Queerly Ill

The Rise and Fall of the Illness of Homosexuality

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Abstract

This article traces the development of the illness of homosexuality from its legal origins through its political demise within a framework of social control exerted by the medical profession. The rise of an authoritative medical profession and the stigmatizing effects of its positivist ideology are examined in the context of Goffman's theory of stigmatization, and the development of positive homosexual identity from within a negative illness model is explained using David Matza's naturalist theory of deviance. Recent developments suggesting remedicalization of homosexuality by the gay community are explored.

> *The mental processes of the man with whom one disagrees are always wrong. Where is the line between wrong mind and insane mind?*
>
> Jack London in Elrich and Abraham-Magdamo (1978): 64

The history of homosexuality—particularly that of sanctions against homosexuality—is a curious one from the point of view of the theory of social problems and social control. For thousands of years, same-sex sexual behaviour has been considered, in one way or another, to be unacceptable; the historical universality of the homosexuality taboo has been compared to that against clan incest in staying power and mythology (Plummer (1981)). Yet for all this, the actual enforcement of the norm has seen tremendous variation, as new institutions of social control gain authority and power at the expense of that of their predecessor.

In particular, homosexuality has, for a little more than a century, found itself in the domain of the medical profession; exceptionally, it has toward the second part of the century found itself able to escape, to an extent which will be discussed below, from the control of that domain. This paper examines the genesis of the medical conception of homosexuality,[1] its effect on the identity of those engaging in homosexual behaviour, and the political effects of that identity on freeing homosexuality from institutional control.

The Church and State

Prohibitions against same-sex sexual behaviour have a long and established history in Western society, although the form of those prohibitions has changed over time, especially in the

[1] This paper concerns itself almost entirely with male homosexuality. For reasons documented elsewhere, historical prohibitions against same-sex behavior have been targeted primarily at men. For more on this, see Miller (1995).

last century or so. Institutionalized limits on homosexual behaviour originated, predictably, with the Christian church. While there have been occasional disputes over its proper interpretation, the historical Christian approach to homosexual behaviour finds itself rooted in the Biblical tale of Sodom, in which two (male) angels take residence in the house of Lot, and are called upon by the townspeople:

> But before they lay down, the men of the city, even the men of Sodom, compassed the house round, both old and young, all the people from every quarter: and they called unto Lot, and said unto him, Where are the men which came in to thee this night? Bring them out unto us, that we may know them.
>
> And Lot went out at the door unto them, and shut the door after him, and said, I pray you, brethren, do not so wickedly. Behold now, I have two daughters which have not known man; let me, I pray you, bring them out unto you, and do ye to them as is good in your eyes: only unto these men do nothing; for therefore came they under the shadow of my roof.
>
> (Genesis 19:4–8, KJV)

For their desire to "know" (*i.e.*, to have sexual relations with) the visitors, God destroyed the cities (Genesis 19:24). The religious prohibition of homosexual behaviour found itself codified in law as early as the 16th century, when it was thus incorporated in the ecclesiastic sanctions of 1530 (Weeks (1981)). The rise of the State and corresponding decline of the Church brought on by the transition from feudalism served to an extent to divorce the letter of the law from the moral code upon which it was based (Kutchins and Kirk (1997)); one result of this secularization was that by 1885, the only law in the United Kingdom to deal directly with homosexual acts was that which made buggery a capital crime (Weeks (1981)), but even that made no distinction of gender or even species. While buggery was no longer a capital crime by 1861, the late 1800s would find increased legal

sanctions against homosexual behaviour; the 1885 Labouchere Amendment made all male homosexual activity illegal under the label "Gross Indecency", punishable with two years hard labour (Weeks (1981)).

The legal approach to homosexuality was to send a strong message that homosexual *acts* were not to be tolerated. Homosexual behaviour was considered abominable, and what was originally considered a grave sin was later considered a grave crime (Kutchins and Kirk (1997)). However, there was until this point no corresponding category for the perpetrator himself; a man convicted of committing homosexual acts was an undesirable, a criminal, even a sinner, but nothing more specific than that (Miller (1995)). Homosexual acts were by their nature committed in privacy; while failing to keep a secret probably had reputation effects, it was the commission of the act, and not the character of the offender, with which the courts were concerned, and because of the private nature of the offense prosecution rates tended to remain low (Weeks (1981): 82).

By the turn of the century, that had begun to change. An anti-homosexual crackdown in the mid-1890s found many leading citizens at the heart of scandal, including Oscar Wilde, of whom the London Telegraph of 25 May 1895 (in Weeks (1981)) wrote, "We venture to hope that the conviction of Wilde for these abominable vices, which were the natural outcome of his diseased intellectual condition, will be a salutary warning to the unhealthy boys who posed as sharers of his culture." The paper's use of medical metaphor provides a first glance into the reconceptualization of homosexual behaviour which was beginning to establish itself.

The Medical Institution

With the beginning of the 20th century came a shift in emphasis. The sinner was no longer only the criminal; instead, therapeutic intervention had begun to compete with criminal

punishment, and undesirable behaviour was beginning to be cast in medical, rather than criminal, terms. In order to properly understand the implications of this shift, it is first necessary to jump back slightly in time and examine the origin of the roots of medical ideology. Historically, the Christian church had objected to the physician's practice of charging a fee for his work; healing was a Christian charity, and if laymen were to practice it, they should be doing so without obliging their patients (Turner (1987)). Predictably, this met objections from the physicians. Their work was science, not religion, and they intended to pursue their livelihood. Medicine adapted by developing their own set of professional standards; by maintaining these standards, medicine could become not only an occupation but a *calling*, in the same manner as but distinct from the Church. While it was not clear that the Church agreed to such a distinction, the structural differentiation which occurred between it and other institutions with the Industrial Revolution solidified the division between it and competing institutions, at the same time compartmentalizing categories of Sin, Deviance, and Crime, although not necessarily defining what would fall in which category.

In the 19th century, the medical fraternity was far from a single united body. While licensing of medical practitioners began as early as 1800 in the United States, it had since been repealed due to its elitist nature (Conrad and Schneider (1985)). The field was divided between "regular" practitioners practicing surgery, bleeding and similar invasive practices, and "medical cults" practicing noninvasive techniques such as homeopathy and botanical medicine. In 1847, a group of American regular physicians formed the American Medical Association (AMA) in order to promote what they termed the "science of medicine" which excluded the medical cults (Conrad and Schneider (1985): 10). As with most professional organizations, the intention of the group was to exert control over the profession itself; after an anti-abortion crusade in the middle of the century, the AMA found itself with some authority over the medical cults, who continued to practice now-criminalized abortions. A number of convenient advances followed: the discovery of scientific medicine (based on, but not limited to, germ theory), a general decline in disease mostly attributable to im-

proved living conditions arising from improved sanitation and nutrition, and a perception of vastly variant conditions of medical practice across the United States led to the state granting in 1910 of medical licenses (Conrad and Schneider (1985)). The medical profession, via the AMA, became functionally autonomous, being regulated internally—what Conrad and Schneider (1985)) referred to as a "legally enforced monopoly of practice" which "[had] won the almost exclusive right to reign over the kingdom of health and sickness, no matter where it may extend."

The discipline of psychiatry soon took advantage of the gains of the physicians. The discovery in 1913 of a physiological basis to general paresis, or syphilitic madness, solidified the contested theory of a physical etiology of what was then termed insanity, bringing psychiatry firmly under the umbrella of medicine. In 1921, the Association of Medical Superintendents of American Institutions of the Insane—originally a group of institution managers and caretakers, not doctors—changed its name to the American Psychiatric Association (APA) (Conrad and Schneider (1985)). The APA resembled the AMA in more than name; the group quickly became authoritative on insanity, legitimizing psychiatry by excluding those without formal training. The implications of the formation of such organizations are crucial to understanding the conceptions of homosexuality which were to follow. The establishment of medicine as a "calling" and the medical profession's monopoly of practice combined to create an institution with absolute authority over things medical.

The ideology of the medical profession is primarily one of positivist science. Parsons (1951) described the basis of medical ideology as "the application of scientific knowledge to the resolution of problems of illness and health." The scientific knowledge to which he refers is that of specific etiology. Doctors are trained to see illness as an individual phenomenon; diseases result from physiological, biological, and organic abnormalities inside the body and cures are those techniques which remove or return to normal those abnormalities (Turner (1987): 17, Conrad and Schneider (1985): 35, Parsons (1951): 431). If

sickness brings with it social effects, they are considered secondary, and traditionally not addressed in treating the disease itself; the doctor's job is to neutrally apply the scientific method to physiological problems, and the assumption of neutrality is maintained even when social effects might be present (Parsons (1951)).

Combining the monopoly power of the medical profession with its professional ideology results in an institution with tremendous social and regulatory power. The collegiate nature of the profession gives it absolute authority to define sickness and health. Especially within psychiatry, this provides the means to label certain attributes or behaviours as abnormal. One behaviour which psychiatry labeled abnormal was that of homosexuality.

Birth of the Homosexual

While the psychological origins of homosexuality had been considered since the early 1900s, it was Sigmund Freud (1856–1939) whose theories of stunted emotional growth and parental attachment firmly planted same-sex attraction and sexual behaviour in the domain of psychiatry. Unfortunately, while Freud for the most part refrained from taking a moral stance on homosexual behaviour—often refusing to treat patients who were "only" homosexual but did not suffer from other psychological ailments (Miller (1995))—psychiatrists following Freud quickly determined that an inclination toward members of one's own sex was a sign of sickness which needed to be treated. Sandor Rado (1890–1972) started the ball rolling immediately following Freud with a theory of homosexuality based on an incapacitating fear of the same sex (Miller (1995)); his theories proved influential, and by the 1950s, a psychiatric explanation for homosexual behavior was dogmatic within the profession. The leaders of that school of thought were Irving Bieber (1908–) and Charles Socarides (1922–). Bieber claimed a 25% cure rate among homosexuals he had treated, claiming that "every homosexual is a latent heterosexual" (Miller (1995): 248); Socarides declared that "heterosexual object choice is determined by two and a half billion years of

evolution" and claimed that half of those engaged in homosexual practices were paranoid or schizophrenic, while the other half were merely neurotic. The homosexual was sick; homosexual acts and desire became not just undesirable but a disease, something in need of a cure, the basis of which would have to originate in the afflicted individual (Matza (1969), Scheff (1999)).

These theories of homosexuality—treated by the profession, as are many medical theories, as undeniable fact—had a curious if predictable effect. As homosexuality became an illness, homosexual acts became essentializing. It was no longer what someone *does*, but rather what one *is*. As with most psychiatric conditions, homosexuality became a diagnostic category, a means of separating out (Plummer (1981)), into which fell the Homosexual. By declaring a medical basis for homosexual behaviour, the psychiatric profession created the concept of an individual, with psychological abnormality, suffering from a disease, with specific causes outside of the individual's control. In other words, by committing homosexual acts one exhibited a symptom of a mental illness, and as one thus inflicted, became a homosexual.

There exists an incongruity between the professional and public conceptions of mental disorder: while professionals explain away behaviour by considering it as having resulted from the disorder, the public, while accepting of the *existence* of the disorder, is considerably less willing to ignore behaviour which conflicts with its norms (Conrad and Schneider (1985)). In other words, deviance remains deviance even when given a medical explanation. From the point of view of the psychiatrist, social aspects of sickness are side-effects, and are all but ignored in determining the cause of a psychiatric illness. For the layman, though, in the case of homosexuality, the initial pre-medical taboo lingers. On one hand, the layman knows that the medical profession has stated that homosexuality is a mental illness, and that homosexuals are sick, but at the same time he also knows from his socialization and myths that homosexual acts are sins and crimes and willful behaviour. To those

outside the medical profession, the homosexual is no longer just bad—rather, he is now sick *and* bad. Matters are made worse by the particular sort of badness homosexuality implies: the homosexual, engaging in forbidden acts in secret, becomes not only immoral but subversive, doubly so since the idea of a nonreproductive male is at odds with the family structure upon which the society is built.

Further, "sick" in this case does not imply a medical, morally neutral state. Parsons (1951) details four aspects of what he termed the "sick role": (1) an exemption from normal social responsibility relative to the nature and severity of the illness; (2) an expectation that the sick person cannot be expected to get better by decision or will; (3) definition of the state of sickness as undesirable; (4) an obligation to seek technically-competent help. Homosexuality does not fit well with the sick role; assuming that same-sex sexual relations are engaged in in private for (at least) positive physical sensations, the homosexual implicitly disagrees with the third and fourth aspect of the sick role. As such, his sickness may fail to generate a sympathetic response as would, for instance, a broken leg. Since homosexuality is chronic, the exemption of the first aspect of the sick role is minimal. Lastly, viewed as the layman as the commission of unnatural acts, the second aspect of the sick role also fails to hold; there remains a suspicion that the homosexual could simply *stop*, and in refraining from any sexual behaviour fit into convention as well as someone not thus branded could. The homosexual fails to play the sickness role as expected and is thus disallowed the exemptions usually made for the sick.

All of this combines to create a popular image of the homosexual as inherently and irreparably if imperceptibly *different* (Scheff (1999)). The medical profession provides the basis for the distinction, which the layman believes because of the doctor's position of authority and alleged neutrality. The distinction recalls traditional taboos on same-sex relations as well as stereotypes of mental illness. The homosexual's behaviour suggests a subversive refusal to comply with the expectations following self-diagnosis. While the med-

ical profession creates the *category* of the homosexual, the popular imagination creates the archetype. The homosexual, judged evil but from ascribed characteristics, finds himself as one of a long tradition of diabolic Others in Western history/mythology, like the Vampire, the Gypsy, and the Witch (Young (1995): 11), a deviant near-human with the capacity to bring himself under control but refusing to do so.

Being Homosexual

The fate of the homosexual himself, between the efforts of the medical establishment and the perspective of the layman, at first seems sealed. First, he lives with the threat of treatment from the medical establishment. Treatments for homosexuality varied, but at one time or another included surgical interventions from vasectomy to lobotomy, chemical treatments from hormones to pharmacological shock, electroshock and aversion therapy, and incarceration (Kutchins and Kirk (1997)). As it turns out, homosexuality was relatively easy to conceal from medical authorities. Incarceration was falling out of favour due to budgetary problems and ensuing deinstitutionalization starting in about 1950 (Turner (1987)). Keeping away from treatment meant keeping one's homosexuality a secret—staying 'closeted'. Staying away from doctors was a common approach, but occasionally a visit would be necessary, as Young (1995) notes: "Gay people hid their sexual orientation from their doctors, knowing that if it was discovered, their real illnesses would take second place to the pressing need to 'cure' their affections". Nonetheless, the homosexual undergoing involuntary treatment became the exception, and the violent nature of the treatment kept the rest away from all but psychotherapy. Those that did end up in psychotherapy, claimed psychoanalyst Judd Marmor, had bought the majority line that "... it was bad to be gay, and that if they possibly could, they ought to try to be heterosexual" (Kutchins and Kirk (1997): 63).

The effects of popular opinion were not so easily avoided, and are most easily explained

from the viewpoint of Goffman: the homosexual was constantly forced to conceal his homosexuality from the public and to place himself at risk when revealing himself to other homosexuals or homophiles. The unexposed homosexual was stigmatized. He became *discreditable* (Goffman (1963)); while no-one would have to know about his homosexual status, he would feel transparent in mixed encounters even though his stigma was easy to conceal. Goffman (1963) quotes an unnamed homosexual from 1960:

> [T]he strain of deceiving my family and friends often became intolerable. It was necessary for me to watch every word I spoke, and every gesture that I made, in case I gave myself away. (90)

It was not necessary for anyone to actually censure him; the imagined censure and fear of being 'outed' was enough to exert control over his actions. 'Normal' society labeled those that were like him as 'homosexuals', and since he found himself attracted to, in the company of, and having sex with other homosexuals, he soon began to consider himself a homosexual as well (Gerhardt (1985a)).

The homosexual label differs slightly from the conventional labeling theory in one respect: while it tends to behave as a master status in terms of risk of exposure and dominance over one's life, it does so in an adjectival, rather than a nounal sense (Gerhardt (1985b)); where a banker caught stealing is labeled a thief, a banker caught in a homosexual act is labeled a *homosexual banker*. Unfortunately, Gerhardt only acknowledges that behaviour, without explaining why it might be the case. I suspect that 'banker' plays as much of a role in that example as does 'homosexual'; that is, that high-prestige occupation isn't completely crowded out by the homosexual label, or that retaining the high-prestige occupation in the label serves the purpose of the labelers better through irony or shock.

The nature of the homosexual label was pervasive. It was not immediate; Plummer (1981) observed that a single homosexual encounter was only sufficient for four of thirty

men to consider themselves homosexual. But men attracted to men with the means to have one encounter also had the means to have more, and these repeated encounters would more and more encourage the as yet unlabeled neophyte to consider himself a homosexual. Matza (1969) following Becker separates affinity from affiliation in the factors which lead to the adoption of a role; as the neophyte meets more self-identified homosexuals (affinity) and engages in homosexual practices with them (affiliation) he mediates the process of becoming, the whole time feeling as though he was, or could at any moment be, under the eye of the authority supplying the label. Engaging apparently willingly in a forbidden act and finding himself at constant risk of being discovered and branded homosexual, he begins to adopt the label for himself, making it easier to repeat the behaviour. Knowing that it is prohibited, he finds himself attempting to stay safe by avoiding situations in which it is necessary to work at concealing his invisible secret, favouring instead the company of others similarly identified. He is, in Becker's terminology, "turned on" (in Matza (1969)).

Forming a Community

Having been signified as a homosexual and then self-identifying as same, the homosexual could be expected to organize his life to minimize opportunity for being "outed"—*i.e.*, discredited by having his deviant identity revealed to those from whom he had kept it secret—while at the same time attempting to maintain the associations and activities by which he found himself becoming a homosexual, and by which he may satisfy his sexual needs.

Goffman observed the tendency for stigmatized individuals to form local and wider networks of those "acquainted or acquainted-once-removed" who share the stigma (Goffman (1963)). For homosexuals, the advantages of such a network were many. Amongst other homosexuals and the occasional homosexual-friendly heterosexuals, it would not be necessary to engage in impression-management techniques to prevent being discredited; since the norm would be homosexuality, finding sexual partners did not involve risk of further

stigmatization; and the simple awareness of others in the same situation would reduce the anxiety of being fundamentally different from the heterosexual majority. At the same time, it was unnecessary to completely abandon the mainstream; as mentioned previously, homosexuality was private enough that avoiding discrediting was possible. The homosexual led something of a double life: able to maintain a normal role in the public sphere, he could keep a job and use public resources, while assuming a homosexual role in his private life.

As more and more homosexuals found themselves in this situation, the ad-hoc means by which they would associate started to institutionalize; what started as convenient associations with others known to be homosexual turned into what Plummer (1981) refers to as a "life-sustaining 'hero system' around which [they] could organize their lives". With little need to spend time with 'straights' in their private lives, a community developed in which "members of one's own sex are defined as the most desirable sexual objects, and sociability is energetically organized around the pursuit and entertainment of these objects" (Goffman (1963): 143). Nearly fully immersed in their homosexuality, the community established a culture of outrageousness and camp which at every bend found itself distancing itself further and further from the mainstream. The nascent homosexual culture rested in part upon the immasculine homosexual stereotype conferred by the mainstream and the homosexual community's simultaneous acceptance and rejection of the stereotype, as well as a seemingly universal appreciation for irony which led to a system of feedback in which developments of homosexual culture would once established be taken to an extreme through self-parody, only to be established and parodied in their new form.. As the foundations of the homosexual community stabilized, means to establish a solid subcultural identity became explicit. On one cornerstone of the subculture, admiration of Hollywood 'divas', an unnamed man notes, "It was as if the fact that we had gathered to see [Judy Garland in concert] gave us permission to be gay in public for once" (Harris (1997): 17). Magazines, fiction and film catering to the community began to appear, and by the midpoint of the century it would be common knowledge which nightclubs in major North American cities

catered to a homosexual clientèle.

Getting Political

The establishment and institutionalization of a homosexual community and subculture created a contradictory situation. On one hand, for members of the community, its existence and its shared values and culture served to solidify homosexual identity, create a certain amount of solidarity among homosexuals, and remove some of the stigmatization of being a homosexual. For the mainstream public, however, it was more evidence that there was something inherently different about homosexuals, and the fear that, despite what the medical profession told them, that there was something politically subversive about homosexuality (Miller (1995)). To an extent they were correct—with the solidarity and increasing numbers, the homosexual community for the first time began to realize that homosexuality didn't *have* to be unacceptable.

The homosexual community found its first opportunity to organize after the 1948 release of Alfred Kinsey's (1854–1956) *Sexual Behavior in the Human Male*, popularly referred to as the Kinsey Report. Kinsey's findings on homosexual behaviour were startling. Over a third of men had had a homosexual experience to orgasm since adolescence; nearly a tenth were exclusively homosexual for more than three years, and four percent were exclusively homosexual for life (in Miller (1995): 249–251). Kinsey had shown to be invalid the 'species' hypothesis of homosexuality; it would be near impossible from here to scientifically claim that homosexuals were subhuman when homosexual behaviour was "neither deviant nor exceptional" (in Miller (1995): 252). In light of such an influential and popular study—the report spent weeks on the New York Times bestseller list—parts of the homosexual community began to organize.

The first major homosexual political organization following Kinsey was the Mattachine Society, whose purpose according to founder Harry Hay was to "rock the boat of American

conformity" (Young (1995): 49) and legitimize homosexuality through decriminalization. There was little discussion of whether homosexuality should be considered deviance, only that it was not worthy of legal sanctions (Kutchins and Kirk (1997)). That the Mattachine never once drew attention to the medical status of homosexuality says something of the extent to which medical ideology stands as fact; despite active work in the field—both Bieber and Socarides were active at this time, and German physicians were working to establish which part of the hypothalamus needed to be removed to get rid of the 'female part' of the brain (Kutchins and Kirk (1997))— the Mattachine's stance was that of requesting permission to engage in homosexual activity, and not for legitimation.

Unfortunately, there was more than one way to read Kinsey's figures. In 1954, Senator Joseph McCarthy began his campaign to rid the United States of what he called "the Communist menace". McCarthy equated that which his committees found subversive with Communists, and used the numbers from the Kinsey report to support his claim that homosexuals were also a subversive group of which America should free itself; in the words of Kenneth Wherry, a McCarthy subordinate, "You can hardly separate the homosexuals from the subversives" (in Miller (1995): 261). McCarthyism and the Communist panic conflated sexual heresies and political ones; the Mattachine and similar groups which had appeared quickly moved back underground. What was left of homosexual politics was a quiet, conservative, and anti-Communist movement which, where the Mattachine asserted rights, meekly acknowledged its own existence (Kutchins 1997: 60).

With the fall of McCarthy's crusade in the mid-1950s, the homosexual community found itself without the momentum that the building of its institutions had conferred on the early activists. McCarthy had reaffirmed the inherent differentness of the homosexual, adding anti-Americanism to the mythology on which claims of differentness rested. While the 1960s found a generation concerned with social change, homosexuality was seldom included; however, the civil-rights protests of the 1960s did, in all probability, provide an

example for what was to become the coming-of-age of American homosexuality. It was common in the big cities for bars and clubs catering to homosexuals to have made an arrangement with the police, often via organized-crime syndicates, to be able to operate (Miller (1995)). Despite this—or possibly because of it—police would occasionally stage raids on these establishments, in which the proprietor would be charged with some alcohol-related offense such as serving without a license, the clientèle would be ushered into the street and dispersed, and the bar would open days later, after the proper payoffs had been made.

When the police raided the Stonewall Inn in New York's Greenwich Village on June 17, 1969, however, the usual scenario didn't play out. For reasons mostly unknown (although Young (1995) notes that the then-recent death of Judy Garland has been alleged to have been an aggravating factor) the patrons of the Stonewall Inn decided not to submissively file out of the bar. Once out in the street, they began throwing rocks, shoes, and cans at police; in a short while, a full-fledged riot was underway. By the climax of the evening, the police had barricaded themselves in the bar awaiting reinforcements and the homosexual community had found itself a new militant voice and a new label—'gay' (Miller (1995)). Demonstrations and protests occurred for the next few nights outside the Stonewall Inn, and otherwise-inactive gay activists began to organize and mobilize. The Stonewall Riots, as gay cultural history labeled the night, effected no social change in themselves, but reminded the gay community that they had numbers, and that they had voice. But there was no target; gay liberation had begun, but no-one was sure who was holding the chains in the first place.

Fighting the APA

Before examining the efforts of gay activists, we need a framework by which their efforts can be analyzed. Spector and Kitsuse (1977) suggest a framework for the study of social problems in which the sociologist identifies and analyzes the *claimsmaking behavior*; that

is, that social problems are " the activities of individuals or groups making assertions of grievances and claims with respect to some putative conditions" (75). In such an analysis, the nature and genesis of a social problem is determined by "identify[ing] the causes and antecedents of the *definition* of the social problem" (41); that is, by examining what is being claimed, who is making the claims, who the claims are being made against, and the interests and values driving the claim. As it turns out, the efforts of the new gay liberation movement lend themselves to this sort of analysis.

The work of psychiatrists on homosexuality—in particular, that of Socarides—was not unknown to activists; there had been a protest in 1968 of a talk he gave to the AMA at their annual convention, by a pre-Stonewall "homophile" group demanding bias-free research into homosexuality (Kutchins and Kirk (1997)). With their new voice, gay activists decided to take on the APA at their own convention; their goal was the removal of homosexuality from the Diagnostic and Statistical Manual (DSM), the diagnostic bible of psychiatry and psychology. Organized protests first arose at the 1970 APA convention, which was disrupted repeatedly by confrontational gay protesters threatening violence (Kutchins and Kirk (1997)). While the protesters certainly caught the attention of the psychiatrists attending, their demands went unheeded; when they took the microphone at a meeting demanding to be heard, many of the attending psychiatrists were enraged, and one asked the police to shoot the protesters (Kutchins and Kirk (1997): 67). While the activists were making their claims of bias and abuse known, they were doing so in such a way that the psychiatric profession needn't take notice of them; if nothing else, their behaviour was a manifestation of their mental illness.

The failures of 1970 led to the protesters' reevaluation of their methods. In 1971, while there were no meetings on the convention schedule worthy of protest, gay activists maintained a booth on the convention floor, a practice they would continue for the next few years, and arranged for a discussion panel on homosexuality at which they would present

their point of view. While they had tried this the year before, this session was substantially different—the panel featured psychiatrists as well as protesters. One was Judd Marmor, who had previously attacked Charles Socarides' most recent findings; the other was a cloaked, hooded and anonymous psychiatrist who declared that he was gay, and told the attendees of the Gay Psychiatrists' Association, a social group which secretly met during the APA conventions. The Gay Psychiatrists' Association, claimed the anonymous speaker, comprised over two hundred APA members. It is not clear whether or not this revelation was a surprise to the average APA member or a confirmation of a suspicion. In either case, the recognition of a large number of gay psychiatrists reportedly opened the ears of some of the APA membership to the complaints of the protesters. It was no longer a bunch of perverts protesting; now the claims of bias were coming from psychiatrists themselves. With this collapse of distance between doctor and subject and between claimsmaker and recipient came increased difficulty in maintaining that homosexuality was a sickness and that the claims were not worthy of attention.

The 1972 convention was a watershed for the activists' cause. After a hundred gay demonstrators interrupted a meeting on behaviour therapists, psychiatrist Robert Spitzer found himself talking with the leader of the disruption, Ron Gold. Gold described the exchange (in Kutchins and Kirk (1997): 68):

> [Spitzer] said he believed in the illness theory. I said, alright, who do you believe? And he hadn't read any of it. . . . But he happened to know Socarides and thought he was a nut. Whom do you believe? Bieber? I don't know. Have you read it? No. But they all believed it.

Spitzer, as a result of this conversation, arranged a meeting between gay activists and the APA's Committee on Nomenclature, which organizes the diagnostic manual. While the initial interpretation of this event would be a simple matter of the activists' claims being

acknowledged by the psychiatric establishment in light of the newly-recognized gay psychiatric contingent and Spitzer's own discovery of prejudice in the area, there were further details involved. Spitzer knew that the committee to revise the Manual was going to be appointed during the next year (Kutchins and Kirk (1997)); having orchestrated such a meeting would almost certainly merit consideration when it came time to choose the new committee. Unfortunately, missed deadlines meant that any change to the DSM regarding homosexuality would have to wait.

In 1973, another panel was organized in the same manner as in 1972, and the audience of over one thousand psychiatrists responded positively to the idea of depathologizing homosexuality; the proceedings were then published in the *American Journal of Psychiatry*. The question of the nature of homosexuality was no longer being raised by claims from gay activists; rather, it had become a matter of competing claims within the association. For the most part the discussion was taking place in terms of what Spector and Kitsuse would term 'value groups' (Spector and Kitsuse (1977): 88), who took positions based on their beliefs on the illness theory of homosexuality; the previous 'interest group' (Spector and Kitsuse (1977): 88) organizing which found homosexuals looking out for homosexuals and psychiatrists looking out for psychiatry had faded. The question of values was driven further home when Spitzer found himself invited to a meeting of the Gay Psychiatrists' Association; the emotional exchanges at that meeting "helped to persuade Spitzer that many homosexuals ... function at a high level" (Kutchins and Kirk (1997): 69); he immediately prepared a proposal to change the DSM. In his proposal, he suggested that while homosexuality *per se* was not worthy of psychiatric diagnosis, there should remain a diagnosis for homosexuals unhappy with their orientation.

The Committee on Nomenclature refused to adopt the proposal, choosing instead to adopt a resolution calling for recognition of the civil rights of homosexuals. Nonetheless, Spitzer's presentation was referred by the committee to the Council on Research and Devel-

opment along with the suggestion that the Council hold a survey of the APA membership to determine the outcome. The Council rejected the suggestion of a survey as ridiculous; a survey was not compatible with the positivist, scientific basis of medicine. The Council itself had no reservations, though; it voted unanimously to adopt the proposal, as did the rest of the committees involved in the process. Further, the proposal was modified at one stage to be even more inclusive; Spitzer had, in his new diagnosis for those unhappy with their sexuality, referred to homosexuality as 'irregular', which was removed from the final product. Homosexuality was no longer an illness, according to the American Psychiatric Association; the Washington Post ran the headline, *Doctors Rule Homosexuals Not Abnormal*.

Shortly thereafter, Socarides organized a referendum on the change; his efforts to reinstate the diagnosis failed (Kutchins and Kirk (1997)). The DSM was not completely free of references to homosexuality, however; there was still Spitzer's diagnosis for those troubled by their homosexual orientation, but no corresponding diagnosis for heterosexuals. It would not be until 1987 until homosexuality would be completely expunged from the DSM; then, while Spitzer and the Nomenclature Committee was undergoing a battle with feminists reminiscent of the early battles with gay liberation activists, the gay activists found themselves with an unbeatable opportunity. They threatened to raise the homosexuality issue and the APA immediately removed the remaining diagnosis. By this point, what had originally been a scientific diagnosis of the medical profession was reduced to a political token.

Analysis: the post-psychiatric homosexual

The medical history of homosexuality is not without irony. It was, after all, the diagnosis of the medical profession which created the discreditable Homosexual. The public opinion of the homosexual, based on medical 'fact' combined with the inevitable myth surrounding an invisible enemy, served to push the homosexual underground, but without cutting him off

entirely from mainstream society. The homosexual, thus partially cut off from the world, turns to the company of other homosexuals, both for sexual and social purposes; without such severe stigma, the homosexual community may not have been so large and institutionalized to start off the chain of events which started the APA talking about homosexuality in the early 1970s. On the other hand, the ease by which homosexuality could be concealed, living a conventional public and homosexual private life, resulted in large numbers of homosexuals establishing careers in psychiatry (although I make no claims as to whether this is only a matter of percentages or something specific to psychiatry and homosexuals), while still maintaining a homosexual identity in the adjectival sense discussed previously—"gay psychiatrist", not just "gay".

Both of these factors—the stigmatization of homosexuals and resulting community, and the ability for homosexuals to maintain professional careers, in our case as psychiatrists—were *necessary* causes for psychiatric reform on the homosexual issue. As demonstrated by the confrontations at the 1970 and 1972 conference, the APA was not prepared to listen to unqualified homosexual activists; it was necessary for the professionally-qualified gays within the organization to effect real change. But without the urgings of the homosexual community, the insiders wouldn't have had the prompting to do anything in the first place. However, not even the combination of gay psychiatrists and angry activists were *sufficient* causes for reform; starting the bureaucratic gears in motion took the political motivation of Spitzer, whose decision to make a proposal for the removal of homosexuality as a diagnostic criteria and eventual concession to completely purge the DSM of homosexual diagnoses were motivated by internal APA politics, and not by science as would befit the medical profession's own ideology.

Unfortunately, homosexuality since the DSM revision has not been happily free of medicalization. 1984 found the gay community facing a medical stigma of a much larger scope than the psychiatric diagnoses it had fought off previously—real life-threatening disease.

The medical establishment was initially baffled by an epidemic of gay men coming down with diseases which had previously only been thought to affect livestock (Young (1995)). The condition was traced to a sexually-transmitted deficiency of the immune system, and Gay-Related Immune Disorder (GRID) was born. Socarides blamed the APA decision of the previous decade, claiming that the decriminalization of homosexual behaviour that followed the demedicalization of homosexuality led to a rise in gay bathhouse culture that allowed the epidemic to spread. This "gay disease" was fodder for those opposed to homosexuality, referred to by the Christian right as the "ultimate wage of sinners" (Young (1995)), and reestablishing the myth that there is something different and dangerous about gays. It was not until the epidemic began showing up in the straight population that extensive research began, and it was at that point that the disease, no longer confined to gay men as originally supposed, was relabeled to Acquired Immunodeficiency Syndrome, or AIDS. But the damage had already been done; the old homosexual myths, which had never entirely left the popular imagination, had been strengthened further, and stereotypes reaffirmed. As late as 1990, the World Health Organization still listed homosexuality in its classification of diseases (Young (1995): 13).

But the ultimate post-psychiatric irony is to be found in a debate currently raging within the gay community. In a 1995 experiment on twins, researcher Richard Pillard—gay himself—found preliminary evidence of a genetic explanation of homosexuality (Kutchins and Kirk (1997)). Homosexual activists immediately picked up the news, their reasoning being that a biological explanation removes the question of intent and choice from homosexual behaviour. After all, they argue, if homosexuals are born that way, then there exists no excuse to discriminate against them. Whether this is because homosexuality is like a race or like a disability is not immediately clear from the arguments, but in either case, history has shown us that medical explanations of homosexuality need not be in the interest of homosexuals. Kutchins suggests that a genetic causation for homosexuality could be read by Christian fundamentalists as a mark of the Devil (Kutchins 1997: 97). After a century-long

battle to be no different from straights, an astounding lack of historical appreciation and foresight threatens to drag homosexuality back to its turn-of-the-century not-quite-human status. And we put our faith back to the objective science of the medical profession for hope; according to Scheff (1999), the claim of genetic causation "seems premature". The status of homosexuality remains, again, firmly under medical power.

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