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Article

Homosexuality and scientific evidence: On suspect anecdotes, antiquated data, and broad generalizations

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The American Psychiatric Association and the American Psychological Association have suggested for many years now that there is significant empirical evidence supporting the claim that homosexuality is a normal variant of human sexual orientation as opposed to a mental disorder. This paper summarizes and analyzes that purported scientific evidence and explains that much (if not all) of the evidence is irrelevant and does not support the homosexuality-is-not-a-mental-disorder claim. As a result of their deficiencies and arbitrariness, the credibility those two groups that are typically deemed authoritative and trustworthy is called into question.

***Lay summary**: At one time, homosexuality was considered to be mentally disordered. Since the 1970s, however, major medical associations in the U.S. have labeled homosexuality as a normal counterpart of heterosexuality. Those medical associations have proposed that their homosexuality-is-normal claim is based on "scientific evidence." This article critically reviews that "scientific evidence" and finds that much of their literature does not support the claim that homosexuality is normal. This article suggests that instead of supporting their claim with scientific evidence, those major medical associations arbitrarily label homosexuality as normal.*

Keywords: Homosexuality, Mental disorder, Same-sex attraction, Scientific evidence, Empirical evidence, United States v. Windsor, Lawrence v. Texas, Adjustment

Introduction

Shortly before this paper was written, a Catholic nun was accused of "using suspect anecdotes, antiquated data, and broad generalizations to demonize gays and lesbians" (Funk 2014). Regarding the same event, another individual wrote that the nun deviated "into realms of sociology and anthropology," which are "beyond the scope of her expertise" (Galbraith 2014). It is not outright evident what was said, but the event brings to mind some important questions. The accusation of using outdated material and deviating into realms beyond the scope of one's expertise implies two things; first, it implies that there actually is information that is more up-to-date than what the nun presented on the topic of homosexuality, and secondly it implies that there are credible experts who are more qualified to teach or speak on the topic of homosexuality. The question comes to mind, then, what exactly does

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the non-antiquated, that is, the up-to-date, data show about homosexuality? Also, what do the so-called credible experts say about homosexuality? When one browses the Internet, one will see that apparently many of the so-called experts on mental disorders claim that there is a significant amount of scientific evidence in support of the claim that homosexuality is not a mental disorder. Hence, it is necessary to provide a summary and analysis of that purported up-to-date scientific evidence which supports the claim that homosexuality is not a mental disorder.

The two groups that are typically deemed authoritative and credible experts on mental disorders in the United States are the American Psychological Association (APA) and the American Psychiatric Association; thus, I will present their stances on homosexuality and then analyze the "scientific evidence" that they claim supports their stances. I will show that there are significant deficiencies in the literature put forth as scientific evidence in support of the claim that homosexuality is not a mental disorder. Specifically, much of the literature they put forth as scientific evidence is irrelevant to the topic of homosexuality and mental disorders. As a result of their deficiencies, the credibility of the American Psychiatric Association and the APA, at least in their claims regarding human sexuality, is called into question.

The American Psychological Association and the American Psychiatric Association

I will begin by describing the APA and the American Psychiatric Association, and I will then present their stances on the topic of homosexuality. The APA claims to be

> the largest scientific and professional organization representing psychology in the United States. APA is the world's largest association of psychologists, with nearly 130,000 researchers, educators, clinicians, consultants, and students as its members. (American Psychological Association 2014)

Their mission "is to advance the creation, communication, and application of psychological knowledge to benefit society and improve people's lives" (American Psychological Association 2014).

The American Psychiatric Association (which also uses the acronym APA)

> is the world's largest psychiatric organization. It is a medical specialty society representing growing membership of more than 35,000 psychiatrists … Its member physicians work together to ensure humane care and effective treatment for all persons with mental disorders, including intellectual disabilities and substance use disorders. APA is the voice and conscience of modern psychiatry. (American Psychiatric Association 2014a)

The American Psychiatric Association publishes the *Diagnostic and Statistical Manual of Mental Disorders* (DSM) which is

> the handbook used by health care professionals in the United States and much of the world as the *authoritative* guide to the diagnosis of mental disorders. *DSM* contains descriptions, symptoms, and other criteria for diagnosing mental disorders. It provides a common language for clinicians to communicate about their patients and establishes consistent and reliable diagnoses that can be used in the research of mental disorders. It also provides a common language for researchers to study the criteria for potential future revisions and to aid in the development of medications and other interventions. (American Psychiatric Association 2014b, emphasis added)

The *Diagnostic and Statistical Manual of Mental Disorders* has been considered to be the authoritative guide to the diagnosis of mental. It follows, then, that those psychiatrists that make up the American Psychiatric Association, especially those involved in determining the contents of the DSM, are considered to be the authorities and experts in psychiatry. (For those who may not be aware, the study of psychology is different from the study of psychiatry, which is why there are two different professional organizations that study mental disorders.)

The stances of the APA and the American Psychiatric Association on homosexuality are discussed in at least two important documents. The first is the Brief of Amici Curiae for APA, American Psychiatric Association, and others given during the Supreme Court case *Lawrence v. Texas*, 539 U.S. 558, which overthrew laws against sodomy. The second is the APA document titled "Report of the Task Force on Appropriate Therapeutic Responses to Sexual Orientation." The task force "conducted a systematic review of the peer-reviewed journal literature on sexual orientation change efforts" in order to provide "more specific recommendations to licensed mental health practitioners, the public, and policymakers" (Glassgold et al. 2009, 2). Both documents provide citations of "evidence" supporting the claim that homosexuality is not a mental disorder. I will refer to the scientific evidence cited in the documents, and I will follow with an analysis of that literature put forth as scientific evidence.

It should be noted that the "task force" that produced the second document was chaired by Judith M. Glassgold, Psy.D., who is a lesbian psychologist. She sits on the board of the *Journal of Gay and Lesbian Psychotherapy* and is past president of the APA's Gay and Lesbian Division 44 (Nicolosi 2009). Other members of the task force were Lee Beckstead, Ph.D.; Jack Drescher, M.D.; Beverly Greene, Ph.D.; Robin Lin Miller, Ph.D.; Roger L. Worthington, Ph.D.; and Clinton W. Anderson, Ph.D. According to Joseph Nicolosi, Beckstead, Drescher, and Anderson are all "gay," while Miller is "bisexual" and Greene is lesbian (Nicolosi 2009). So, prior to assessing their discussions, the reader should note that those involved with this APA task force are not speaking or writing from neutral standpoints.

I will be drawing quotes from two different documents. Doing so will provide more evidence of the stance of both the APA and the American Psychiatric Association.

The Two Associations' Stance on Homosexuality

The APA writes:

> Same-sex sexual attractions, behavior, and orientations per se are normal and positive variants of human sexuality—in other words, they do not indicate either mental or developmental disorders. (Glassgold et al. 2009, 2)

They explain that by "normal" they mean "both the absence of a mental disorder and the presence of a positive and healthy outcome of human development" (Glassgold et al. 2009, 11). The authors writing for the APA believe that the previous claim "has a significant empirical foundation" (Glassgold et al. 2009, 15).

The Brief of Amici Curiae for both the APA and the American Psychiatric Association uses similar language:

> Decades of research and clinical experience have led all mainstream mental health organizations in this country to the conclusion that homosexuality is a normal form of human sexuality. (Brief of Amici Curiae 2003, 1)

Hence, the basic stance of the APA and the American Psychiatric Association is that homosexuality is not a mental disorder but is rather a normal form of human sexuality, and they propose that their stance is based on significant scientific evidence.

Sigmund Freud

Both documents proceed by providing historical reviews of homosexuality and psychoanalysis. One document begins with Sigmund Freud, who suggested that homosexuality was "nothing to be ashamed of, no vice, no degradation, it cannot be classified as an illness, but a variation of sexual function" (Freud 1960, 21, 423–4). They note that Freud attempted to change one woman's sexual orientation, but after failing to do so, "Freud concluded that attempts to change homosexual sexual orientation were likely to be unsuccessful" (Glassgold et al. 2009, 21).

It goes without saying that a letter written in 1935 is outdated—or antiquated, depending on one's choice of words. Freud's conclusion that changing a homosexually inclined person's sexual orientation is "likely impossible" after one try should qualify as a "suspect anecdote." Hence, Freud's literature is deficient; it cannot support the proposition that homosexuality is a normal variant of human sexual orientation. (It is noteworthy that Freud also suggested that homosexuality is a "variation of the sexual function produced by a certain arrest of sexual development" [Herek 2012]. The omission of that line from Freud's work is misleading.)

Alfred Kinsey

The APA Task Force document proceeds by citing two books written by Alfred Kinsey in 1948 and 1953 (*Sexual Behavior in the Human Male* and *Sexual Behavior in the Human Female*):

> At the same time that the pathologizing views of homosexuality in American psychiatry and psychology were being codified, countervailing evidence was accumulating that this stigmatizing view was ill founded. The publication of *Sexual Behavior in the Human Male* and *Sexual Behavior in the Human Female* demonstrated that homosexuality was more common than previously assumed, thus suggesting that such behaviors were part of a continuum of sexual behaviors and orientations. (Glassgold et al. 2009, 22)

Implied in that statement is a "normality" of the sexual behaviors, specifically homosexuality, on the continuum; for a study to be cited as "countervailing evidence" of the claim that homosexuality is abnormal, the study must suggest that homosexuality is normal. In other words, the APA is suggesting the following based off of Kinsey's books:

1. In human beings, homosexuality has been demonstrated to be more common than previously assumed;
2. Therefore, there is a normal variation (or a normal "continuum") of sexual attractions to different genders.

Kinsey's argument (that is adopted by the APA) is equally as deficient as Freud's. A "continuum" is a "continuous sequence in which adjacent elements are not perceptibly different from each other, although the extremes are quite distinct" (New Oxford American Dictionary 2010, s.v. continuum). An example of a "continuum" is temperature readings—"hot" and "cold" are very different from each other, but 100 °F and 99 °F are difficult to distinguish. Kinsey explains his theory of continuums in nature:

> The world is not to be divided into sheep and goats. Not all things are black nor all things white. It is a fundamental of taxonomy that nature rarely deals with discrete categories. Only the human mind invents categories and tries to force facts into separated pigeon-holes. *The living world is a continuum in each and every one of its aspects*. The sooner we learn this concerning human sexual behavior the sooner we shall reach a sound understanding of the realities of sex. (Kinsey and Pomeroy 1948, emphasis added)

In regards to homosexuality, Kinsey (and the APA authors) concludes that because some people experience sexual attraction to the same gender, then it automatically follows that there is a normal continuum of sexual attractions. It does not take a PhD to identify the deficiency in the argument. *The normality of a behavior is not determined simply by observing a behavior in society*. This is the case in all of medicine.

It may be easier to understand problems with the argument by using examples of observed human desires for specific actions. Some human beings desire to remove healthy body parts; others desire to cut themselves with razor blades, while others desire to harm themselves in other ways. These people are not necessarily suicidal; instead, they desire to remove their healthy limbs or they desire to inflict harm on themselves without causing death. These are two different conditions—one is known as "body integrity identity disorder," "xenomelia," or "apotemnophilia"; and the other is known as "nonsuicidal self-injury," "self-mutilation," or "self-harm."

Xenomelia is "the desire of a healthy individual to have a fully functional limb amputated" (Brugger, Lenggenhager and Giummarra 2013, 1). It has been noted that "most subjects with xenomelia are male," that "the majority desire leg amputation" although a "considerable minority of persons with xenomelia desire a bilateral amputation" (Hilti et al. 2013, 319). One study of 13 males noted that all of their participants with xenomelia "*longed for* a leg amputation" (Hilti et al. 2013, 324, emphasis added). Studies have reported that the condition has an onset in early childhood and that it may even be present since birth (Blom, Hennekam, and Denys 2012, 1). In other words, some individuals may be born with the desire to remove or a "longing for" the removal of a healthy limb. It has also been reported in a study of 54 individuals with the condition that 64.8 percent had a university degree (Blom, Hennekam, and Denys 2012, 2). One study suggested that the removal of healthy limbs results "in impressive improvement of quality of life" for individuals with the condition (Blom, Hennekam, and Denys 2012, 3).

To summarize, then, there is a mental condition in which people "desire" and "long for" the removal of their healthy limbs. This desire to remove healthy limbs may be inborn, or in other words, people may be born with the desire to remove their healthy limbs. This "desire" and "longing" is the same thing as an "inclination" or "tendency." The "desire" or "longing" is different from the action of having body parts removed, but both the inclination, desire, and longing as well as the action of removal are considered *disordered* (Hilti et al. 2013, 324).[1] The removal of healthy limbs is a *disordered action*, and the desire for the removal of healthy limbs is a *disordered desire* or a *disordered inclination*. The disordered desire comes in the form of a thought, as is the case of most (if not all) desires. In many cases, the disorder is present since childhood. Finally, individuals who act on the inclination to have a limb removed feel better after the limb is removed. In other words, those who act on their disordered desire (disordered thoughts) and perform the disordered action of removing a

healthy limb experience an improved "quality of life," or they feel pleasure after performing the disordered action. (The reader should notice here a parallel between the disordered-nature of xenomelia and the disordered-nature of homosexuality.)

The second example I mentioned previously is "self-harm" or "self-injury." E. David Klonsky noted that:

> Self-injury is defined as the intentional destruction of body tissue without suicidal intent and for purposes not socially sanctioned … Common forms of self-injury include cutting, burning, scratching, and interfering with wound healing. Other forms include carving words or symbols into one's skin, banging body parts, and needle-sticking. (Klonsky 2007, 1039–40)

Klonsky and Jennifer J. Muehlenkamp write that:

> Some may use self-injury as a means for generating excitement or exhilaration in a manner similar to skydiving or bungee jumping. For example, reasons given by some self-injurers include "to experience a high," "I thought it would be fun," and "for excitement." When performed for this reason, self-injury may occur around friends or peers. (Klonsky and Muehlenkamp 2007, 1050)

Similarly, Klonsky notes that

> The *prevalence of self-injury is high and probably increasing among adolescents and young adults* … it has become apparent that self-injury occurs even in nonclinical and *high-functioning populations* such as secondary school students, college students, and active-duty military personnel … The *increasing prevalence of self-injury* suggests that clinicians are more likely than ever to encounter the behavior in their clinical practice. (Klonsky 2007, 1040, emphasis added)

The American Psychiatric Association notes that in nonsuicidal self-injury, the injury is "often preceded by an urge and is experienced as pleasurable, even though the individual realizes that he or she is harming himself or herself" (American Psychiatric Association 2013, 806).

To summarize, then, nonsuicidal self-injury is a *disordered action* that is preceded by a *disordered desire* (or "urge") to harm oneself. Those who injure themselves do so for "pleasure." Some patients with the disorder are "high-functioning" in that they are able to live, work, and act in society while at the same time they still have a mental disorder. Finally, the "prevalence of self-injury is high and probably increasing among adolescents and young adults" (Klonsky 2007, 1040).

Now, back to the original purpose for providing the examples of body integrity identity disorder and self-injury. The APA claims that Alfred Kinsey's studies of homosexuality in men and women were "countervailing evidence" to the idea that homosexuality is a pathology. They based that claim off of Kinsey's studies which "demonstrated that homosexuality was more common than previously assumed, thus suggesting that such behaviors were part of a continuum of sexual behaviors and orientations" (Glassgold et al. 2009, 22). Again, an abbreviated version of Kinsey's argument looks like this:

1. In human beings, homosexuality has been demonstrated to be more common than previously assumed;
2. Therefore, there is a normal variation (or a normal "continuum") of sexual attractions.

By replacing homosexuality with the examples of body integrity identity disorder and self-harm/self-mutilation in

Alfred Kinsey's and the APA's argument (that is, if we follow the logic of Kinsey and the APA) the argument would be as follows:

1. In human beings, it has been observed that some people are attracted to and desire to cut themselves and remove their healthy body parts;
2. The attractions to cut oneself and remove one's healthy body parts have been demonstrated to be more common than previously assumed;
3. Therefore, there is a normal variation of attractions to self-harm; there is a continuum of normal variations of orientation to harm oneself.

Hence, we can see how illogical and deficient Kinsey's and the APA's argument is; the observation that a behavior is more common than previously assumed does not automatically lead to the conclusion that there is a normal continuum of behaviors. One would have to conclude that every human behavior observed is simply one normal behavior on the "continuum" of human behaviors; if the desire to harm oneself or the desire to remove a healthy limb is shown to be more common than previously assumed, then (according to their logic) such behaviors would be part of a normal continuum of self-harm behaviors and orientations.

On one end of Kinsey's spectrum would be those who desire to kill themselves, while on the other end of the spectrum there would be those who desire health and normal functioning of their body. Somewhere between, according to Kinsey's logic, would be those who desire to cut their arms, and next to them would be those who desire to remove their arms completely. This brings up the question—why are all behaviors not considered to be normal variants of human behavior? Kinsey's continuum argument, when it is followed to its logical conclusion, entirely does away with any need for psychology or psychiatry; Kinsey wrote that "*The living world is a continuum in each and every one of its aspects*" (emphasis added). If that were the case then there would be no such thing as a mental disorder (or physical disorder for that matter), and there would be no need for those groups that diagnose and treat mental disorders. The desire to be a serial killer would be, according to Kinsey's logic, simply a normal variant on the continuum of human desire. Hence, the APA's claim that Kinsey's study is "countervailing evidence" against the claim that homosexuality is a pathology is deficient and erroneous. The literature does not support their conclusion, and the conclusion itself is absurd. (Additionally, it should be noted that along with illogical arguments, much of Kinsey's research has been discredited [Browder 2004]. Kinsey suggested that 10 percent of the U.S. male population "are gay or bisexual," but recent estimates suggest that 3.9 percent of the U.S. male population have sex with men [Purcell et al. 2012, 98], and overall, according to the U.S. Department of Health and Human Services, 1.6 percent of Americans claim to be gay or lesbian, while 0.7 percent claim to be bisexual. [Ward et al. 2014, 1].)

C.S. Ford and Frank A. Beach

Another source that was put forth as scientific evidence that homosexuality is not a mental disorder is a study by C.S. Ford and Frank A. Beach. The APA wrote:

> C. S. Ford and Beach (1951) revealed that same-sex behaviors and homosexuality were present in a wide range of animal species and human cultures. This finding suggested that there was nothing

> unnatural about same-sex behaviors or homosexual sexual orientation. (Glassgold et al. 2009, 22)

The quotation is in reference to a book titled *Patterns of Sexual Behavior*. It was written in 1951, and it suggested that homosexual activity was accepted in 49 out of 76 cultures after looking at anthropological data (Gentile and Miller 2009, 576). Ford and Beach also "point out that among non-human primates both males and females engage in homosexual activity" (Gentile and Miller 2009).

Thus, the APA authors suggest that because two researchers in 1951 found that homosexual sex is observed in some humans and animals then the conclusion follows that there is "nothing unnatural about it." (The phrase "nothing unnatural" seems to connote the activity being normal.) The argument is simplified in the following manner:

1. Any action or behavior present in a wide range of animal species and human cultures suggests that the behavior or action is not unnatural;
2. Same-sex behaviors and homosexuality are present in a wide range of animal species and human cultures;
3. Therefore, there is nothing unnatural about same-sex behaviors or homosexual sexual orientation.

Here again we have "antiquated data" (a study from 1951) with an absurd conclusion. The observation of a behavior in both non-human and human animals is not a sufficient condition to determine that there is "nothing unnatural" about that behavior (unless the APA re-defines the word "natural" to accommodate that statement). In other words, there are many behaviors or actions that non-human animals and human animals both perform, but this does not always result in the conclusion that "there is nothing unnatural" about those behaviors.

For example, cannibalism has been shown to be widespread in human cultures and non-human animals (Petrinovich 2000, 92).[2] Applying the behavior of cannibalism to the logic used by the APA would result in the following argument:

1. Any action or behavior present in a wide range of animal species and human cultures suggests that the behavior or action is not unnatural;
2. The behavior of humans eating humans and other animals eating their own species is present in a wide range of animal species and human cultures;
3. Therefore, there is nothing unnatural about humans eating other human beings.

Yet, there is something "unnatural" about human beings eating other human beings. We can arrive at that conclusion through common sense (without being an anthropologist, sociologist, psychologist, or biologist). Thus, the APA's use of Ford and Beach's faulty conclusion as "evidence" that homosexuality is not a mental disorder is both antiquated and deficient. Once again, the literature does not support their conclusion, and the conclusion itself is absurd; their argument is not a scientific argument. (The discussion could also be used to illustrate Kinsey's and the APA's absurd logic: on one end of the "normal continuum of food orientation" would be veganism while on the other end would be eating humans.)

Evelyn Hooker and Others on "Adjustment"

The APA task force continues with its claims that homosexuality is not a mental disorder by writing:

> Psychologist Evelyn Hooker's research put the idea of homosexuality as mental disorder to a scientific test. She studied a nonclinical sample of homosexual men and compared them with a matched sample of heterosexual men. Hooker found, among other things, that based on three projective measures (the Thematic Apperception Test, the Make-a-Picture Story test, and the Rorschach), the homosexual men were comparable to their matched heterosexual peers on *ratings of adjustment*. Strikingly, the experts who examined the Rorschach protocols could not distinguish the protocols of the homosexual cohort from the heterosexual cohort, a glaring inconsistency with the then-dominant understanding of homosexuality and projective assessment techniques. (Glassgold et al. 2009, 22, emphasis added)

The Amici Curiae Brief for the APA and the American Psychiatric Association cites Hooker's study as well, citing it as a rigorous examination:

> In one of the first *rigorous* examinations of the mental health status of homosexuality, Dr. Evelyn Hooker administered a battery of standard psychological tests to homosexual and heterosexual men who were matched for age, IQ, and education … She concluded from her data that homosexuality is not inherently associated with psychopathology and that "homosexuality as a clinical entity does not exist." (Brief of Amici Curiae 2003, 10–11, emphasis added)

So, in 1957 Evelyn Hooker compared men who claimed to be homosexual with men who claimed to be heterosexual. She tested the men by using three different psychological tests known as "the Thematic Apperception Test," "the Make-a-Picture-Story test," and "the "Rorschach test." She concluded that "homosexuality as a clinical entity does not exist" (Brief of Amici Curiae 2003, 11). A thorough analysis and criticism of Hooker's study is beyond the scope of this paper, but a few points should be made.

The most important aspect of a research study is the endpoints measured in the study and whether those measurements support the stated conclusion. Another important aspect of a study is whether measurements are properly defined. In Hooker's study, the endpoint measured was the "adjustment" of homosexuals and heterosexuals, and Hooker claimed that the adjustment measured for homosexuals and heterosexuals was similar; she does not, however, outright define that term "adjustment." For now, the reader should keep the term "adjustment" in mind, and I will return to it in a moment. It should be noted that since the publication of Hooker's study, other papers have exposed methodological errors in Hooker's study. My focus for this paper is the irrelevant endpoint —"adjustment"—used by Hooker as scientific evidence supporting the claim that homosexuality is normal; I focus on that endpoint because as of 2014 "adjustment" is still the endpoint cited by the major associations as scientific evidence supporting the claim that homosexuality is a "normal variation of human sexual orientation." (Two papers explaining the methodological errors in Hooker's study are Schumm (2012) and Cameron and Cameron (2012) cited at length in the references section.)

Following the citation of Evelyn Hooker's study as scientific evidence, the APA Task Force authors state:

> Armon performed research on homosexual women and found similar results [as Evelyn Hooker]…. In the years following Hooker's and Armon's research, inquiry into sexuality and sexual orientation proliferated. Two major developments marked an important change in the study of homosexuality. First, following Hooker's lead, more researchers conducted studies of nonclinical samples of homosexual men and

> women. Prior studies primarily included participants who were in distress or incarcerated. Second, quantitative methods to assess human personality (e.g., Eysenck Personality Inventory, Cattell's Sixteen Personality Factor Questionnaire [16PF]) and mental disorders (Minnesota Multiphasic Personality Inventory [MMPI]) were developed and were a vast psychometric improvement over prior measures, such as the Rorschach, Thematic Apperception Test, and House-Tree-Person Test. *Research conducted with these newly developed measures indicated that homosexual men and women were essentially similar to heterosexual men and women in adaptation and functioning*. (Glassgold et al. 2009, 23, emphasis added)

That last line which I emphasized is extremely important; the "newly developed measures" compared the "adaptation" and ability to function in society in homosexuals and heterosexuals and used the comparison to support the conclusion that homosexuality is not a disorder. It should be noted here that "adaptation" has been used interchangeably with "adjustment" (Jahoda 1958, 60–63; Seaton 2009, 796–99). Hence, the APA again implies that because homosexual men and women were "essentially similar" to men and women in adjustment and social functioning, it necessarily follows that homosexuality is not a mental disorder. That was the same argument proposed by Evelyn Hooker; she supported her conclusion that homosexuality is not a pathology with data showing that homosexuals and heterosexuals were similar in "adjustment."

A review by John C. Gonsiorek is also cited by the APA and the American Psychiatric Association as evidence that homosexuality is not a disorder (Glassgold et al. 2009, 23; Brief of Amici Curiae 2003, 11). The review is titled "The Empirical Basis for the Demise of the Illness Model of Homosexuality." In the article, Gonsiorek makes multiple claims that are similar to Evelyn Hooker's. He wrote that

> psychiatric diagnosis is legitimate, but its application to homosexuality is erroneous and invalid because there is no empirical justification for it. In other words, the diagnosis of homosexuality as an illness is bad science. Therefore, whether one accepts or rejects the plausibility of the diagnostic enterprise in psychiatry, there is no basis for viewing homosexuality as a disease or as indicative of psychological disturbance. (Gonsiorek 1991, 115)

Gonsiorek accuses others of using "bad science" to support the claim that homosexuality is a disorder. Furthermore, Gonsiorek suggests that "The only relevant issue is whether any well-adjusted homosexuals exist at all" (Gonsiorek 1991, 119–20) and

> Whether homosexuality per se is or is not pathological and indicative of psychological disturbance is easily answered. As I will discuss later, studies on a variety of samples have consistently concluded that *there is no difference in psychological adjustment between homosexuals and heterosexuals*. Therefore, even if other studies find that some homosexuals are disturbed, *it cannot be maintained that sexual orientation per se and psychological adjustment are related*. (Gonsiorek 1991, 123–24, emphasis added)

Hence, Gonsiorek's paper used "adjustment" as the endpoint measured. Again, the scientific evidence referred to in the claim that "homosexuality is normal and is supported by scientific evidence as a normal behavior" measured the "adjustment" of homosexuals. Gonsiorek implies that if sexual orientation is "related" to psychological adjustment, then one could consider homosexually inclined people to be mentally disordered; if, however, there is no difference in adjustment measurements of heterosexuals and homosexuals, then

(according to Gonsiorek) homosexuality is not a mental disorder. His argument is almost identical to Evelyn Hooker's argument, which was the following:

1. There are no measurable differences in psychological adjustment between homosexually inclined people and heterosexuals;
2. Therefore, homosexuality is not a mental disorder.

The Brief of Amici Curiae in *Lawrence v. Texas* filed by the APA and the American Psychiatric Association also cites Gonsiorek's review as scientific evidence which supports the claim that "homosexuality is not related to psychopathology or social maladjustment" (Brief of Amici Curiae 2003, 11). The brief then offers a few more citations of scientific evidence supporting that claim; one article cited is a review study from 1978 which also looked at "adjustment" and "concludes that findings to date have not demonstrated that the homosexual individual is any less psychologically adjusted than his heterosexual counterpart" (Hart et al. 1978, 604). The American Psychiatric Association and the APA also cited Gonsiorek's and Hooker's papers as scientific evidence in their brief for the recent U.S. Supreme Court Case *United States v. Windsor* (Brief of Amici Curiae 2013, 8). Hence, once again, "adjustment" measures were used to support the claim that homosexuality is not a mental disorder. We must, then, inquire into what exactly is meant by "adjustment," since it is the major foundation for much of the "evidence" supporting the claim that homosexuality is not a mental disorder.

"Adjustment" in Psychology

Previously I noted that "adjustment" is a term that has been used interchangeably with "adaptation." Marie Jahoda wrote in 1958 (a year after the publication of Evelyn Hooker's study) that

> The term "adjustment" is actually used more frequently than adaptation, particularly in the popular mental health literature, but often in an ambiguous manner that leaves to anyone's whim whether it should be understood as a passive acceptance of whatever life brings—that is, as meeting situational requirements indiscriminantly—or as a synonym for adaptation. (Jahoda 1958, 62)

Both Hooker's study and Gonsiorek's review are prime examples of ambiguous use of the term "adjustment"; neither author outright defines the term, but Gonsiorek hints at what he means by the term when he cites multiple studies published between the years 1960 and 1975 (which are difficult to obtain due to being outdated):

> A number of researchers utilized the Adjective Check List (ACL). Chang and Block using this test, found no differences in general *adjustment* between homosexual and heterosexual males. Evans, using the same test, found that homosexuals appeared to have more problems with self-acceptance than heterosexual males, but that only a small minority of homosexuals could be considered *maladjusted*. Thompson, McCandless, and Strickland used the ACL to study psychological *adjustment* of both male and female homosexuals and heterosexuals, concluding that sexual orientation was not related to personal *adjustment* in either sex. Hassell and Smith used the ACL to compare homosexual and heterosexual women, and found a mixed pattern of normal range differences that might suggest poorer *adjustment* in the homosexual sample. (Gonsiorek 1991, 130, emphasis added)

So, according to Gonsiorek, at least one indicator of one's adjustment is "self-acceptance." Lester D. Crow, in a book published during the same time period as those studies reviewed by Gonsiorek, notes that

> Wholesome, healthy adjustment can be recognized by noting that an individual displays certain definite characteristics. He recognizes himself to be an individual, both like and different from other individuals. He is self-confident, but with a practical realization of his strengths and weaknesses. At the same time he is able to appreciate the strengths and weaknesses of others and adjusts his attitudes toward them in terms of positive values … The well-adjusted person feels secure in his understanding of his ability to bring to his interrelations those attitudes that are conducive to effective living. He is helped by his self-confidence and sense of personal security to so direct his activities that they are pointed toward a continuous consideration for the welfare of himself and others. He is able to solve adequately the more or less serious problems that he encounters from day to day. Finally, the individual who has achieved successful adjustment gradually evolves a philosophy of life and a system of values that serve him well in the various areas of experience—school or work activities, and relationships with all the people with whom he comes in contact, younger or older. (Crow 1967, 20–21)

A more recent source, *The Encyclopedia of Positive Psychology*, notes that

> In psychological research, adjustment refers both to an achievement or outcome as well as a process … Psychological adjustment is a popular outcome measure in psychological research, and often measures such as self-esteem, or the absence of distress, anxiety, or depression are used as indicators of adjustment. Researchers may also measure an individual's level of adjustment or well-being in response to some stressful event, such as divorce, or as the absence of deviant behavior, such as drinking or drug use. (Seaton 2009, 796–7)

Both the excerpt from 1967 and the more recent excerpt in the encyclopedia match endpoints in studies mentioned by Gonsiorek. He cites multiple studies that

> found significant differences between homosexual, heterosexual, and bisexual groups, but not to a level that would suggest psychopathology. Measures of depression, self-esteem, relationship discord, and sexual discord were utilized. (Gonsiorek 1991, 131)

Evidently, then, a person's "adjustment" is determined (at least in part) by measuring depression, self-esteem, "relationship discord," "sexual discord," distress, and anxiety. Presumably then, a person who is not depressed or distressed, has high or normal self-esteem, can maintain relationships, and does not show signs of "sexual discord" would be considered to be "adjusted" or "well-adjusted." Gonsiorek claims that because homosexuals are similar to heterosexuals in measures of depression, self-esteem, relationship discord, and sexual discord, it automatically follows that homosexuality is not a disorder, as he notes: "The general conclusion is clear: These studies overwhelmingly suggest that homosexuality per se is not related to psychopathology or psychological adjustment" (Gonsiorek 1991, 115–36). Here is a simplified version of Gonsiorek's argument:

1. There are no measurable differences in depression, self-esteem, relationship discord, or sexual discord between homosexually inclined people and heterosexuals;

2. Therefore, homosexuality is not a psychological disorder.

Like Evelyn Hooker's conclusion, Gonsiorek's conclusion does not necessarily follow from the data that he believes supports it. One could likely discover many mental disorders that do not lead a person to become depressed or distressed or have low self-esteem; in other words, "adjustment" is not a proper endpoint to determine the psychological normalcy of every thought process and the behaviors associated with those thought processes. Depression, self-esteem, "relationship discord," "sexual discord," distress, and one's ability to function in society are not relevant to every mental disorder; that is, not all psychological disorders result in "maladjustment." This idea is mentioned in *The Encyclopedia of Positive Psychology*. It notes that measuring self-esteem and happiness to determine one's adjustment is problematic.

Those are subjective measurements, the author notes,

> which are subject to social desirability. An individual may also be consciously unaware of and therefore unable to report his or her disturbance or mental illness. Likewise, individuals with severe mental illnesses may nonetheless report being happy and satisfied with their lives. Finally, subjective well- being is necessarily dependent on situation. (Seaton 2009, 798)

Some examples are necessary here to prove the point. Pedophiles can report not being distressed with their "intense sexual interest" in children, and they report being able to function in society; both distress and social functioning have been included under the umbrella terms "adjustment" and "adaptation." The American Psychiatric Association wrote that:

> If individuals also complain that their sexual attractions or preferences for children are causing psychosocial difficulties, they may be diagnosed with pedophilic disorder. However, if they report an absence of feelings of guilt, shame, or anxiety about these impulses and are not functionally limited by their paraphilic impulses (according to self-report, objective assessment, or both), and their self-reported and legally recorded histories indicate that they have never acted on their impulses, then these individuals have a *pedophilic sexual orientation but not pedophilic disorder*. (American Psychiatric Association 2013, 698, emphasis added)

Also, people who cut themselves ("self-injurers" or "self-mutilators") are able to function in society; it was noted previously that the behavior occurs in "high-functioning populations such as secondary school students, college students, and active-duty military personnel." (Klonsky 2007, 1040) Those who self-injure to cause pleasure, then, are able to function in society, just like those adults with an "intense sexual interest" in children are able to function in society and not be distressed. Some anorexics may "remain active in social and professional functioning" (American Psychiatric Association 2013, 343) and the persistent eating of nonnutritive, nonfood substances (like plastic) "is rarely the sole cause of impairment in social functioning"; there is no mention of depression, low self-esteem, or sexual or relationship discord as a requirement to diagnose the mental disorder in which individuals eat nonnutritive, nonfood substances to cause pleasure (known as "pica") (American Psychiatric Association 2013, 330–1).

The American Psychiatric Association also mentions that Tourette's disorder (one of the "tic disorders," a type of mental disorder) can occur without distress or functional consequences (and therefore

without any relation to measures of "adjustment"). They wrote that "Many individuals with mild to moderate tic severity experience no distress or impairment in functioning and may even be unaware of their tics" (American Psychiatric Association 2013, 84). Tic disorders are disorders that are experienced as involuntary (American Psychiatric Association 2013, 82) (that is, the patient will express they do not choose to have their rapid, recurrent, nonrhythmic motor movement or vocalization; others could likely even claim they were "born that way"). DSM-5 does not require distress or social impairment for one to be diagnosed with Tourette's disorder, and hence, it is yet another example of a mental disorder in which "adjustment" measures are irrelevant; it is a disorder in which one could not use measures of adjustment as scientific evidence to claim Tourette's disorder is or is not a mental disorder.

A final mental disorder unrelated to "adjustment" is delusional disorder.

Individuals with delusional disorder have false beliefs that are

> based on incorrect inference about external reality that is firmly held despite what almost everyone else believes and despite what constitutes incontrovertible and obvious proof or evidence of the contrary. (American Psychiatric Association 2013, 819)

The American Psychiatric Association notes that "apart from the impact of the delusion(s) or its ramifications, functioning is not markedly impaired, and behavior is not obviously bizarre or odd" (American Psychiatric Association 2013, 90). Furthermore, "A common characteristic of individuals with delusional disorder is the apparent normality of their behavior and appearance when their delusional ideas are not being discussed or acted on" (American Psychiatric Association 2013, 93). Those individuals with delusional disorder, it appears, do not show signs of "maladjustment"; besides their delusional ideation, they appear to be normal. Hence, delusional disorder is a prime example of a mental disorder which is unrelated to "adjustment" measures; "adjustment" is irrelevant to delusional disorder. One could say that homosexuals, though their behavior is mentally disordered, "appear to be normal" in other aspects of their lives—aspects like social functioning and areas that would indicate maladjustment. Hence, there are multiple mental disorders in which measuring adjustment has no relevance whatsoever to the mental disorder; this is a major deficiency in the literature used as scientific evidence to support the conclusion that homosexuality is not a mental disorder.

This is a significant finding, although I am not the first to mention the problem with diagnosing mental disorders by looking at distress, social functioning, or other endpoints that are included under the terms "adjustment" and "adaptation." The topic was discussed by Robert L. Spitzer and Jerome C. Wakefield in their article addressing the diagnosis of mental disorders based on clinically significant distress or impairment in social functioning (the article was written as a criticism of an older version of the *Diagnostic and Statistical Manual*, but the criticism is applicable to this discussion).

They noted that some mental conditions are mis-labeled due to

> the assumption that the way to determine that a condition is pathological is to ensure that it causes sufficient distress or impairment in social or role functioning. In the rest of medicine, a harmful condition is considered pathological if there is evidence of a biological dysfunction in the organism. Neither distress nor role functioning failure is necessary to make most medical diagnoses, although both

> often accompany severe forms of disorder. For example, a diagnosis of pneumonia, heart disease, cancer, or innumerable other physical disorders can be made in the absence of subjective distress and even if the individual is successfully functioning in all social roles. (Spitzer and Wakefield 1999, 1862)

An additional disease that can be diagnosed without distress or role functioning failure that should be mentioned here is HIV/AIDS; HIV has a long latent period, and many people will not even be aware of being HIV positive. It has been estimated that 240,000 people are not aware that they have HIV (CDC 2014).

Spitzer and Wakefield imply that in many cases a disorder may be present even if an individual is functioning well in society or if the individual scores well on measurements of "adjustment." In some situations, appealing to measurements of distress and impairment in social functioning leads to "false negatives," which are instances in which an individual's mental condition is disordered but is not labeled as disordered (Spitzer and Wakefield 1999, 1856). Spitzer and Wakefield give multiple examples of mental conditions that can be mis-diagnosed as false negatives if social functioning or distress (which they call the "clinical significance criterion," referring to clinically significant distress) are used as diagnosing criteria. They wrote that

> It is common to encounter individuals who have lost control over their drug use and are suffering various harms (e.g., threat to health) as a result (and who therefore, to us, have a disorder) but who are not distressed and who can carry on successful role functioning. Consider, for example, the case of a successful stockbroker who is addicted to cocaine at a level that is threatening his physical health but who has no distress and whose role performance has not suffered. Without the clinical significance criterion, the DSM-IV criteria correctly classify the individual's condition as a substance dependence disorder. Applying the DSM-IV clinical significance criterion, it is not a disorder. (Spitzer and Wakefield 1999, 1861)

Spitzer and Wakefield give other examples of mental disorders that would not be diagnosed if one looks only at clinically significant distress and social functioning; among those are some of the paraphilias, Tourette's disorder, and sexual dysfunction (Spitzer and Wakefield 1999, 1860–1).

Others have expanded on Spitzer's and Wakefield's discussion by noting that the definition of mental disorder that relies on adjustment ("distress or impairment in functioning") is circular:

> Spitzer and Wakefield (1999) have been among the most prominent critics of the clinical significance criterion, dismissing its addition to DSM-IV as "strictly conceptual" (p. 1857) rather than empirical. The vagueness and subjectivity of the criterion terminology are considered particularly problematic and result in a circular definition: a disorder is defined by clinically significant distress or impairment, which is distress or impairment significant enough to be considered a disorder … Use of the clinical significance criterion does not coincide with the perspective of general medicine that distress or functional impairment is generally not required to make a diagnosis. Indeed, many asymptomatic conditions in general medicine are diagnosed based on knowledge of their profession or increased risk for a poor outcome (e.g., early malignancies or HIV infection, hypertension). To suggest that such disorders do not exist until they cause distress or disability would be unthinkable. (Narrow and Kuhl 2011, 152–3, 147–62)

Again, the quotation is in regard to DSM-IV, but the lack of "distress or impairment in social functioning" criterion is still being used to claim that homosexuality is not a mental disorder. Furthermore, as the quotation rightly acknowledges, a definition of mental disorder that relies on "distress or impairment in social functioning" as a criteria is circular. Circular definitions are failures in reasoning, and they are meaningless. The definition of "mental disorder" on which the American Psychiatric Association and the APA base their homosexuality-is-normal claim relies on the "distress or social impairment criterion." So, the homosexuality-is-not-a-mental-disorder claim is based on a meaningless (and outdated) definition.

Dr. Irving Bieber, "one of the key participants in the historic debate which culminated in the 1973 decision to remove homosexuality from the psychiatric manual" (NARTH Institute n.d.) recognized the same error in reasoning (The same thesis was addressed by Socarides (1995, 165); cited below). He identified the same problem with the American Psychiatric Association's criteria for sexual disorders. A summary of Bieber's article notes that

> The [American] Psychiatric Association pointed to the excellent occupational performance and good social adjustment of many homosexuals as evidence of the normalcy of homosexuality. But such factors do not, Dr. Bieber countered, exclude the presence of psychopathology. Psychopathology is not always accompanied by adjustment problems; therefore, the criteria are in reality, inadequate to identify a psychological disorder. (NARTH Institute n.d.)

Robert L. Spitzer, a psychiatrist involved with removing the disordered label from homosexuality, quickly recognized the irrelevance of "adjustment" in diagnosing psychiatric disorders. Ronald Bayer summarized the events surrounding the American Psychiatric Association's (1973) decision by noting that Spitzer's

> restricted definition of mental disorders, articulated after he had decided that homosexuality had been inappropriately classified, entailed two elements: For a behavior to be termed a psychiatric disorder, it had to be regularly accompanied by subjective distress and/or "some generalized impairment in social effectiveness or functioning." With the exception of homosexuality and some of the other sexual deviations, Spitzer argued, all other entries in DSM-II conformed to this definition of disorder. (Bayer 1981, 127)

Yet, as Bayer notes, "within a year even he [Spitzer] was to recognize" the inadequacy of the conceptual basis of his own conclusion (Bayer 1981, 133). In other words, Spitzer recognized the irrelevance of "distress," "social functioning," or "adjustment" in regards to the definition of mental disorder, as his paper cited previously (Spitzer and Wakefield 1999) acknowledged at length.

It is evident, then, that at least some official DSM mental disorders and other non-official DSM-5 mental disorders do not result in problems with "adjustment" or social functioning. Those who cut themselves with razor blades for pleasure and those who have an intense sexual interest in and fantasize sexually about children are clearly not mentally normal; anorexics and those who persistently eat plastic are officially considered to be mentally disordered by DSM-5, and those with delusional disorder are also officially considered to have a mental disorder. Yet, many of those appear normal and "experience no distress or impairment in functioning." In other words, many people who are not mentally normal can function

in society and do not show signs or symptoms of "mal-adjustment." Some mental disorders seem to have a latent period or "waxing and waning" periods marked by the ability to function in society and apparent normality.

Homosexually inclined people, those with delusional disorder, pedophiles, self-injurers, plastic eaters, and anorexics can all function in society (again, at least for a certain time period) and may not always show signs of "maladjustment." Psychological adjustment, then, is irrelevant to some mental disorders; that is, research studies that look at measures of "adjustment" as an endpoint are inadequate to determine the normalcy of psychological thought processes and their associated behaviors. Hence, *the (outdated) studies that used psychological adjustment as their endpoints are deficient; they are not sufficient to prove that homosexuality is not a mental disorder*. It follows, then, that the APA's and the American Psychiatric Association's claim that homosexuality is not a mental disorder is not supported by the evidence they cite. The evidence they cite is irrelevant to their conclusion. It is an absurd conclusion arrived at from an irrelevant premise. (In addition to the conclusion not following from the premise, Gonsiorek's claim that there is no difference between homosexuals and heterosexuals in measures of depression and self-esteem also happens to be false in itself. Homosexually inclined people have been shown to be at higher risk of major depression, anxiety, and suicidality than heterosexuals (Bailey 1999; Collingwood 2013; Fergusson et al. 1999; Herrell et al. 1999; Phelan et al. 2009; Sandfort et al. 2001); those statistics are often used to conclude that discrimination harms homosexuals, but it is another conclusion that does not necessarily follow from the premise. Common sense informs the inquirer that depression, anxiety, and other negative emotional effects may result in conflict any time someone is told that their behavior or habit is abnormal or unhealthy. In other words, one cannot necessarily conclude that the depression etc. results from stigma. That has to be scientifically demonstrated. It may be that both are true: the depression, etc. are pathological and individuals who are homosexual are not seen as normal, which in turn adds to the individual's distress.)

"Adjustment" and Sexual Disorders

Here I will need to go on a bit of a tangent and discuss the implications of looking only at "adjustment" measures and social functioning to determine whether sexual behaviors and their associated thought processes are mentally disordered. Basically, looking at adjustment measurements is both arbitrary and irrelevant to all psychosexual disorders. One should ask, why do the APA and American Psychiatric Association solely look at "adjustment" and social functioning measures in some mental disorders but not in others? For instance, why do they not look at other aspects of the paraphilias (sexual perversions) that clearly indicate their mental disorder liness? Why is a person who stimulates himself and masturbates to the point of orgasm while fantasizing about causing psychological or physical suffering in another person (a sexual sadist) not mentally disordered, yet those with delusional disorder are considered mentally disordered? There are individuals who believe that there is an infestation of insects on or in the skin, when the evidence clearly shows they are not infested with insects; those individuals are diagnosed with delusional disorder. On the other hand, there are men who believe that they are actually women, there is evidence that clearly indicates the contrary,

and yet those men are not diagnosed with delusional disorder.

Individuals with other sexual disorders have shown similar measurements of adjustment as homosexuals. Exhibitionists, also known as "exposers," are those individuals who have intense urges to expose their genitals to unsuspecting people in order to sexually arouse the exposer (the sexual arousal they seek is personal, that is, in themselves, not necessarily in the unsuspecting person) (American Psychiatric Association 2013, 689). One source notes that

> One-half to two-thirds of exposers are married, although marital and sexual adjustment is marginal. Intelligence, educational level, and vocational interests do not differentiate them from the general population … Blair and Lanyon stated that most studies were consistent in reporting that exhibitionists suffered from inferiority feelings and were viewed as timid and unassertive, socially inept, and had problems expressing hostility. *Other studies, however, have found that exposers are unremarkable in terms of personality functioning.* (Adams et al. 2004, emphasis added)

The finding that those with "deviant" sexual attractions can function in society is also observed in homosexual and heterosexual sadomasochists. Sexual sadism, as I mentioned previously, is "intense sexual arousal from the physical or psychological suffering of another person, as manifested by fantasies, urges, or behaviors" (American Psychiatric Association 2013, 695); sexual masochism is "recurrent and intense sexual arousal from the act of being humiliated, beaten, bound, or otherwise made to suffer, as manifested by fantasies, urges or behaviors" (American Psychiatric Association 2013, 694). Sadomasochists in Finland were studied and were noted to be "socially well-adjusted" (Sandnabba et al. 1999, 273); the authors noted that 61.0 percent of sadomasochists studied "had leading positions at work, while 60.6 percent had [sic] different forms of service in the community, such as being a member of the local school board" (Sandnabba et al. 1999, 275). So, both sadomasochists and exposers apparently do not necessarily exhibit problems with social functioning or distress (again, terms which have been included under the umbrella term "adjustment").

Some have noted that the "defining features" of all of the sexual perversions or sexual deviances (also known as the paraphilias) "may be limited to the individual's sexual behavior and causes minimal impairment in other areas of functioning" (Adams et al. 2004). Furthermore, they suggest that

> There are currently no universal and objective criteria for evaluating the adaptive value of sexual attitudes and practices. Outside of sexual homicide, no sexual behavior is universally deemed dysfunctional … The rationale for excluding homosexuality from the category of sexual deviation category was apparently the lack of evidence that homosexuality per se is a harmful dysfunction. Curiously, the same line of reasoning has not been applied to other "disorders" such as fetishism and consensual sadomasochism. We agree with Laws and O'Donohue that such conditions are not inherently harmful and their inclusion in this category reflects an inconsistency in classification. (Adams et al. 2004)

Hence, they propose that the only sexual behavior that is "universally deemed dysfunctional" (and therefore universally considered to be a mental disorder) is sexual homicide. The conclusion is arrived at by implying that any sexual behavior and associated thought processes that do not cause impairment in social functioning or measures of "adjustment" is not a sexual disorder. As I have explained up to this point, that premise is an error, and it leads

to an erroneous conclusion. What is evident is not that all sexual deviances are normal, but rather that those in psychiatry and psychology have misled society by citing irrelevant measurements as evidence that a condition is normal. (I am not claiming they intentionally misled. Honest errors may have been made.)

The catastrophic consequences of solely looking at irrelevant endpoints ("adjustment" and social functioning) when attempting to determine whether a sexual desire is mentally disordered or normal is further observed by appealing to DSM-5's discussions on sexual sadism and pedophilia. The American Psychiatric Association no longer considers sexually sadistic behavior itself as mentally disordered. The American Psychiatric Association writes:

> Individuals who openly acknowledge intense sexual interest in the physical or psychological suffering of others are referred to as "admitting individuals." If these individuals also report psychosocial difficulties because of their sexual attractions or preferences for the physical or psychological suffering of another individual, they may be diagnosed with sexual sadism disorder. In contrast, if admitting individuals declare no distress, exemplified by anxiety, obsessions, guilt, or shame, about these paraphilic impulses, and are not hampered by them in pursuing other goals, and their self-reported, psychiatric, or legal histories indicate that they do not act on them, then they should be ascertained as having sadistic sexual interest but they would *not* meet criteria for sexual sadism disorder. (American Psychiatric Association 2013, 696, original emphasis)

Hence, the American Psychiatric Association does not consider the "sexual attractions for physical or psychological suffering" of another person to be a mental disorder in itself; *that is, sexual attractions and fantasies occur in the form of thoughts, and the thoughts of a person who thinks about physically and psychologically abusing another person to stimulate themselves to orgasm are not considered to be mentally disordered by the American Psychiatric Association*.

It should be noted that the American Psychiatric Association does not consider pedophilia in itself as a mental disorder either. After discussing the ways that a pedophile could disclose "intense sexual interest in children," they write:

> If individuals also complain that their sexual attractions or preferences for children are causing psychosocial difficulties, they may be diagnosed with pedophilic disorder. However, if they report an absence of feelings of guilt, shame, or anxiety about these impulses and are not functionally limited by their paraphilic impulses (according to self-report, objective assessment, or both), and their self-reported and legally recorded histories indicate that they have never acted on their impulses, then these individuals have a pedophilic sexual orientation but not pedophilic disorder. (American Psychiatric Association 2013, 698)

Again, sexual fantasies and "intense sexual attractions" occur in the form of thought, so a 54-year-old man who has "an intense sexual interest" in children thinks repetitively about children in order to stimulate himself to orgasm. That person's thoughts, according to the American Psychiatric Association, are not disordered. Irving Bieber made this same observation in the 1980s, as is noted in a summary of his work:

> Is the happy and otherwise well-functioning pedophile "normal"? As Dr. Bieber argues … psychopathology can be ego-syntonic and not cause distress; and social effectiveness—that is, the ability to maintain positive social relations and perform work effectively—"may coexist with psychopathology, in some cases even

> of a psychotic order." (NARTH Institute n.d.)

It is alarming that a sadistic or pedophilic fantasy could be considered *not* to meet the criteria for a mental disorder. Michael Woodworth et al. note that

> Sexual fantasy has been defined as almost any mental imagery that is sexually arousing or erotic to the individual. The content of sexual fantasies varies greatly between individuals and is thought to be highly dependent on internal and external stimuli, such as what individuals see, hear, and directly experience. (Woodworth et al. 2013, 145)

Sexual fantasies are images or thoughts in the mind, they result in "arousal," and it is not a stretch to say that those fantasies are used to stimulate orgasm during masturbation. The content of sexual fantasies depends on what individuals see, hear, and directly experience. So, it is also not a stretch to claim that a pedophile with young neighbor children has sexual fantasies of those neighbors; it is also not a stretch to claim that a sexual sadist fantasizes about causing psychological or physical suffering in his or her neighbor. Yet, if the sexual sadist or the pedophile do not experience distress or impairment of social functioning (again, those terms are included under the umbrella term "adjustment") or if they do not harm another person, then they are not considered to be mentally disordered. The sexual *images or thoughts* about a 10-year-old in the mind of the 54-year-old pedophile or the images or thoughts of a sexual sadist fantasizing about causing psychological or physical suffering in his neighbor are not disordered unless they cause distress, impairment in social functioning, or harm of another person.

That is arbitrary, and it is an absurd conclusion arrived at from the erroneous premise that any thought process that does not cause maladjustment is not a mental disorder.

One will see that the APA and the American Psychiatric Association have dug themselves a deep hole with their assessment of sexual disorders. It seems that they have already normalized sexual deviances as long as there is "consent" of those individuals involved in the actions. In order to be consistent with their logic used to normalize homosexuality, they must normalize all other sexual actions that stimulate one to the point of orgasm that do not cause bad measurements of "adjustment" or result in impaired social functioning; it is true that they also allow a diagnosis of a sexual disorder if a deviance causes "harm" to another, but that is only if there is lack of consent. Sadomasochism is basically stimulating oneself or another to orgasm by harming someone or by being harmed by someone, and as I discussed previously, this is considered to be normal by the American Psychiatric Association.

Some might call this paper a "slippery slope" argument, but that is an incorrect assessment of what I have proposed; the American Psychiatric Association has already normalized all orgasm-stimulating behaviors except those that cause "adjustment" problems (distress, etc.), problems in social functioning, or harm or risk of harm to another person. The last part—"harm or risk of harm"—needs an asterisk because there are exceptions to that criterion; if there is consent, then an orgasm-stimulating behavior that results in harm is permitted, which is evident in the normalization of sadomasochism (This explains why there is a push by pedophiles to claim that young children are able to consent to pedophilia (LaBarbera 2011); they do not want to be considered to be mentally disordered either.). Hence, an accusation that this paper proposes a

slippery-slope argument would be off-base; those mental disorders have already been normalized by the American Psychiatric Association. It should be alarming that the authority on mental illness has normalized any orgasm-causing behavior to which one consents; that normalization is a result of the erroneous premise that "any orgasm-stimulating behavior and its associated mental processes that does not result in problems with adjustment or social functioning is not a mental disorder." That is deficient reasoning.

While another paper would be required to thoroughly explain criteria for determining what constitutes a mental and sexual disorder, I will attempt to propose briefly some criteria. It has been shown, up to this point, that mainstream psychology and psychiatry have arbitrarily determined that any and every sexual behavior (except sexual homicide) is not a mental disorder. I have already alluded to the concept that many mental disorders involve physically disordered uses of the body—xenomalia, self-mutilation, pica, and anorexia nervosa. Other mental disorders could be mentioned here as well.

Physical disorders are often diagnosed by measuring the functioning of bodily organs or systems. A physician or other practitioner would be negligent or ignorant to claim that there is no such thing as proper functioning of the heart, lungs, eyes, ears, or other organ systems of the body. Physical disorders are somewhat easier to diagnose than mental disorders because of available objective measurements such as blood pressure, heart rate, and respiratory rate that can be used to determine the health or disorder of certain organs and organ systems. So, in the field of medicine, a foundational principle is that there are proper functions of bodily organs. That foundational principle has to be acknowledged by practitioners, otherwise they have nothing upon which to base their claims (they would be reduced to Alfred Kinsey-like medicine—every organ of the body would simply have a normal continuum of functioning).

An (arbitrary) exception to the foundational principle of medicine is in regards to the orgasm-causing organs; many have arbitrarily, it seems, ignored the reality that the sex organs also have proper physical functioning.

The mental orderliness of a sexual behavior could be (at least in part) determined from the physical orderliness of the sexual behavior. So, in regard to men who have sex with men, *the physical trauma caused by penile-anal intercourse is a physical disorder; penile-anal intercourse almost always results in a physically disordered state in the anorectal area (and possibly the penile area of the inserter as well)*:

> The optimal state of health of the anus requires the integrity of the skin, which acts as the primary protection against invasive pathogens … Failure of the mucous complex to protect the rectum is seen in various diseases contracted through anal intercourse. *The act of intercourse abrades the mucous lining* and delivers pathogens directly to the crypt and columnar cells allowing for easy entry … *The mechanics of anoreceptive intercourse, as compared to vaginal intercourse, almost demands denuding of the protecting cellular and mucous protection of the anus and rectum*. (Whitlow et al. 2011, 295–6, emphasis added)

It seems that the information in the previous paragraph is established as a solid scientific fact; it seems that a researcher, practitioner, psychiatrist, or psychologist would have to be ignorant or negligent to deny that fact.

So, one sign or indicator of whether a sexual behavior is normal or disordered could be whether or not it physically harms one or both people. It seems to be

clear that penile-anal intercourse is physically disordered and it causes physical harm as well. Since many men who have sex with men desire to perform those physically disordered actions, it seems to follow that the desire to engage in such actions is disordered. Since desires occur at the "mental" or "thought" level, it follows that such male homosexual desires are mentally disordered.

Furthermore, the body has within it various types of fluids. Those fluids are "physical," and they have proper physical functions (again, that is simply a reality of medicine or health—the fluids in the human body have proper functions). Saliva, plasma, interstitial fluids, and tears all have proper functions. For example, one proper function of plasma is to transport blood cells and nutrients to other parts of the body.

Semen is a male bodily fluid, and hence (unless one arbitrarily applies one's own rules to the field of medicine) semen has a proper physical function (or multiple proper functions) as well. Semen typically has within it many cells, known as spermatozoa, and those cells have a proper location to be transported to—the cervical area of the woman. A physically ordered sexual act of a male, then, would be one in which the semen physically functions properly. Hence, another criteria for a normal or "ordered" sexual behavior is one in which the semen functions properly by delivering spermatozoa to the female's cervical area. (Some might counter that some men experience azoospermia/aspermia, or lack of measurable sperm in semen; they might conclude, then, that the healthy or proper function of semen is not delivering spermatozoa to the cervical area of the woman, or they might suggest that, according to my argument, aspermic individuals can place their ejaculate wherever they wish. Azoospermia/aspermia is an exception to the norm and a result of either "profound impairment of sperm formation (spermatogenesis) due to damage to the testes … or—more commonly—to obstruction of the genital tract (e.g., resulting from vasectomy, gonorrhoea, or *Chlamydia* infection)" (Martin 2010, 68, s.v. azoospermia). Healthy males produce spermatozoa, whereas medical impairments may result in no measurable spermatozoa in semen. If there are objective normal functions of body parts, then the malfunctioning or absence of one body part does not necessarily result in normal change in function of another body part. Such a claim would be similar to claiming that healthy or normal plasma does not function to deliver red blood cells to the body because some people are anemic.)

It is also very evident that the body has a "pleasure and pain" system (which could also possibly be called "reward and punishment system"). That pleasure-and-pain system, like all other body systems, has a proper function; its basic function is to act as a signal sender to the body. The pleasure-and-pain system communicates to the body what is "good" verses what is "bad" for the body. The pleasure-and-pain system, in a way, regulates human behavior; eating, excreting urinary and fecal waste, and sleeping are common human behaviors which involve a degree or type of pleasure as a motivator or reinforcer. Pain, on the other hand, is either an indicator of a physically bad human behavior or a disordered bodily organ; the pain associated with touching a hot stove should steer one away from that behavior, while painful urination often indicates a problem with a bodily organ.

A person with "congenital insensitivity to pain with anhidrosis (CIPA)" cannot feel pain, and hence, it is said that the pain system (using broad, non-medical terms) is disordered. It does not send the

proper signals to the mind to assist in one's bodily actions. The pleasure system can also be disordered, and this is observed in individuals with "ageusia" who cannot taste food.

Now, orgasm is a special type of pleasure. It has been compared to the drug-like high experienced by those who use opiates like heroine (Pfaus 2009, 1517). Orgasm, though, occurs normally in human beings who have properly functioning sex organs. Some (apparently including the American Psychiatric Association) have taken the stance that orgasm is a type of pleasure that is good in and of itself regardless of the circumstances surrounding the orgasm. Again, another paper is needed to show the flaws in that argument, but basically, if those in the field of medicine are to be consistent (and non-arbitrary), it seems that they would have to acknowledge that the pleasure associated with orgasm serves as a signal or a communication to the body that something good occurred (it also would have to be argued that orgasm occur in marriage, which again, requires another paper). That "something good" associated with orgasm is the stimulation of the penis to the point of releasing the semen near the cervix. Any other type of orgasmic stimulation (like any type of masturbation—whether it is self-stimulation, same-sex, or opposite-sex masturbation) would be an abuse of the pleasure system.

The abuse of the pleasure system that occurs during masturbation (and in all same-sex orgasm-stimulating actions) can be better understood by referring to other bodily pleasures. If one could press a button that caused the "full" or "satiety" feeling associated with eating, one would be abusing the pleasure system; the pleasure system would be sending a "false-reading" or an incorrect signal to the rest of the body. The pleasure system would be "lying" to the body in a sense. If the body felt the pleasure associated with a full-night's rest but had not actually rested at all, or the pleasure of urination or defecation without actually urinating or defecating, eventually the body would suffer significant ill-health.

Thus, another criterion for determining whether a sexual behavior is normal or disordered is whether the sexual behavior causes a malfunctioning of the pleasure or pain systems in the body.

Finally, it should go without saying that consent (and therefore appropriate age-of-consent) is a criterion that should be involved with determining healthy versus mentally disordered "sexual orientations."

Conclusion

The American Psychiatric Association and the APA provide the aforementioned studies as the scientific evidence that homosexuality is a normal variant of human sexual orientation. The APA noted that homosexuality per se implies no impairment in judgment, stability, reliability, or general social and vocational capabilities. Further, the APA urges all mental health professionals to take the lead in removing the stigma of mental illness that has long been associated with homosexual orientations (Glassgold et al. 2009, 23–24).

The Amici Curiae Brief reiterates the same claim, and it supports the claim by citing the aforementioned literature which looked at "adjustment" and social functioning (Brief of Amici Curiae 2003, 11). As has been shown, though, adjustment and social functioning are irrelevant to determining whether the sexual deviations are mental disorders. As a result, the scientific studies that only looked at measures of adjustment and social functioning draw erroneous conclusions and result in "false negatives" as Spitzer,

Wakefield, Bieber, and others have noted. Unfortunately, fatally flawed reasoning has served as the basis for "rigorous" and "scientific evidence" supporting the claim that homosexuality is not a mental disorder but is rather a normal variant of human sexual orientation.

One cannot conclude (with Alfred Kinsey) that a human behavior is normal simply because it is more common than previously assumed—otherwise all human behaviors, including serial killing, would have to be considered normal. One cannot conclude (with C.S. Ford and Frank A. Beach) that there is "nothing unnatural" about a behavior simply because it is observed in both humans and animals—otherwise cannibalism would have to be considered to be natural. Most importantly, One cannot conclude (with Evelyn Hooker, John C. Gonsiorek, the APA, the American Psychiatric Association, and others) that a mental condition is not disordered because it does not result in "maladjustment," distress, or impairment in social functioning—otherwise, many mental disorders would have to be labeled erroneously as normal. The conclusions arrived at in the cited literature are not supported by the premises proposed to be scientific fact; the faulty works cannot be considered credible sources.

It is always best to give others "the benefit of the doubt." Maybe the APA and the American Psychiatric Association accidentally made catastrophic logical mistakes in the literature they cite as evidence supporting the claim that homosexuality (and other sexual deviances) is not a mental disorder; that scenario is quite possible. Still, one should not be naïve and ignore the potential for powerful organizations to perform advocacy science. There are major inconsistencies in logic as well as arbitrary applications of certain principles by those upheld as "authoritative" in identifying and diagnosing mental disorders. The present summary and analysis in this paper of the literature put forth as "rigorous" and "significant" empirical evidence uncovers major deficiencies—irrelevant, outdated, and absurd literature—and calls into question the credibility of the APA and the American Psychiatric Association's discussion and identification of sexual disorders. Indeed, suspect anecdotes and antiquated data have been used in the debates surrounding homosexuality, but the evidence shows that even the authoritative sources on mental disorders are guilty of those charges.

Notes

1. The *Diagnostic and Statistical Manual*, 5th edition, does not consider body identity integrity disorder to be a disorder; the DSM-5 writes: "Body identity integrity disorder (apotemnophilia) (which is not a DSM-5 disorder) involves a desire to have a limb amputated to correct an experience of mismatch between a person's sense of body identity and his or her actual anatomy." See American Psychiatric Association (2014b, 246-7).
2. Thanks to an anonymous reviewer for this suggestion.

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