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Homosexuality: The Ethical Challenge

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It is suggested that behavior therapists have not attended sufficiently to the factors influencing the desire of some homosexuals to change their sexual orientation. Therapists of all persuasions constantly make decisions for their voluntary clients, encompassing both the goals of therapy and the means to be used to achieve those goals. A perusal of the psychotherapy and behavior therapy literature indicates that therapists generally regard homosexuality as undesirable, if not pathological. Since professionals are unlikely to work on treatment procedures unless they see a problem, it is probable that the very existence of change-of-orientation programs strengthens societal prejudices against homosexuality and contributes to the self-hate and embarrassment that are determinants of the "voluntary" desire by some homosexuals to become heterosexual. It is therefore proposed that we stop offering therapy to help homosexuals change and concentrate instead on improving the quality of their interpersonal relationships. Alternatively, more energy could be devoted to sexual enhancement procedures in general, regardless of the adult gender mix.

Behavior therapy is nothing if it does not represent a profound commitment to dispassionate inquiry. The best of the literature, and there is much of it, illustrates a sober appraisal of other approaches to behavior change as well as candid appraisals of what behaviorists themselves have accomplished (e.g., Bandura, 1969; Davison & Neale, 1974; Franks & Wilson, 1973; Lazarus, 1971). I want to voice some concerns I have been wrestling with for over 4 years. My suggestions may he bothersome to many, as indeed they have been causing me distress over the past few years. I hope at least that they occasion some self-examination. While we often help our clients to be less self-conscious, I believe such a goal is inappropriate for the professional healer.

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I believe it would be a mistake to regard the objections raised about institutional programs (Davison & Stuart, 1975) as the only threats to the ethical foundations of behavior therapy. T suggest that more serious objections can be raised about many other things we have been doing over the past couple of decades. A few of these objections are at least as problematic as those raised by our colleagues in the American Civil Liberties Union and perhaps even more so because they exist, at least in part, in settings that we have tended to view as voluntary. Even though behaviorists are metatheoretically committed to determinism, I believe that most of us fall into the habit of distinguishing between situations in which people are forced to change their behavior and situations in which people make free or voluntary decisions to change. It seems to me that if we are to take the basic deterministic dictum of science seriously, however, we must come to grips with the conditions surrounding even those decisions in therapy that have hitherto been termed voluntary or free.

As illustrative of this point, I could have chosen to focus on any number of problems. For example, I believe it would be useful to discuss the ethical issues surrounding the choice of target for any of the various anxiety-reduction procedures that are used by

behavior therapists. This would be instructive since I doubt that most of us have given sufficient thought to the biases we exercise in deciding what kind of anxiety is appropriate for a procedure such as systematic desensitization. For example, should we reduce test anxiety, or should we perhaps address ourselves to the problematic educational system that can contribute to the kind of test anxiety we desensitize? And what therapy goals do we favor when consulted by a married woman who is upset by having to entertain her husband's business associates whom she cannot bear? Why do we engage in assertion training for people who are taken advantage of by an unfeeling society rather than attempt to persuade the offenders that their sometimes unkind actions cause others grief?

These and other questions would, I believe, make for worthwhile discussion. What I would like to discuss in detail here are some of the ethical issues surrounding the way behavior therapists, and for that matter most therapists, have been approaching homosexuality. It is my thesis that we have been remiss in appreciating as we should the ethical and societal implications of what we have been doing over the past years in dealing with people who come to us and announce "freely" that they wish to change.

The Myth of Therapeutic Neutrality

The basic premise is, to paraphrase Halleck (1971), that therapists never make ethically or politically neutral decisions.

> Any type of psychiatric intervention, even when treating a voluntary patient, will have an impact upon the distribution of power within the various social systems in which the patient moves. The radical therapists are absolutely right when they insist that psychiatric neutrality is a myth (Halleck, 1971, p. 13).

The very naturalness of what most of us agree to do with particular kinds of cases tends to blind us to the prejudices and biases that we exercise. Surely we believe that no ethical issues are worth discussing when we help the severely disturbed child to stop banging his head against the wall; and quite frankly, I find it compelling that we should do our best to decrease such behavior. But these are extreme cases, and I suggest that most of what we deal with falls into that important gray area in which our biases play a role in what we do. This seems to be particularly the case in our approach to those people who relate to us that they are troubled by their homosexual behavior or feelings. I believe that any comprehensive perusal of the clinical and experimental literature in behavior therapy (and in other therapies as well) will confirm the assertion that therapists by and large regard homosexual behavior and attitudes to be undesirable, sometimes pathological, and at any rate in need of change toward a heterosexual orientation. And I do not take special issue with aversion therapy since T suggest that the more positive therapies of homosexuality are similarly to be questioned on ethical grounds.

Some Relevant and Irrelevant Issues Surrounding Homosexuality

Allow me to mention briefly some exclusions that I hope will be obvious. I am not talking about homosexual behavior that is part of a psychotic pattern of existence. For example, the male who has the delusion that he is Marie Antoinette out to bed down with every available 20th century man would be exhibiting a pattern of sexual behavior that is best viewed as part of an unfortunate psychotic aberration. I would similarly not want to conclude that heterosexuality is sick because there are psychotics who chase female nurses and try to fornicate with them in hospital clay rooms.

There is something else implicit in what I will be saying, so let me make it explicit at this juncture. Though I will often he referring to "homosexuals," I am really in agreement with investigators such as Kinsey, Pomeroy, and Martin (194S) and Churchill (1967), who urge that we construe sexual preference as a continuum on which people can be placed according to the relative frequencies of their homosexual heterosexual ideation, affect, and behavior. Clearly the available survey data strongly indicate that a significant number of human beings lie between the extremes of exclusive homosexuality and exclusive heterosexuality.

In any discussion of homosexuals in therapy, the question of the normality of homo-

sexual preference has often been raised. Many of you arc no doubt familiar with the failure to find differences in "mental health" between heterosexuals and homosexuals (cf. Evans, 1970; Gagnon & Simon, 1973; Green, 1972). However, some point to Bieber et al.'s (1962) data and to a conceptual replication by Evans (1969) as evidence supporting a pathology view of homosexuality. Does the finding that male homosexuals have similar child-rearing experiences different from male heterosexuals demonstrate pathology? My answer is no. One cannot attach a pathogenic label to a pattern of child rearing unless one a priori labels the adult behavior pattern as pathological. For example, Bieber et al. found that what they called a "close-binding intimate mother" was present much more often in the life histories of the analytic male homosexual patients than among the heterosexual controls. My question is simple. What is wrong with such a mother unless you happen to find her in the background of people whose current behavior you judge beforehand to be pathological? Or, as Begelman (1975) has recently put it:

> Studies finding differences between heterosexuals and homosexuals in developmental or familial patterns . . . or hormonal patterns . . . do not attest to the *pathogenic* determination *of* homosexuality but simply to a difference between experimental populations. The concept *of* `pathology' is strictly applicable only to the causal determinants of behaviors already socially evaluated as "undesirable." (p. 183)

Moreover, even if one were to discover emotional disorders among homosexuals, I would agree with many that such problems are due to the extreme duress under which these people have to live in a society that tells them they are "queer" and that actively oppresses them.

Maybe this can be made personally more meaningful by the following fantasy.

> Imagine for a moment that you are an anxious person and that being anxious is against the *law*. You must try to hide your fears from others. Your own home may he a safe place to feel anxious, but a public display of apprehension can lead to arrest or at least to social ostracism. At work one day an associate looks at you suspiciously and says, "That's funny, for a crazy moment there I thought you were anxious." "Heck no," you exclaim a bit too loudly, *"not me! " You* begin to wonder if your fellow worker will report his suspicions to your boss. If he does, your boss may inform the police or will at least change your job to one that requires less contact with customers, especially with those who have children. (Davison & Neale, 1974, p. 293)

There is another issue that is worth discussing. Many people point to brutality in homosexual relationships, prompting them to ask how one can say that such human relationships are normal. To such objections I would reply that homosexuals who engage in destructive activities and who suffer in poor relationships, certainly do not have a monopoly on difficult interpersonal functioning. Simply because there is so much marital discord in this country, one seldom hears people concluding that heterosexuality is inherently bad. What I am suggesting is that as behavior therapists and clinicians, we might perhaps pay more attention to the *quality* of human relationships, to the way people deal with each other rather than to the particular gender of the adult partners. If one follows this further, we might consider a shift in focus in therapy with homosexuals that pays little attention to the fact that the partners are the same sex and more attention to the kind of relationship a person might be in and how that relationship might be improved. Naturally when one orients his therapeutic efforts in this direction, I believe one inevitably ends up having to deal with the tremendous legal and social oppression of these groups of people.

No Cure Without a Disease

I believe that clinicians spend time developing and analyzing procedures only if they *are* concerned about a problem. It seems very much the case with homosexuality. And yet, consider our rhetoric that typically speaks of social labeling of behavior rather than viewing a given behavior as intrinsically normal or abnormal. Consider also the huge literature on helping homosexuals (at least males) change their sexual preference and the paucity of literature aimed at helping the labelers change their prejudicial biases and encouraging the homosexual to develop as a person without going the change route. How can we honestly speak of nonprejudice when we participate in therapy regimens that by their very existence—and regardless of their effi-

cacy— condone the current societal prejudice and perhaps also impede social change?

This point has been enunciated independently by Begelman (1975) as follows:

> [The efforts of behavior therapists to reorient homosexuals to heterosexuality] *by their very existence* constitute *a significant causal element in reinforcing the social doctrine that homosexuality is* ***bad.*** Indeed, the point of the activist protest is that behavior therapists contribute significantly to preventing the exercise of any *real* option in decision-making about sexual identity, by further strengthening the prejudice that homosexuality is a "problem behavior," since treatment may he offered for it. As a consequence of this therapeutic stance, as well as a wider system *of* social and attitudinal pressures, homosexuals tend to seek treatment *for being homosexuals.* Heterosexuals, on the other hand, can scarcely be expected to seek voluntary treatment for being "heterosexual," especially since all the social forces arrayed—including the unavailability of behavior therapy for heterosexuality—attest to the acknowledgement *of* the idea that whatever "problems" heterosexuals experience are not due to their sexual orientation. The upshot of this is that contrary to the disclaimer that behavioral therapy is "not a system of ethics" (Bandura, *1969, p. 87),* the very act *of* providing therapeutic services for homosexual "problems" indicates otherwise. (p. *180)*

I further suggest that the availability of a technique encourages its use. For example, many behavior therapists who have good clinical success with systematic desensitization and who are also persuaded by the experimental literature that it is useful for reducing anxiety try to conceptualize client problems in terms of this technique. Thus, reactive depression might be viewed as a consequence of unnecessary sensitivities that, themselves, could be translated into an anxiety hierarchy. By the same token I wonder whether the extensive clinical and experimental work in aversion therapy (e.g., Feldman & MacCulloch, 1971) or "Playboy therapy" (e.g., Davison, 1968), or heterosocial-heterosexual skills training do not channel the assessment and problem-solving activities of behavioral clinicians into working to change sexual orientation and *to* persuade homosexual clients that this is a worthwhile goal—Why else would we be spending so much time working on the techniques?

A *Proposal on Therapy with Homosexuals*

Consistent with much of the thoughtful gay literature, particularly the work of Charles Silverstein and his colleagues at the Institute for Human Identity in New York City, I suggest that we stop engaging in voluntary therapy programs aimed at altering the choice of adult partners to whom our clients are attracted. I am referring not only to aversion therapy but to more positive approaches as well, including the orgasmic reorientation that I played some role in popularizing. As Silverstein (Note 1) put it at the Association for Advancement of Behavior Therapy convention 2 years ago in a discussion of male homosexuality:

> To suggest that a person comes voluntarily to change his sexual orientation is to ignore the powerful environmental stress, oppression *if* you will, that has been telling him for years that he should change. To grow up in a family where the word "homosexual" was whispered, to play in a playground and hear the words "faggot" and "queer," to go to church and hear of "sin" and then to college and hear of "illness," and finally to the counseling center that promises to "cure," is hardly to create an environment of freedom and voluntary choice. The homosexual is expected to want to be changed and his application for treatment is implicitly praised as the first step toward "normal" behavior.
>
> What brings them into the counseling center [Silverstein continues) is guilt, shame, and the loneliness that *comes* from their secret. *If* you really wish to help them freely choose, I suggest you first desensitize them to their guilt. Allow them to dissolve the shame about their desires and actions and to feel comfortable with their sexuality. After that, let them choose, but not before. I don't know any more than you what would happen, but I think their choice would be more voluntary and free than it is at present. (p. *4).*

In other words, Silverstein suggests that we must go back in the causal chain and ask ourselves as determinists, what are the determinants of the client asserting to you that he or she wants to change. Silverstein proposes that these determinants may be based on prejudice and ignorance and therefore *should not* be catered to or even strengthened by an establishment of therapists who offer their services to those clients who "express the wish to change."

But what would be the consequences of this? Does this not limit the choices available to the person troubled by his sexual orientation? Who is the behavior therapist or psychotherapist to decide for potential clients which options should be available in therapy? To

my mind the most frank answer has been elaborated thoughtfully by Halleck (1971), namely that we already have made these decisions, perhaps not fully aware of their larger implications. By working so diligently on change techniques, particularly but not exclusively aversive procedures, I would ask whether we have not been saying that the prejudices and laws against certain sexual acts are in fact well founded. What are we really saying to our clients when, on the one hand, we assure them that they are not abnormal and on the other hand, present them with an array of techniques, some of them painful, which are aimed at eliminating that set of feelings and behavior that we have just told them is okay? What is the real range of "free choice" available to homosexually oriented people who are racked with guilt, self-hate, and embarrassment, and who must endure the burden of societal prejudice and discrimination? What of the anxieties arising from this discrimination—how have we helped them with *these* problems?

London (1969) has suggested that an unappreciated danger in behavior control technology is the increasing ability we have to engineer what we have regarded as free will. Thus we seem to be capable of making people want what is available and what we feel they should want. Moreover, just because we can say to ourselves that we are not doing something against the will of our clients does not free us from the responsibility of examining those factors that determine what we call free expression of intent and desire on the part of our clients.

In a related vein—and this should not be surprising to anyone familiar with the psychotherapy research literature Halleck (1971) says:

> At first glance, a model of psychiatric practice based on the contention that people should just be helped to learn to do the things they want to do seems uncomplicated and desirable. But it is an unobtainable model. Unlike a technician, a psychiatrist cannot avoid communicating and at times imposing his own values upon his patients. The patient usually has considerable difficulty in finding the way in which he would wish to change his behavior, but as he talks to the psychiatrist his wants and needs become clearer. In the very process of defining his needs in the presence of a figure who is viewed as wise and authoritarian, the patient is profoundly influenced. He ends up wanting some of the things the psychiatrist thinks he should want. (P. 19).

While Halleck, as a psychiatrist, is addressing himself to a medical audience, his questions are obviously relevant to all the helping professions.

But is it not harsh and unfeeling to propose that we deny a particular client sitting before us the possibility of loosing himself or herself from his or her homosexual attraction and turning him or her on to the other half of the adult population? What about the homosexual client who could conceivably want to switch, not out of societal pressures but out of a sincere desire for those things that in our culture are usually part of the heterosexual package -a spouse and children? Why deny such a person—rare though he or she may be—the opportunity to fulfill such desires? Is not the scheme I am proposing a kind of "coercive liberalism," to use London's phrase? Coercive liberalism goes something like this: T will help you be happier, freer, more fulfilled, etc.—and you will have no choice but to be so according to my standards. By proposing that we terminate our preference-change programs with homosexuals, I am obviously running this risk. One solution would be simply to accept the risk; that, I believe, is consistent with the feelings of Halleck. But another way out of this dilemma is to propose that a concerted program of clinical research be encouraged for the development of maximally effective procedures to help heterosexually oriented people become homosexually oriented if we can somehow determine that they *really want to.* That is, we might consider most seriously the possibility that many heterosexuals may wish to change, or at least *expand* their sexual activities, as some homosexuals may wish to do. Are we prepared to devote ourselves to this kind of sexual enhancement enterprise (cf. Gagnon & Davison, Note 2) ?

If We Can Do Something, Should We?

Let me mention something else in passing. When trying to garner support for my proposal that we should stop trying to change homosexual orientations, I was interested for some time in documenting the failure of vari-

ous behavior change regimens in eliminating homosexual inclinations. Of particular interest was the question of whether aversion therapy of various kinds had proven successful (if you will) in stamping out homosexual behavior and inclinations. And indeed, I tend to believe the evidence is still lacking for a suppression of homosexual behavior or ideation via aversive procedures. Nonetheless, even if one were to demonstrate that a particular sexual preference could be wiped out by a negative learning experience, there remains the question as to how relevant this kind of data is to the ethical question of whether one *should* engage in such behavior change regimens. In discussing this possibility with some students and colleagues, I am convinced that data on efficacy are quite irrelevant. Even if we *could* effect certain changes, there is still the more important question of whether we *should.* I believe we should not.

There are many human problems that would seem amenable to the mode of scientific analysis that is the essence of behavior therapy. We do not demean the human being by our concepts and methodologies. Indeed, the benefits already realized justify considerable optimism that increased knowledge of how we behave will enable people to increase their alternatives and truly fulfill their potential. I hope we continue to devote the necessary energy to the important challenges.

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