

Psychosocial aspects of homosexuality

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Editor's note

This paper and that which follows by M J MacCulloch were prepared for a London Medical Group symposium entitled 'Homosexuality: congenital or acquired?' held at the Middlesex Hospital Medical School in October 1979.

Dr Crown deals with the psychological and social factors of homosexuality. While he believes that part of homosexual behaviour may be genetic, Dr Crown feels that the acquired factors are likely to remain more salient especially the intrafamily ones.

Clinicians and researchers of a wide variety of theoretical backgrounds accept that sexual orientation and sexual expression relate to the interaction of many factors – inborn, psychological, social, cultural and situational.

I am concerned in this paper with psychological and social factors. Obviously there is a constant interaction between what is 'psychological' and what is 'social', never more clearly demonstrated than in the family environment and its impact on the individuals within it.

My contribution to this symposium is to suggest that psychosocial factors are important in the background to, and expression of, homosexuality and to the treatment of problems arising in relation to it.

I restrict myself to male homosexuality. The research literature on lesbianism is scattered, patchy in quality and difficult to synthesise. Also, like many male clinicians working with psychosexual problems – partly, perhaps, because we *are* male – my psychotherapeutic experience with female homosexuals has been meagre.

Homosexuality or homosexualities

The more reading, thinking and psychotherapy one does with homosexuals the more one realises that the general label 'homosexual' is as non-discriminatory as the label 'heterosexual'. Just as there are many, perhaps an infinite number of, ways of expressing heterosexuality so there are a very large number of ways of expressing homosexuality. In this sense the term should be in the plural.

This plural expresses itself in several ways. In the first instance there is a differentiation between 'obligatory' homosexuality which Kinsey says has a prevalence in the USA of 4 per cent and in which the person concerned is homosexual from childhood and expresses his sexuality in no other way, compared with

elective, 'facultative' or situational homosexuality with a prevalence of 37 per cent. Thus over one third of the male population has some homosexual experience in adulthood.

Another way of classifying homosexuality is to express sexual orientation in terms of a spectrum or scale as Kinsey and his collaborators do. Their 7-point scale has homosexuality and heterosexuality at the two extremes and, at the central point, bisexuality in which the sexual expression is equally homosexual and heterosexual. In between these nodal points are persons who are either more hetero- than homo- or more homo- than heterosexual.

The question arises whether homosexuality forms a perversion of the normal sexual instinct, as psychoanalysts still hold¹ because a psychoanalyst's essential criterion for normality is that a person should form a mature relationship with someone of the opposite sex including having children. Opposed to this is the view of the homophile organisations, forcefully argued by Tripp² that homosexuality is a normal sexual variant. A mid-way position, followed by many who find homosexuality difficult to regard either as a perversion or as a normal sexual variant, is that of sociologists who use the term sexual deviance.

There are, however, many forms of sexual deviance. What seems of fundamental importance to the present writer³ is that, compared with other expressions of sexual deviance, homosexuality is unique in that a relationship is not only formed with a whole person as compared say, to part of a person (*eg* a foot fetish); but also that homosexuality between consenting adults involves an appropriate person, whereas other sexual deviances may involve an inappropriate person (*eg* a child as in paedophilia or a dead body).

We are dealing therefore with homosexualities rather than with homosexuality. It is also relevant to remind the reader that if sexual orientation towards one's own sex is difficult to understand so is the fact that the majority of persons tend to develop a sexual orientation towards the opposite sex. Bancroft⁴ underlines a further paradox: why is masturbation not sufficient to reduce the sexual drive? Why is a sexual partner needed at all?

A consideration of the major research literature on male homosexuality seems to me to suggest that, while the importance of inborn factors remains to be established, especially prenatal hormonal effects, during 'sensitive' periods of development of the nervous sys-

tem, it is the complicated learning history of the sexual drive within a social-cultural milieu, that guides the minority of persons towards a homosexual orientation. It also seems likely, in terms of clinical practice and published research, that the more important psychosocial factors are those happening in early life especially early family life.

Given the establishment of a homosexual orientation, social-cultural factors are highly relevant too as to how the individual homosexual expresses his sexuality. Social factors also are of significance therapeutically because therapeutic systems and the therapists who practice them live in the same social system and are subject to the same social pressures as their clients.

Psychological aspects of homosexuality

This is a confused and confusing area with dogmatic statement and equally dogmatic counter-assertions – a situation all too frequent in psychiatry because of the paucity of reliably established facts. There are two **important broad areas**: First, are homosexuals more psychologically disturbed than appropriately matched comparison groups? Secondly, as regards causation, can significant family constellations of attitudes and emotions be regarded as contributory?

HOMOSEXUALITY AND PSYCHIATRIC MORBIDITY

Psychiatrists have tended to regard homosexuality as abnormal and to make homosexuality a diagnosis. In the USA the American Psychiatric Association officially removed the designation of homosexuality as a mental disorder in 1974.⁵

The suggestion that there is no demonstrable psychological disorder in homosexuals is supported by two studies. Hooker (quoted by Kolodny *et al*⁶) showed that when psychological tests of a projective type were given to 30 homosexuals and 30 matched heterosexuals, no valid differentiation, including sexual orientation, could be established by an expert outside assessor shown the test results 'blind'. O'Connor⁷ made a systematic clinical comparison of 50 homosexuals with 50 neurotics seen in RAF psychiatric practice. The two groups were indistinguishable as regards neurotic traits in childhood and family history of neurosis; homosexuality *as such* was the only factor that differentiated the groups.

In contrast Saghir *et al*⁶ systematically compared 89 male homosexuals contacted through homophile organisations with 35 unmarried men. Although the differences were only slight they were in the direction of an increase in difficulties among the homosexual group. These included a slightly greater prevalence of manifest psychopathology and difficulty in coping with it, especially affective disorder. A higher proportion had experience of psychotherapy; had more – although not statistically significantly more – trouble with excessive drinking; a greater proportion had attempted suicide; there were more college dropouts.

So far as psychological adjustment is concerned,

therefore, there is probably little to differentiate male homosexuals from appropriately matched controls, a conclusion also reached after a critical review of the research literature by Hart *et al*.⁸ However, where there are suggestive minor differences, these are in the direction of greater disturbance among the homosexuals.

FAMILY CONSTELLATIONS

Accepting that male homosexuals are not significantly psychologically disturbed, it is still important, in terms of the emphasis placed on family factors by psychoanalytically orientated psychiatrists, to consider the evidence.

Bieber's research⁹ is seminal in this area. Questionnaires were completed by psychoanalysts for 106 male homosexuals and their responses compared with those of 100 heterosexual male patients. A family constellation of the homosexuals was described where the mother is close-binding intimate (CBI), seductive, inhibiting and over-controlling. Fathers of homosexuals also tended to be detached, hostile, minimising and openly rejecting towards the potentially homosexual son. The combination of a close-binding, intimate and dominant mother and a hostile detached father is especially important for the development of homosexuality. Bieber and others particularly note the father's influence for good or ill.

In a follow-up report Bieber and Bieber¹⁰ note that by this time they have seen over 1000 male homosexuals in psychoanalytically focused psychiatric interviews and 100 pairs of parents. The socio-economic stratum was lower than in their original sample and there were three ethnic groups; white, black, Puerto Rican. The previously noted family psychological constellation was confirmed and the negative relation with the father particularly emphasised: 'we have never interviewed a male homosexual whose father openly loved and respected him'. Bene¹¹ used a projective test, the Family Relations Test, from which was derived a quantitative score for early family relationships. Eighty-three male homosexuals were compared to 84 married men. A negative, hostile and affectionless, relation of the homosexual with the father was noted but there was also a hostile relationship of the homosexuals to the mother – an unusual finding. O'Connor⁷ in the study previously referred to found statistically significant differences between his homosexuals and his neurotic patients on several aspects of family interpersonal relationships. The homosexuals were more attached to mother than to father than the neurotics; more frequently had a poor relationship with their father; and the father was away from home for a long period during childhood and adolescence more for the homosexual group than the neurotics.

On balance, therefore, the family psychological constellation seems relevant to the development of male homosexuality. More detailed investigation is needed of parental relationships and major interest attaches to the supposedly poor relationship with the father.

The expression of homosexuality

The expression of a man's homosexuality is peculiarly related to factors in the social environment; from secretive, tortured, sensitive professional men terrified that being found out will lead to personal ruin, to the raucous, aggressive, exhibitionism of those with a compulsive need to demonstrate their 'liberation'.

Within one sub-culture, and I speak about London which I know well, the form of homosexual expression is related not only to societal forces as they are at the moment but also as they have changed over the last 20 years. In the early 1960s a young homosexual might express the fear that 'I might be homosexual'; now his problem is more likely to be that he would like to 'come out' in the gay world but is afraid to do so. Adult homosexuals, from young to late middle age, vary in their sexual and coupling arrangements from the extremely promiscuous inadvertently involved in the current spread of sexually transmitted diseases (Judson *et al*¹²) to those living in a stable relationship with one partner.

It is not possible usefully to generalise about homosexual expression except to underline its extreme variability. No one therapist sees persons from the whole spectrum of homosexuality. One's view is inevitably through the eyes of one's clients who, by definition, have a problem either with their homosexual orientation *as such* or, more likely, with the limitation that, even in our apparently liberated society, deviant sexual expression has on personal, social or occupational choice.

The social context of therapy

Therapy for homosexuality is as deeply embedded in our culture as is the behaviour it is designed to help. Outside formal psychoanalysis¹ the idea of 'cure' in the sense of changing homosexual orientation is unfashionable, frowned upon by gay organisations, as within the province of despised 'change therapists'.² Any attempt even to discuss these problems in public arouses intense feelings of hostility and meetings may be disrupted.

On the other hand most eclectic therapists, whether psychodynamic or behavioural in orientation, see their task as helping homosexual clients with problems arising directly or indirectly from their homosexuality using any therapeutic method likely to be appropriate. Bancroft¹³ expresses this as 'a behaviourist's view'; but few non-behaviourists would quarrel with the thesis presented in his well argued paper. Marteau, a priest and psychotherapist, in a discussion of the present writer's paper,³ movingly discusses the additional therapeutic problems presented by homosexuals with a religious background and an overlay of religious guilt. He points out that the 'gay' scene is not always gay; some homosexuals feel deprived of family or of being accepted in their society or subculture.

With therapists varying in their attitudes and approach to homosexuality from a perversion to be cured as in psychoanalysis, to behaviour to be changed

as by a strict behaviourist, to the eclectic therapist's attempt to help with problems as defined by the clients themselves, therapist and patient should be matched in values and attitudes. Unfortunately this is not something that is usually possible in the current structure of our psychiatric and psychological services.

Conclusions

Insofar therefore as there is any answer to the title of this Symposium 'Homosexuality – congenital or acquired?' it seems likely that part of homosexual behaviour may ultimately be shown to be inborn. Acquired factors are, however, likely to remain more salient, especially intrafamily factors. The role of the father may be particularly important in the development of male homosexuality. Social and cultural factors are relevant to the actual form of homosexual expression, whether full social acceptance is afforded the homosexual man or whether he is in some way, socially or occupationally, stigmatised. Psychotherapists dealing with homosexual problems live, as much as their clients, within a specific culture which conditions their own attitudes to homosexuality and to their therapy goals. Because of this, therapist and potential client need to discuss goals and methods before embarking on therapy.

References

- ¹Socarides, C W (1979). The psychoanalytic theory of homosexuality: with special reference to therapy. In Rosen, I (Ed) *Sexual deviation* (2nd edn) pp 243–277.
- ²Tripp, C A (1977). *The homosexual matrix*. London, Quartet Books.
- ³Crown, S (1979). Male homosexuality: perversion, deviation or variant? In: *Sex, hormones & behaviour*. CIBA Foundation Symposium 62, Excerpta Medica.
- ⁴Bancroft, J H J (1970). Homosexuality in the male. *British journal of hospital medicine*, 3, 168–181.
- ⁵Kolodny, R C, Masters, W H and Johnson, V E (1979). *Textbook of sexual medicine*, Chapter 17. Homosexuality. Boston. Little, Brown & Company.
- ⁶Saghir, M T, Robins, E, Walbran, B and Gentry, K A (1970). Homosexuality III. Psychiatric disorders and disability in the male homosexual. *American journal of psychiatry*, 126, 1079–1086.
- ⁷O'Connor, P J (1964). Aetiological factors in homosexuality as seen in Royal Air Force psychiatric practice. *British journal of psychiatry*, 110, 381–391.
- ⁸Hart, M, Roback, H, Tittler, B, Weitz, L, Walston, B and McKee, E (1978). Psychological adjustment of nonpatient homosexuals: critical review of the research literature. *Journal of clinical psychiatry*, 39, 27–31.
- ⁹Bieber, I (1962). *Homosexuality. A psychoanalytic study*. Basic Books. New York.
- ¹⁰Bieber, I and Bieber, T B (1979). Male homosexuality. *Canadian journal of psychiatry*, 24, 409–419.
- ¹¹Bene, E (1965). On the genesis of male homosexuality: an attempt at clarifying the role of parents. *British journal of psychiatry*, 111, 803–813.
- ¹²Judson, F N, Miller, K G and Schaffnit, T R (1977). Screening for gonorrhoea and syphilis in the gay baths: Denver, Colorado. *American journal of public health*, 67, 740–742.
- ¹³Bancroft, J (1975). Homosexuality and the medical profession: a behaviourist's view. *Journal of medical ethics*, 1, 176–180.