexual orientation could be changed to a heterosexual one, and that it is a form of sexual perversion . . . psychological in origin [with] no valid evidence that homosexuality is inherited. Homosexuality is an arrest at, or a regression to, an immature level of psychosexual development. While the treatment of homosexuality is difficult and time-consuming, success has been reported. Psychotherapy offers the best chance of success, particularly in the turbulent transition period from adolescence to maturity wherein sexual goals have not been finally established [p. 6].

The report questioned the prevailing view that people's homosexual orientation posed high security risks due to their "lack of emotional stability . . . and the weakness of their moral fiber" and cautioned against the pursuit of "witch hunts" (p. 6). In closing, the Committee observed, "In the governmental setting as well as in civilian life, homosexuals have functioned with distinction, and without disruption of morale and efficiency. Problems of social maladaptive behavior, such as homosexuality, therefore need to be examined on an individual basis, considering the place and circumstances, rather than from inflexible rules" (p. 6).

In the middle of this century, scientists, scholars, and researchers in biology, biochemistry, endocrinology, ethology, evolutionary studies, experimental psychology, genetics, history, literary theory, neuroanatomy, religion, the social sciences, and philosophy began the process of advancing alternative models of homosexuality (Kinsey, Pomeroy, and Martin, 1948; Friedman, 1988; McWhirter, Sanders, and Reinisch, 1990; Cabaj and Stein, 1996; Drescher, 1998b) opened up new knowledge about homosexuality and raised new questions that were not considered by psychiatrists in 1955. However, taken in its historical context, the 1955 GAP Monograph strongly argued against commonly accepted negative stereotypes that depicted a homosexual orientation

prejudicially. It is uncertain what influence this report had on the implementation of antihomosexual policies of US governmental agencies. Of note, brief mention was also made of the topic of homosexuality in the Sex and the College Student (The Group for the Advancement of Psychiatry, 1960).

In contrast to directly addressing the issue of homosexuality, *The Educated Woman: Prospects and Problems* (The Group for the Advancement of Psychiatry, 1975), formulated by the Committee on the College Student, mentioned the topic as a footnote: "In the ensuing discussion we have primarily focused on heterosexual relationships because, besides being statistically most likely, they inevitably highlight issues relating to gender differences" (p. 188). They went on to state:

Most individuals will opt for a heterosexual orientation, but for some a homosexual orientation may represent the orientation of choice. In either case the opportunity exists to learn how one's self concept, gender identity, and sexual responsiveness work in actual practice. In arriving at an adult sexual orientation, patterns of sexual relationships, both heterosexual and homosexual, may become exceedingly complex and will inevitably be affected by earlier developmental events, identification, and conflicts. . . . No single life style can be presumed a priori to be "healthier" or "more adaptive" for all persons. What is adaptive may not only differ from one person to another, but may also change for any given person as development proceeds throughout the life cycle [p. 189].

In 1990, fifteen years later, *Psychotherapy with College Students* (The Group for the Advancement of Psychiatry, 1990), formulated by the same Committee on the College Student, did discuss gay and lesbian students in the section, "Some Special Student Populations." In that report, the Committee more openly specified student problems to include 1) recognition and acceptance of sexual identity and orientation, 2) difficulties in establishing stable love relationships, and 3) managing relations with fellow students. Special attention was given to concerns of gay and lesbian students seeking psychotherapy in the college mental health services:

Some gay students feel that they would prefer to work with a therapist who is openly gay, because no matter what the therapist claims, such students are suspicious that a therapist, presumably heterosexual, will be critical of their homosexuality. Most, however, are willing to work with any therapist who is nonjudgmental and accepting of the student's homosexual orientation. In confirming this acceptance, therefore, it is important for the therapist to be careful about asking questions that can be "heard" by the student as suggesting or urging heterosexual behavior. As gay students become more open about their orientation, they may become less conflicted about seeking therapy for whatever reasons, but they may also be more influenced by political positions of the campus gay organization [p. 119].

Fear of AIDS, problems with family, and discomfort with their own homosexuality were identified as common concerns in these students. The report was generally supportive of lesbian and gay students' efforts to find a healthy expression of their sexual orientation. Although it had been previously recognized that psychiatrists should come to terms with their own biases before they can successfully treat members of the other sex or of different races or other minority groups, that monograph was the first to call attention to the issue of antihomosexual bias (AHB), often referred to as "homophobia" in therapy. The tragic emergence in 1981 of the AIDS epidemic made it obvious that antihomosexual bias not only impeded adequate care of AIDS patients, but also prevented educational measures and interfered with rapid governmental funding for medical research. The compelling practical need to better understand the nature of AHB and to reduce its impact both in the larger social picture and in the specific area of clinical psychiatry is the principal topic of this monograph.

Since Weinberg's (1972) definition of the term homophobia, the scientific and theoretical literature on the subject of AHB has grown (Boswell, 1980; Marmor, 1980; De Cecco, 1985; Herek and Glunt, 1988; Herek, 1990; Herek and Berrill, 1992; Abelow, Barale, and Halperin, 1993; Domenici and Lesser, 1995; Cabaj and Stein, 1996). Studies have concentrated on AHB's presence in specific groups and professions, such as government, business, law, and various branches of medicine. This report, however, is among the first to address the question of AHB specifically within psychiatric practice, training, and professional relationships. This report also raises questions about the adequacy of current knowledge and training of psychotherapists in the areas of sexual orientation and the impact of AHB in the treatment setting.

Background of the GAP Committee on Human Sexuality

The GAP Committee on Human Sexuality was created in 1989. Founding members of the Committee were influenced by the work of Rieker and Carmen (1984), who taught how to effectively combat prejudice through fostering attitude reassessment and modification. Their approach emphasized that overcoming prejudice was best done in small group settings in which conflicts about sex roles, gender identity, moral values, and other areas could be openly discussed.

Two GAP members, Dr. John Spiegel and Dr. Bertram Schaffner, were eager to find a way to extend these principles to the area of bias about homosexuality. They felt that AHB was as pervasive in the medical profession as it was in the general population and that it was usually ignored in medical and psychiatric education. They requested that the officers of GAP consider forming a new committee whose initial task would be to take up this issue. GAP's positive response was consistent with its commitment to open discussion of subjects that have been traditionally avoided in the psychiatric community.

At a GAP plenary session, speakers discussed problems faced by lesbian and gay psychiatrists. They reported that considerable numbers of gay and lesbian psychiatrists felt the need to be secretive or "closeted" about their sexual orientation. They described obstacles to obtaining a psychiatric residency by physicians known to be homosexual. They reviewed the well-known discriminatory policies of psychoanalytic institutes that considered lesbian and gay candidates unfit for training (Drescher, 1995; Isay, 1996; Magee and Miller, 1997).

Following the plenary session presentation, the discussion period began with a memorable 10 to 12 minutes of tense silence, an awkward reaction that seemed to mirror the anxiety, confusion, and conflict about homosexuality present in the psychiatric profession as a whole. The dialogue that followed was also more anxiety laden than usual, despite GAP's long history of focusing on controversial topics. It was productive, however, and in 1987 the Committee on Human Sexuality was established and chose as its first subject of study "Antihomosexual Bias in Psychiatry and Psychotherapy."

In this report, we identify and draw attention to the problem of bias against lesbians and gay men as it exists in psychiatry and the practice of psychotherapy. The manifestations of bias are seen in the treatment of patients and in the education and training of mental health professionals. We also discuss relevant presentations of antihomosexual bias (AHB) in the legal system, as well as in the general medical response to patients infected by the Human Immunodeficiency Virus (HIV) and those who have Acquired Immunodeficiency Syndrome (AIDS).

The Committee on Human Sexuality of the Group for the Advancement of Psychiatry chose this subject because of our increasing awareness of the harmful effects of AHB on patients and their therapists alike, on the progress of treatment and on the reputation of the mental health profession itself. The issue appears more and more often in daily practice, in teaching and supervision, and in the public press.

The members of the Committee on Human Sexuality of GAP are a diverse group of psychiatrists, coming from different social, clinical and theoretical backgrounds. While recognizing that our personal and professional histories have inevitably helped to shape our views, we have attempted to present a balanced description of the ways in which AHB affects the teaching and the practice of psychiatry.

Antihomosexual bias is widespread in many cultures, including our own. It is difficult to think of anyone in our society (including lesbians and gay men themselves) who is able to avoid its impact. Therefore, it should not be surprising that mental health professionals, as members of a society, also consciously and unconsciously absorb that society's values. When this bias is selectively inattended, it may operate outside of conscious awareness. It is not realistic to expect that recognition of a bias will automatically eliminate it.

Prejudice of any kind is not easily modified or shed, even with the best motives. However, we hope to encourage practicing psychiatrists and psychotherapists to recognize when they are speaking with or acting on a bias that previously would have been outside their awareness. This will enable professionals in our field to be better able to prevent AHB from affecting treatment and to understand and assist their gay and lesbian patients.

Acknowledgments

This GAP Report, *Homosexuality and the Mental Health Professions: The Impact of Bias*," has been a long time in the making, and the Committee on Human Sexuality, which produced it, has a large debt of gratitude to many persons that needs to be expressed.

Henry Work and Michael Zales were instrumental in helping to establish a Committee on Human Sexuality within the GAP framework, which opened the door to an examination of the issues that the present report addresses-not an easy task. The encouragement from Judd Marmor, a former president of GAP, was very influential in promoting the acceptance of the newly formed Committee. Martha Kirkpatrick and Harold Lief were most helpful as early advisors.

The original members of this Committee should be recognized for their courage in coming together to form this fledgling group, which was at first regarded with some skepticism by many GAP members. The founding members were the late John Spiegel and I, soon joined by Paul Adams, Peggy Hanley-Hackenbruck, Joan Lang, Stuart Nichols, and Terry Stein. Not long after, we were joined by Debbie Carter, Johanna Hoffman, and the late Harris Peck. This original group of individuals established a presence within GAP, providing greater visibility and a forum for open discussions of gay and lesbian issues, and they gave this report its initial momentum. I deeply regret that John Spiegel and Harris Peck did not live to see the completed report.

Early on, while searching for a research topic to address in a GAP report, the Committee hosted talks by three outside consultants: James Weinrich, Phyllis Chessler, and Tom Mazur. The discussions within the Committee that followed their presentations helped to clarify the future direction of the Committee's work.

For several years, the Committee worked arduously on the production of a potentially comprehensive handbook on homosexuality and psychiatry intended for medical students, psychiatric residents, practicing psychiatrists, psychologists, social workers, nurses, and the like. As time went on, the Committee became mired in the enormity of that task, and it gradually became clear that this noble goal was overly ambitious, given the limitations of GAP's traditional way of working in semiannual, two-day Committee

meetings.

In order to reconceive and focus the Committee's efforts and to produce a publishable report in the near future, Richard C. Friedman and Jack Drescher, both well known for their expertise and writing skills, were asked to join the Committee. They were later followed by Joseph Merlino and Jennifer Downey. At the same time, Justin Richardson, in his capacity as a Ginsburg Fellow, made a vital contribution to the section of this monograph related to HIV and AIDS; Richard A. Friedman, a faculty member at Cornell Medical Center, provided valuable assistance as a consultant to the Committee. As a result of intense discussions, the Committee adopted the present report's emphasis on antihomosexual bias (AHB) in the mental health professions.

I wish to thank three other Ginsburg Fellows who participated in our Committee's work: Martha Bird; John Burton, who made many substantive and editorial contributions; and Gwen Zornberg, to whom we owe special gratitude, along with her associate, Pauline Quirion, for contributing the important chapter on the legal manifestations of antihomosexual bias.

Christina Sekaer, who attended Committee meetings as a guest, deserves special recognition for her brilliant observations and literary acumen. I look forward to her joining the Committee as a member.

As the report neared readiness for publication, Knight Aldrich reviewed it critically, line by line, and we are grateful for his trenchant observations on both its substance and its style. Carol Nadelson gave astute advice in her role as a member of the GAP Publications Committee. Frances Roton, Executive Director of GAP, has been a most supportive resource for the Committee.

This report could not have come to publication without Jack Drescher, currently Chair of the Committee on Human Sexuality. When the initial publishers ran into difficulties getting the report to press, it was he who resourcefully contacted The Analytic Press and later took charge of the final complex editing process. Jack's forceful leadership saved the day and made this report a reality.

My deep personal thanks go to Mark Koenig, who was my secretary during much of the time that this report was being prepared. He spent long hours editing, copying, and mailing out the many manuscript versions that were required during the period of my Chairmanship of the Committee on Human Sexuality, from 1987 to the completion of the report in November 1998.

Bertram Schaffner, MD
New York City
November 21, 1999

This GAP Report was long in the making, and at this juncture it must be noted that it owes its very existence to the ongoing perseverance and dedication of one man: Bertram Schaffner, M.D. The members of the Committee on Human Sexuality know Bert well and are keenly aware of his great modesty. Because of his unwillingness to draw attention to himself, those who do not know him well are unaware of his many professional accomplishments throughout this last half century. Bert has done much to enrich the professional lives of his professional colleagues and the personal lives of his friends and patients. He has singularly done more on a personal basis for gay psychiatrists and psychotherapists than any other figure known to us.

Bert took on a challenge as founding Chair of the GAP Committee on Human Sexuality and did so at a time of his life when most people have already gone into retirement. Even today, Bert is working full time. Even overtime. His capacity for finding pleasure in his work has been an inspiration to many. Bert works diligently, patiently, cautiously when he can, expeditiously when necessary, and always thoughtfully. But, above all, Bert works.

Bert has provided what Winnicott called a "holding environment" for a number of high-risk professional endeavors, this monograph on antihomosexual bias being just the latest. As most GAP members know, writing an article by committee, let alone a monograph of this magnitude, is an almost impossible venture. Furthermore, GAP's Committee on Human Sexuality comprises members with strong personalities and disparate views of what should be the report's primary focus. Bert's gift was to allow the individual group members' creative differences to emerge while keeping the Committee focused on a difficult, common task. A few eggs were broken in the making of this omelet. However, this monograph illustrates what a successful "chef" Bert has been. For that, and for so much more, Bert has earned the deepest respect of the members of the Committee on Human Sexuality, who dedicate this monograph to him.

Committee on Human Sexuality
Group for the Advancement of Psychiatry
White Plains, New York
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1
Dimensions
of
Antihomosexual
Bias

Historical Influences on AHB

Negative perceptions of homosexuality are rooted in many aspects of our history and culture. These include:

1. Biblical interpretation: From early in the history of Judeo-Christian cultures, there has been a tendency to condemn homosexual behavior, by emphasizing Biblical admonitions against it (Genesis 19, Leviticus 18: 7,22, Leviticus 20:13, Judges 19, I Kings 22:46, II Kings 23:7, Romans 1:27, I Corinthians 6:9, I Timothy 1:9-10).
 2. Sin to illness: The scientific and medical construction of a category representing a particular social group, the term homosexual was coined in the 19th century. Its rapid and widespread usage by the public, as well as by the medical profession, reflected an attempt to replace religious, condemning explanations with more compassionate, scientific ones. The homosexual/heterosexual binary obscured the variety of ways in which one could characterize sexual or other conduct (Bullough, 1979; Gonsiorek, 1991).
 3. Degeneracy theory: Influential in Europe and the United States in the 19th century, degeneracy theory proposed that traits associated with undesirable social behaviors were inherited. According to this theory, homosexuality, like violent criminality, enuresis, and alcoholism, was seen as manifestations of hereditary degeneracy. Thus, this was an early biological theory of homosexuality. Degeneracy theory also illustrated how the concepts of vice and illness are often interchangeable (Krafft-Ebing, 1886; Walter, 1956; Foucault, 1978; Greenberg, 1988).
 4. Antisexual Victorianism: In the 19th century, the Victorian culture's repressive stance toward sexual pleasure was expressed in diverse ways, including the widespread belief that masturbation caused insanity or could lead to homosexuality (Acton, 1865; Rosenthal, 1985; Duberman, 1986, 1991). Victorian sensibility also nourished the concepts of contagion and quarantine, beliefs that both fostered and were derived from degeneracy theories. It was popularly believed, for example, that homosexuality could be transmitted by sexually active people and that people who otherwise would develop as heterosexuals could be "corrupted" by mutual masturbation with a person of the same sex (Bullough, 1979; Weeks, 1985).
 5. Idealization of the nuclear family: Social philosophers of the 18th and 19th centuries emphasized the intimate link between the health of society as a whole and the stability of the nuclear family organized around traditional sex roles. The so-called traditional family became a symbol not only of social cohesion and economic stability, but of correct moral behavior as well. This belief contributed to the development of a heterosexist ethic (Greenberg, 1988).
 6. Heterosexism: Heterosexism is a belief in the inherent superiority of social practices and cultural institutions associated with heterosexuality, such as monogamy, marriage, and child rearing in two-parent, heterosexual families. In its more benign form, it might be referred to as "heterocentrism." In its more malignant presentations, heterosexism is the ideological system that denies, denigrates, and stigmatizes any nonheterosexual form of behavior, identity, relationship, or community (Greenberg, 1988; Herek, 1990, 1995).
- Attitudes Toward Homosexuality
Attitudes in the General Population

There is a dearth of articles in the psychiatric literature on attitudes toward homosexuality in the general population. We hope to stimulate further research in this area.

An important national survey of sexual morality and experience was carried out under the auspices of the Institute for Sex Research at Indiana University in 1970 (Klassen, Williams, and Levitt, 1989). With the help of the National Opinion Research Center, the investigators obtained a representative national sample of more than 3,000 men and women. Interviews revealed that 60% of these individuals believed that lesbians and gay men have unusually strong sex drives and that those who are older commonly seduce younger ones who, as a consequence, then become homosexual. Seventy per cent were concerned that lesbians and gay men seek to become sexually involved with children; half the 70% strongly believed this to be the case. The fear that lesbians and gay men constitute a threat to children was substantial even among the subgroup of the sample whose overall attitudes toward homosexuality were not particularly negative. More than two-thirds of the sample felt that lesbians and gay men should be barred from teaching, the ministry, the judiciary, medical practice, and government service. Almost 50% believed that homosexuality can cause the downfall of civilization. In this investigation, the most powerful predictor of attitudes toward homosexuality was the intensity of religious belief. People with these attitudes were more likely to come from the deep South or Midwest and from religious families that tended to be sexually repressive. A subsequent study by Nyberg and Alston (1977), of a representative sample of more than 1,000 white American adults, found that over 72% believed that homosexual relations were "always wrong."

With the passage of time, public opinion has become more accepting and tolerant. For example, a Gallup poll in 1989 revealed that 71% of respondents believed that gay men and women should have equal job opportunities (Colasanto, 1989). The reasons for this shift in public opinion are not entirely clear. Certainly, the emergence of articulate gay and lesbian spokespeople may be a factor. The AIDS epidemic may have played a role as well. According to polls, the public perception of a minority group struggling valiantly with a dread disease led to the diminution of prejudice and discrimination in some quarters.

The equating of AIDS with homosexuality, however, has also led to an escalation of fearful and hateful attitudes toward gay men and, ironically, to lesbians. Reports of escalating violence against people perceived to be gay suggest that opinion polls do not fully measure the extent of antihomosexual attitudes in the general population. The reported incidence of violence against gay and lesbian persons is increasing in many major American cities and appears to be increasing more rapidly than other bias-related crimes, such as racially motivated hate crimes. Major problems with antigay and lesbian violence and harassment have been reported at college and university campuses, including Yale, Rutgers, Penn State, the University of Massachusetts at Amherst, the University of Illinois at Champaign-Urbana, and other sites. At Yale, of 166 gay and lesbian students studied, 24% had been threatened, 24% followed or chased, and 5%

beaten. Fifty-seven per cent reported that they feared for their safety. At the high school and junior high school levels as well, antigay and antilesbian violence and harassment are widespread (Cort and Corlevale, 1982; Herek and Berrill, 1992; Klinger and Stein 1996). Teenagers surveyed about bias responded more negatively to gay people than to other minorities.

In a review of research on those holding negative attitudes toward lesbians and gay men, Herek (1984) found several similarities among diverse samples. When compared with those with more favorable attitudes toward lesbians and gay men, people with AHB were less likely to a) have had known personal contact with lesbians or gay men; and b) report having engaged in homosexual behavior or to identify themselves as lesbian or gay. They were also more likely to c) perceive their peers as manifesting negative attitudes toward gay people, especially when the respondents are males; d) have lived in areas where intolerance of homosexuality is more the norm (e.g., the Midwestern and Southern United States, the Canadian prairies, and in rural areas or small towns), especially during adolescence; e) be older and less educated; f) be devoutly religious, attend church frequently, subscribe to a conservative religious philosophy; g) express traditional, restrictive attitudes about sex roles; h) manifest guilt or negativity about sexuality and to be less permissive sexually; and i) manifest high levels of authoritarianism and related personality characteristics.

Herek noted that negative attitudes may serve different functions for a person and that people may share similar attitudes for different reasons:

First, such attitudes may be experiential, categorizing social reality primarily on the basis of one's past interactions with lesbian and gay people. Second, attitudes may be mainly defensive, helping a person to cope with some inner conflicts or anxiety by projecting it onto gay men and lesbians. Finally, attitudes may be symbolic, expressing abstract ideological concepts that are closely linked to one's own notion of self and to one's social networks and reference groups [p. 8].

In general, men manifest more negative attitudes toward gay people than do women. Violence against lesbian and gay victims is usually perpetrated by males, as is true of violence in general (Moyer, 1974; Herek and Berrill, 1992). Heterosexually identified men and women alike tend to have more negative attitudes toward people of their own gender who are perceived to be lesbian and gay than toward people of the other gender (San Miguel and Millham, 1976). There are no studies of the profiles of mental health professionals or how likely they are to share some of the culture's stereotypical beliefs about lesbian and gay people.

Attitudes Within Dynamic Psychiatry

Persistent AHB is often rooted more in personal value systems and experiences than in the scientific literature. Since bias is often rationalized or denied, its effects may be especially pervasive and debilitating. An example of a common rationalization of bias is that a homosexual orientation is intrinsically more pathological than a heterosexual one. This kind of rationalization may lead to discrimination against patients and trainees.

During the years after World War II until the 1970s, American psychiatry's formulations of homosexuality were largely based on psychoanalytic models and common cultural stereotypes of human behavior (Lewes, 1988). In the American Psychiatric Association's Diagnostic and Statistical Manual, first edition (DSM-I: American Psychiatric Association, 1952), homosexuality was classified as a sociopathic personality disorder (Bayer, 1981). In the DSM-II (American Psychiatric Association, 1968), it was reclassified as a sexual deviation. The DSM-II was revised in 1973 and homosexuality per se was removed as a diagnostic category (Bayer, 1981).

The pathologizing psychoanalytic theories of homosexuality, as well as the interactive influence of theory and culture, are too extensive to be discussed more than briefly here. The reader interested in these areas is referred to Bieber et al. (1962), Weideman (1962, 1974), Socarides (1968, 1978), Ruitenbeek (1963), Sulloway (1979), Marmor (1980), Bayer (1981), Fisher and Greenberg (1985), Gay (1988), Greenberg (1988), Isay (1989), Lewes (1988), Friedman (1988), Holt (1989), O'Connor and Ryan (1993), Mitchell (1996), Magee and Miller (1997), and Drescher (1998b).

During the socially conservative years following World War II, policy positions taken regarding homosexuality by such institutions as the military and the law were buttressed by pathologizing psychoanalytic constructs. Lewes (1988) has pointed out that, during that era, many psychoanalysts couched their own personal endorsement of traditional religious and family values in supposedly objective psychoanalytic terminology. The image of psychological health was defined as a nuclear family organized around traditional gender roles (Bieber et al., 1962).

The psychiatric literature underemphasized and ignored lesbian and gay people whose capacities to love and work were unimpaired (Hooker, 1957). It also ignored the negative countertransference toward these patients (Mitchell, 1978, 1981; Kwawer, 1980; Lewes, 1988; Frommer, 1995) and the influence of widespread social prejudice on their psychological well-being (Stein and Cohen, 1986; Isay, 1989; Drescher, 1998b).

The psychodynamic literature of that era focused on the etiology of homosexuality, which was presumed to result primarily from preoedipal or oedipal psychic trauma, in contrast to heterosexuality which was assumed to unfold naturally and which therefore had no "etiology" (Bergler, 1944, 1951, 1956; Bieber et al., 1962; Socarides, 1968; Bayer, 1981). Homosexuality was believed to be a sign of psychosexual immaturity. Any role of neurobiological influences on sexual orientation was deemphasized and even denigrated in favor of psychodynamic hypotheses (Lewes, 1988; Friedman and Downey, 1993a, b).

After the American Psychiatric Association removed the diagnosis of homosexuality from its list of mental disorders in 1973, other organizations of mental health professionals soon reached similar conclusions. These groups included the American Psychological Association and the National Association of Social Workers. A careful review of scientific evidence indicated that there was no clear-cut, demonstrable relationship between sexual orientation and psychopathological symptoms or disorders.

The original decision by the American Psychiatric Association to remove homosexuality from the category of pathology was opposed by a substantial minority of psychiatrists (Bayer, 1981). Subsequently, however, a 1977 survey of 2,500 psychiatrists found that a majority felt that homosexuality is pathological and that lesbians and gay men are less capable than heterosexuals of mature, loving relationships (Lief, 1977). Studies of other mental health professionals found that many, sometimes a majority, have had negative attitudes about homosexuality and lesbian and gay people and continue to harbor them (Fort et al., 1971; Clark, 1975; Rudolph, 1989, 1990; Lilling and Friedman, 1995; Friedman and Lilling, 1996).

Until recently there was a notable absence of openly lesbian and gay psychoanalysts willing to criticize the inadequacy of the prevailing psychoanalytic theoretical models of sexual orientation. Although some gay and lesbian psychiatrists began speaking openly and critically of psychoanalytic theory in the mid-1980s, it was not until the 1990s that gay-identified psychoanalysts began to write or speak against prevailing models on the basis of their personal and clinical experience (Blechner, 1993; O'Connor and Ryan, 1993; Domenici and Lesser, 1995; Isay, 1996; Drescher, 1997, 1998b; Magee and Miller, 1997). Thus, an important data source was not available for decades. These new contributions can be analogized to the ways in which women mental health professionals challenged earlier, prevailing phallogocentric theories (Lewes, 1988). The appearance of increasing numbers of openly gay and lesbian psychotherapists within mainstream psychiatric organizations suggests that heterosexual psychoanalytic attitudes are being challenged and may even have undergone substantial changes.

Research scientists have accumulated substantial data indicating that homosexuality per se is not associated with psychopathology any more than is heterosexuality. In any event, personality measures, projective tests, rates of psychiatric symptoms, and lifetime prevalence of psychiatric disorders, with few exceptions, do not distinguish between homosexual and heterosexual subjects (Gonsiorek and Weinrich, 1991; Friedman and Downey, 1994; Cabaj and Stein, 1996). Two types of psychological difficulties have been reported to be more frequent in lesbian and gay populations: attempted (but not completed) suicide in youth (Robins, 1981; Rich et al., 1986; Hendin, 1992; Prenzlauer, Drescher, and Winchel, 1992; Schafer, 1995) and substance abuse (Friedman and Downey, 1994). Even these findings await replication, however, and are not conclusive. Furthermore, studies have corroborated the role that stress plays in the lives of lesbians and gay men and the impact it has on their mental health. Increased exposure to stress might explain why the lifetime history of depression is elevated in gay men, although present history of depression is not (Williams et al., 1991).

Overall, psychodynamic psychiatry in the 1990s has discarded the paradigm that homosexuality is inherently pathological and has adopted the normal variant model. Psychodynamic psychiatric clinicians currently recognize that gay and lesbian patients usually seek treatment for the same reasons that heterosexual patients do: Axis I and Axis II psychiatric disorders, and stress, leading to suffering and disability. The full impact of

these changes within psychiatry on future social, medical, legal, religious, and political institutions remains to be seen.

Attitudes in Fundamentalist Religion

Religious fundamentalists have expressed disparaging views about lesbians and gay men. Some have rationalized and others exhorted violence in their public rhetoric. For example, "When civil legislation is introduced to protect behavior to which no one has any conceivable right, neither the Church nor society at large should be surprised when other distorted notions and practices gain ground, and irrational and violent reactions increase" (Congregation for the Doctrine of the Faith, 1986, paragraph 10, in Herek and Berrill, 1992, pp. 90-91). Many conservative religious groups and movements depict lesbian and gay people as being profligate and immoral and attribute the AIDS epidemic to punishment for sexual "sins." The category "homosexual" has become, in the minds of many, a symbol of one who rejects all of society's rules. From this perspective, homosexual practices must be violently resisted, or else abuse and neglect of traditional family values and structures will inevitably follow.

Conservative mental health professionals appear to subscribe to similar views. So, for example, in a famous case in which a gay man was murdered after revealing his attraction to a heterosexual neighbor, one well-known psychoanalyst blamed "the gay rights movement for the Jenny Jones incident. . . . To turn the world upside down and say it doesn't matter if we are homosexual or heterosexual is folly . . . to ask for total acceptance and enthusiastic approval of homosexuality as a normal and valuable psychosexual institution is truly tempting social and personal disaster" (Socarides, quoted in Dunlap, 1995).

Definitions and Issues

The term homosexuality refers to an erotic attraction to persons of the same anatomical gender; bisexuality, to attraction to persons of both sexes; and heterosexuality, to attraction to persons of the other sex. While the terms may suggest categorical divisions between types of sexual orientation, in fact attraction is usefully conceptualized as existing along a continuum. People experience either extremes of same or other sex attraction on the continuum, and others experience some degree of attraction to both sexes (Kinsey, Pomeroy, and Martin, 1948; Money, 1988). By erotic attraction, we mean that the person experiences the psychophysiological changes of sexual arousal with imagery of males, females, or both. We use the term sexual orientation instead of sexual preference because orientation denotes only direction of attraction, not motivation or conscious choice. Sexual preference suggests willful decision making as to the objects of erotic desire. As a general rule, homosexual, bisexual, and heterosexual orientation are not consciously experienced as volitional processes (Friedman, 1988; Isay, 1989; Money, 1989). Sexual activity, on the other hand, is frequently volitional. Thus, there are often incongruities between desire/arousal and behavior.

Many, but not all, persons who are predominantly or exclusively homosexual in their sexual orientation are referred to in this monograph as gay or lesbian. Gay or lesbian

connotes an awareness of one's homosexual orientation and often an involvement in social and political communities of other individuals with similar sexual orientation. Thus, persons who may be primarily homosexual in their sexual attraction may not necessarily view themselves, nor be viewed, as gay or lesbian unless they also acknowledge and are accepting of their sexual orientation, affiliate with other persons who share this orientation in some manner, and assume some aspects of personal identity associated with their homosexuality. Furthermore, in this report, the word homosexual is not used as a noun (e.g., "He is a homosexual"), but rather as an adjective (e.g., homosexual attraction). Usage as a noun takes sexual orientation, one aspect of a person, and reifies that singular characteristic to label the whole person, often in a stigmatizing, prejudicial fashion (Magee and Miller, 1995, 1997).

Identity as gay, lesbian, or bisexual can be seen as a facet of what Erik Erikson (1959) termed ego identity. This psychological construct refers to identification with a group's attitudes and values and to a continuing sense of self-cohesion over time. Ego identity is formed during adolescence. When it is intact, the person is able to function autonomously, with a sense of uniqueness, while feeling connected to others. Some consider themselves gay but experience erotic arousal to stimuli of both sexes. They place more weight on the homoerotic than on the heteroerotic component for their sense of identity. Others with similar histories of erotic arousal consider themselves heterosexual, and still others label themselves bisexual. Ego identity should not be confused with gender identity, which refers to the enduring awareness that one is either male or female. Because he believed this awareness is a fundamental component of the self-image of most people, the psychoanalyst Robert Stoller (1968) labeled it core gender identity. It is now thought that one's core gender identity is synthesized as the result of complex social, biological, and psychological influences. Social learning, physiological predisposition, and cognitive factors interact to lead a child to label herself or himself as "I am female" or "I am male." Studies of intersexed persons, patients with psychiatric disorders, and normal children suggest that core gender identity is usually formed by the third year of life.

Gender role behaviors are social enactments. They consist of the things one says and does that advertise one's gender identity to others (Money and Ehrhardt, 1972). Concepts of masculinity and femininity may vary in differing social contexts, whereas the ongoing self-assessment of one's masculine and feminine performance, the core gender identity, may endure as a permanent trait.

The term gender identity differentiation was originally invoked by Money to indicate the similarity between the psychological processes involved in establishment of core gender identity and those involved in cellular differentiation. It suggests that the early childhood process of gender identity differentiation is best conceptualized as a continuation of embryologically occurring sexual differentiation of the central nervous and reproductive systems.

Ego identity is formed much later, during adolescence and young adulthood. Core gender identity can be thought of as a component of ego identity in the same way that one's native language is part of one's identity. The field of gender identity studies is relatively new, having emerged long after original theories about sexual orientation put forth by Freud (1905, 1910, 1920, 1933, 1937) and others (Krafft-Ebing, 1886; Ellis, 1938) had exerted great influence on clinical theorizing. Contemporary clinicians need to be consistently aware of the distinction between gender identity and ego identity.

The difference between gender identity and sexual orientation is an important concept. This distinction was frequently blurred in the clinical literature pertaining to homosexuality, particularly during the three decades immediately following World War II (Friedman, 1988). Thus, passivity, effeminacy, and homosexuality were frequently conflated in discussions about gay men, while activity, masculinity, and homosexuality were the nouns used in discussions about lesbians (Freud, 1905; Bergler, 1944, 1951, 1956; Socarides, 1968; Bayer, 1981).

Homophobia has been given a variety of meanings and has been used in vague, nonspecific ways. The term originally referred to fear of gay persons or of homosexuality itself (Weinberg, 1972) but has grown to include any antigay or antilesbian belief, feeling, or behavior. Heterosexism, which we defined earlier, is sometimes used as a synonym for Weinberg's original description of external homophobia. Weinberg also defined the category of internalized homophobia as the self-hatred that many lesbians and gay men experience toward their own homosexual identities, attractions, and world. The origins of homophobia lie in both societal and individual factors (Herek, 1984). Many expressions of homophobia represent accepted views of gender and sexual norms in our own society and others. For example, homosexuality continues to be condemned by many institutions, particularly religious and military groups (Jones and Koshes, 1995), in spite of the damaging effects of such prejudices on both gay and lesbian persons and on the institutions themselves. Prejudicial associations of homosexuality with gender nonconformity is still used to enforce gender role conformity. This is done by social condemnation of effeminate behavior in boys and men, and of masculine behavior in girls and women, under the assumption that these behaviors are synonymous with homosexuality. The deleterious effects of socially condoned homophobia are manifested in the outbreaks of antigay and antilesbian violence, demands for the limitation of civil rights of gay persons, and its damaging effects on the psychological well-being of gays and lesbians who experience discrimination and stigmatization.

Homophobia is particularly destructive at an individual level when it occurs within the context of a psychotherapeutic relationship (Moss, 1992, 1997). In this report, we examine the ways that this prejudice is often expressed in psychotherapy and its distressing effects on patients, the course of therapy, and their therapists. We use the term antihomosexual bias (AHB) rather than homophobia since the former seems more specific and better describes the phenomena we are discussing.

Psychological Mechanisms in AHB

Paranoid Mechanisms

Classical psychoanalytic theory defined paranoia as a defense against unconscious homosexual wishes (Freud, 1911). Few clinicians today would explain paranoia on the basis of repressed homosexuality. There does, however, seem to be a clinical correlation between some forms of antihomosexual feelings and paranoid phenomena. Numerous psychodynamic pathways can lead to negative attitudes toward people perceived to be homosexual.

Paranoid psychodynamics occur along a spectrum of severity from persons with paranoid tendencies who are otherwise functional to psychotic, delusional patients. Some people function well but have a tendency to look at the world through an internal filter that is referential, suspicious, and mistrustful. In some people, this paranoid tendency is state related, while in some it appears to reflect a dominant personality style. Paranoid psychodynamics involve a sense of perceived threat not only to the self, but to the gender identity of the self. A man under the influence of such dynamics tends to experience a solid sense of core gender identity—he knows he is male—but has insecurity about his feelings of masculinity. This psychodynamic component is similar to that experienced by most boys (see AHB in Boys). What is different, however, is the intense anger and anxiety triggered by the sense of gender/self vulnerability in these men. Rageful affect, coupled with cognitive distortions stemming from the use of projection, leads to the belief that the man is the innocent victim of malevolence expressed toward him by others. He therefore feels justified in defending himself in a hostile environment by attacking his "enemies" (Friedman, 1988).

The gender insecurity of paranoid men who are also psychotic often leads them to experience delusions and hallucinations with homosexual content (Klein and Horowitz, 1949; Klaf and Davis, 1960; Planansky and Johnston, 1962). These men equate being unmasculine with being homosexual. Interestingly, psychotic paranoid women do not tend to experience homosexual delusions. Instead, they experience delusions (and hallucinations) with disparaging heterosexual content, for example, "slut, whore, cunt." One psychodynamic explanation could be that the loss of self-integrity associated with paranoid psychoses is experienced by men and women as penetration of the body, represented as oral or anal penetration by men and vaginal penetration by women. A feminist interpretation would be that the gay-disparaged man and the slut-disparaged woman are both being maligned as women. In a society with a double standard, a "fag" is denigrated but a "Don Juan" is admired.

The paranoid psychodynamics of delusional or hallucinating patients may reveal, in amplified form, some psychological mechanisms found among people engaging in violent AHB. Although data about nonpsychotic violent persons are sparse, clinical experience suggests that they are probably people who are easily humiliated and who respond to the demands of intimate relationships or competitive defeat and loss of power and stature with emergency emotional states (Sullivan, 1953, 1956; Cameron, 1967;

Ovesey, 1969). The sense of painful humiliation generates the need to scapegoat others, particularly "homosexuals," who become the repository of projected negative attributes.

Phobic Mechanisms

Homophobia, as a simple phobia, appears to be quite rare, although there are no data indicating its actual prevalence within the general or clinical population. For this reason we prefer the term antihomosexual bias or AHB. However, phobic mechanisms probably operate in some people who express AHB. In these people, defense mechanisms of repression, projection, displacement, and avoidance lead to a consciously experienced irrational fear. The dreaded object is avoided, thus allowing the phobic person to function without having to experience key conflicts from within. The specific object that symbolically represents conflicts that the phobic person seeks to avoid may be chosen as a consequence of actual experiences the person had with similar objects during childhood (Fenichel, 1945). Perhaps some people with phobic predispositions during childhood had experiences that endowed homosexuality with a unique, personal valence, allowing it to be selected as a phobic symbol later in life. Others may be phobic/avoidant toward sexuality in general and displace this avoidance onto homosexuality.

Phobias may also arise in people with obsessional character structures. Here, the avoided stimulus often symbolizes loss of control of aggressivity. An obsessional person who is angry at his boss, for example, may as a consequence of isolation of affect, experience an intrusive, ego-alien repetitive thought, "Shoot your boss." He may then phobically avoid guns and places where guns are sold or used. The reasons that obsessional people may develop phobias of homosexuality are diverse and a function of the different meaning that homosexuality has in the personal scripts of such people. Classical psychoanalytic theory has stated that obsessional people often ascribe special meaning to anality, and it is possible that the image of anal sexuality becomes a phobic stimulus in some cases (Fenichel, 1945). In any event, much research needs to be done in this area.

Internalized Homophobia

Given our culture's profound endorsement of heterosexuality, it is understandable that children who grow up to become gay or lesbian experience difficulties with self-esteem as adults (Cabaj and Stein, 1996). There is a tendency for a stigmatized person to internalize a damaged or "spoiled" identity (Goffman, 1963). Thus, many patients come to loathe themselves for being "homosexual." The specific meaning of antihomosexual attitudes will vary from person to person. These attitudes in lesbians and gay men may result from identification with covert or overt parental attitudes regarding masculinity, femininity, and homosexuality. Antihomosexual attitudes may be internalized as a consequence of painful childhood interactions with peers (Downey and Friedman, 1995b, 1996; Friedman and Downey, 1995; Drescher, 1998b).

Most gay and lesbian patients have found it necessary to hide their inner lives from others for prolonged periods of time. Sometimes, particularly during their early years, these patients may be so influenced by the heterosexually oriented culture in which they are raised that they successfully deny the significance of their own erotic fantasies. Such

patients learn to adopt heterosocial mannerisms and behaviors, as actors learn to assume the roles of characters in a play. Sometimes they believe that by so doing they will influence their erotic fantasies to become heterosexual like those of their peers. Whether or not homosexual desires are denied, they are usually hidden from others at first. Young people often realize that their families and friends might well reject them were they to reveal their homosexual orientation. Conflicts about disclosure of sexual orientation are a commonly occurring cause of depression in gay and lesbian patients, particularly during adolescence and young adulthood, with distressing numbers of suicides and suicide attempts (Cabaj and Stein, 1996). The psychodynamic consequences of the necessity to live a double life because of prejudice and discrimination are just beginning to be systematically described. While the term "coming out" has become part of popular culture, psychiatrists and other mental health providers need to be educated to understand the multitudinous ramifications of this process. For example, some people may become aware of their same-sex feelings only in middle or late life. Gay men and lesbians need to constantly assess the impact that revealing their sexuality might have in their ongoing daily activities.

Internalized homophobia is organized around shame, guilt, anger, anxiety, and loneliness. Its many manifestations depend on the degree to which the representational world of the person is integrated or fragmented and the type of character defenses he or she uses. Among its major adverse consequences are vocational or educational underachievement; a sense of lack of entitlement to give and receive love, resulting in irrational efforts to undermine love relationships; and projection of a devalued self-image to a partner who is then scapegoated. Unconscious antihomosexual attitudes are so common among gay and lesbian patients that some therapists believe they are universal. To achieve a positive and psychologically well-adjusted identity, a person needs to be able to minimize the effects of AHB by challenging and neutralizing the denigrating assumptions of heterosexism and coming to value and affirm his or her homosexuality instead. It is important to note that, in spite of these impediments and challenges, many persons, with or without the help of therapy, have managed to overcome internalized and societal AHB and achieve lives rich in work, love, and play. This achievement may be more common today as public attitudes toward homosexuality become somewhat more tolerant and accepting. Studies that show how people successfully adapt to their own internalized homophobia provide an area of future research.

The Impact of AHB on Psychological Growth and Development

Although definitive studies are lacking, a psychodynamic developmental frame of reference can help us to conceptualize some of the origins of antihomosexual bias. There is widespread cultural confusion between what are referred to as gender identity and sexual orientation. Thus, insecurity about one's own gender role may raise questions about one's sexual orientation and may sometimes contribute to an irrational fear of homosexuality. These fears may often underlie strongly negative attitudes and beliefs

about gay or lesbian persons. Security about one's own gender role and sexual orientation appears to protect against fear of homosexuality.

AHB in Boys

Both gender insecurity and intolerance of homosexuality appear to be more problematic in men than in women. Some explanation for this difference may lie in gender-specific developmental psychodynamics. Many authors believe that a man's sense of masculinity appears to be a more vulnerable psychological achievement than a woman's sense of her femininity (Greenson, 1968; Stoller, 1974). Gilligan (1982) and Chodorow (1978) offer developmental theories that might explain this difference. They suggest that, because the primary caretaker for all children is almost universally a female, there are profound consequences for the way that boys and girls experience feelings of attachment and gender-valued self-esteem. For females, interpersonal intimacy may become associated with a sense of strengthened gender security and self-regard. Boys, however, develop their gender identity in the context of separating from the mother. According to Gilligan (1982), masculinity is defined through separation while femininity is defined through attachment. She further contends that male gender identity is threatened by intimacy while female gender identity is threatened by separation. Psychoanalysts Greenson (1968) and Stoller (1974) have pointed out that there is a tendency in all children to identify with their primary caretaker. Boys must develop a masculine identity against the gradient of motivations arising from maternal identifications. Although most boys appear able to accomplish the developmental task of disidentification, they may always need to defend against the "pull" of their original feminine identifications. (Discussing reasons that this defensive need occurs more in some children than in others is beyond the scope of this report.)

The relationship between masculine self-esteem and antihomosexual attitudes is particularly important between ages six and twelve. This is illustrated in an investigation of preadolescent baseball players carried out by Fine (1987), who studied the behavior of boys on 10 Little League teams in Massachusetts and Minnesota. Fine was mindful that adult sex roles are formed in childhood. He found that Little Leaguers are highly moral, that is, concerned with behaving in specific ways compatible with their values. Their moral universe is, however, quite different from the one that adults usually perceive. The peer group of these 11- and 12-year-old boys prescribed values that in adult life would be viewed as something of a parody of machismo. Toughness, courage, and control of emotional display were prized. Heterosexuality was positively sanctioned, but not deep emotional involvement with girls, which was likely to be seen as feminine overinvolvement. As far as homosexuality goes, Fine comments:

Most of these boys have not met anyone who they believe "really" is a homosexual, and most of these boys do not know how to define homosexual other than to say they are boys who "like other boys" or "a guy who wants to marry another guy." Despite this, homosexuality was a central theme in their speech: "You're a faggot"; "God, he's gay"; "He's the biggest fag in the world"; "He sucks"; "What a queer"; "Kiss my ass" [p. 104].

In the world of these boys gentleness and nonassertiveness were equated with weakness and effeminacy, although none of the boys on the receiving end of insults were feminine in mannerism. Fine suggests that boys constantly feel the need to differentiate themselves from those who are female, weaker, and younger. That cursing and contemptuous scapegoating of peers were heavily organized around homosexual imagery suggests that such imagery reflects a central dimension of the way in which nonhomosexual American youths organize their thoughts about sex and violence. The boys on the teams studied in this investigation were not unusually cruel and, indeed, seemed to have many of the attributes expected in a sample of "normal" American children. The need to be accepted by peers, and particularly to be respected as masculine by male peers, often precedes adolescence and is a hallmark of the latency-age phase of development. The clinical literature dealing with problems of boys in this phase has tended to focus on the so-called sissies, rather than on the bullies in these encounters.

Adult attitudes and beliefs seem to be on a continuum with those of childhood, as is illustrated by the widespread derision expressed by men toward others who are perceived as being somehow not "masculine." Contempt, expressed in the term fag, for example, permeates the fabric of American mass culture. The term has multiple origins, all with a denigrating or demeaning dictionary context: according to the Oxford English Dictionary, "in English schools, a junior student performing tasks for a senior, a flap on a coat, a parasitic insect that infects sheep, a short form of 'faggot'-a bundle of twigs bound together for use as fuel, sometimes with the express purpose of burning heretics alive, or a term used to refer to women in a contemptuous manner." Evidence of adult attitudes may readily be found in popular movies, books, songs, and television and radio shows. From the developmental, psychodynamic point of view, the sense of masculinity of many males is relatively fragile, at least from the latency-age phase of development, and may remain so throughout life. Scapegoating of persons labeled homosexual is a common mechanism by which such men with fragile identities, either as juveniles or adults, seek to cope with their insecurity about their own masculinity. Scapegoating serves the function of distancing the abuser from and feeling superior to the abused. A sense of masculine self-esteem can also be transiently bolstered by a feeling of power associated with the fantasy of dominating another male.

Boys tend to be negatively disposed toward those who are labeled "sissies", "fags", and "homosexuals." They do not appear to hold comparably negative perceptions of lesbians. In the minds of most juvenile boys, and probably many men as well, "homosexual" refers to males only.

AHB in Girls

Cross-gender role behavior in girls is generally much better tolerated by parents and other adults than it is in boys, especially before puberty. Girls also seem less threatened than boys by peers who do not conform to traditional gender-role stereotypes. On the other hand, epidemiological studies indicate that a considerable number of American women have negative attitudes toward both male and female homosexuality.

The issues of development of gender identity and sexual orientation in lesbians differ from those of gay men, although both groups must contend with the heterosexist values of our society. In fact, the differing attitudes toward male and female homosexuality are a lens through which one can see and understand the cultural valuing of masculinity and femininity. Boys who are called "fags" are being denigrated as being like girls—a gender slur—but they are also being called "girls", that is, members of the less valued sex in our heterosexist society. Tomboys are tolerated because they aspire to masculine values. Girls who are called tomboy are being denigrated as being like boys, a gender slur, but are actually being praised to the degree that they achieve masculine goals (such as beating the boys in baseball). Clinically, adult women patients may recall with pride having been "quite a tomboy" in their youth, whereas men invariably experience great hurt and shame in recalling having been labelled sissies. A further complication in comparing antihomosexual teasing of boys with antihomosexual teasing of girls relates to another factor in our society, the invisibility of lesbians. Women are traditionally seen as less sexual than men. Lesbian sexuality has been overlooked historically in many laws regulating gay male sexuality. Children's teasing may include "fag" more than "lezzy" because of a much stronger cultural awareness of gay men and the relative invisibility of lesbians. The counterpart to macho posturing in boys is the phenomenon of heterosexual teenage girls', insecure in their gender identity, adopting stereotypic female roles or even getting pregnant as ways to reinforce their sense of femaleness. That men are expected to be more sexual than women in our society affects women and lesbians in ways that are beyond the scope of this report.

Conclusions

Antihomosexual bias in the United States is part of a cultural tradition that traces its roots to aspects of the Judeo-Christian tradition (Moberly, 1983; Harvey, 1987). Nonetheless, scholars have pointed out that some aspects of that tradition have been accepting of homosexuality (Boswell, 1980, 1984; Pronk, 1993; Helminiak, 1994; Gomes, 1996). Among mental health professionals, the normal variant model of homosexuality is a relatively modern one and has proved sufficiently compelling to become the dominant clinical paradigm (Kinsey et al., 1948, 1953; Ford and Beach, 1951; Hooker, 1957; Bayer, 1981; DeCecco and Parker, 1995). Nevertheless, AHB is common in the culture at large and has an impact on the way clinicians, patients, and families regard homosexuality. This chapter has discussed some of the historical beliefs that perpetuate AHB and has illustrated their impact on psychodynamic theory, modern religious fundamentalism, and the general population. The ubiquity of AHB has an impact on development, both in children who grow up to be gay and those who are heterosexuals. Traditional biases are not easily overcome, as work with lesbian and gay patients has illustrated. Often, coming out does not free them of their own AHB, and in any case coming out is a long process. It can also be a long and challenging process for clinicians to learn about their own AHB. The chapters that follow illustrate how AHB can find its way into the psychotherapeutic setting, the training and supervision of mental health

professionals, and the legal system affecting the material and emotional well-being of gay and lesbian patients. For those with severe illnesses, both medical and psychiatric, AHB frequently impedes the delivery of respectful and appropriate health care.