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The relationship of homosexuality to sexual deviations such as fetishism, sadomasochism, voyeurism, bestiality, and incest can be mentioned only in passing. A closer tie exists between homosexuality and pedophilia, transvestitism, transsexualism, paranoid schizophrenia and the less spectacular inability to enter and sustain a loving relationship than with the preceding syndromes. These latter syndromes will be mentioned somewhat less briefly. Our discussion will center on five related concepts: (1) normal and healthy sexuality; (2) the range of deviancy from the norm; (3) deviant sex behavior associated with disease; (4) the question of deviant sex behavior with psychic health; (5) the cause of these variations; and (6) treatment if any.

Karoly Maria Benkert[1] writing under the name Kertbenny in 1851 coined the term "homosexual." "In addition to the normal sexual urge in man and woman, nature, in her sovereign mood, has endowed at birth certain male and female individuals with the homosexual urge, thus placing them in a sexual bondage which renders them physically and psychically incapable—even with the best intention—of normal erection. This urge creates in advance a direct horror of the opposite sex, and the victim of this passion finds it impossible to suppress the feeling which individuals of his own sex exercise upon him." (Section 143 des Preuszischen Strafgesetzbuches vom 14. April 1851 und seine Aufrechterhaltung)

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Karl Heinrich Ulrichs, defending homosexuality in 1864 and 1870, spoke of these instincts as inborn. The medical community accepted that homosexuality was inborn but pathological. Sex itself was dangerous and those with "perverted" sex instincts were sick. Karl Westphal, in 1869, coined the term "contrary sexual feeling" to describe a homosexual transvestite as resulting from hereditary moral insanity. Moreau, in 1887, argued for therapy rather than punishment, a matter for physicians not magistrates. In general non-procreative sex (Krafft-Ebing) was seen as disease. Not until mid 20th century was contraception seen as non-pathological.

Homosexuality Described

Kinsey devised a rating scale for homosexuals because in his surveys, he found some persons who were exclusively homosexual, some equally hetero and homosexual and some only occasionally homosexual. Freud had earlier introduced the concept of the facultative (or situational, as in prison) homosexual, who becomes exclusively heterosexual on return to normal society and the obligatory homosexual who does not enjoy the opposite sex. Alex Comfort more recently in *Joy of Sex* speaks favorably of deviations as gourmet sex as long as these are not the exclusive means of obtaining sexual gratification. I interpret that Kinsey, Freud, and Comfort would consider a person who is repelled by the conventional sex act and partner as having a less than optimal adjustment.

Summarizing and excerpting from Bieber[2] in the *Comprehensive Textbook of Psychiatry 1967*. Normality and deviance are statistical concepts. Monogamous love relationships in marriage may be statistically deviant in our society yet they are hardly pathological. The cultural relativists reason that if social attitudes toward homosexuality were as accepting as they are toward heterosexuality, inversion would not be pathological. This point of view contrasts sharply . . . that health . . . must be assessed in relation to optimal individual and group development and continuity not on the basis of conformity to a cultural norm.

Contemporary analysts contend that pre-genital sex, that is oral, anal and purely phallic sex, contain elements of aggression. It is the aggression that they find inconsistent with love and genital maturity.

Bieber believed of healthy sexuality, that the couple should be capable of a sustained emotional contact, have mutual respect, pride, interests . . . respect each other's integrity, individuality—have realistic expectation of each other . . . sexuality should be enthusiastically enjoyed. Both should wish for children and have the psychological ability to implement such wishes—that is, if children ensue, they should have the capacity to relate lovingly,

understandingly, responsively to the individual differences of each child. There is a need for racial continuity in a setting for optimal psychic growth as a part of "Healthy Sexuality."[3] I see Bieber pointing out a useful direction but not an absolutely obtainable goal. The striving is of itself important, though the goal may be illusive.

Alex Comfort[4] and Mary Calderone[5] speak of the three "R's" of sex: Recreation, Relationship and Reproduction. I am of the opinion that the reproduction lends a quality and stability to the sexual relationship—a quality not often to be found without it. Perhaps it does not hurt society directly when consenting individuals engage in non-reproductive sex, as much as when the non-prepared couples reproduce, but I do think these childless individuals are shortchanged in their development. It may be desirable to separate the three "R's" conceptually, but the integration of the three I see as more fulfilling.

Clinical observation of the frequent connection of sexual deviation with disease states has reinforced the notion that sexual deviation in itself is pathological. For example, amentia has been associated with pedophilia, mania with transvestitism and paranoid schizophrenia with homosexuality. It ought be said that each may not necessarily be associated with the other. These sexual manifestations are seen independently of the disease state. We must be cautious in associating deviant sex practices with insanity. Physicians elicit a history of masturbation with our emotionally disturbed patients about as often as we do in the general public.

Sexual Deviation in the Presence of Psychic Health

Let us consider the question, may sexual deviations occur in the presence of psychic health? Occasional deviations may occur without impairing the normal psyche. If, however, we speak of obligatory behavior, where the only source of sexual gratification is from the behavioral deviation, it limits one's options. One thing is obvious: the homosexuals will have fewer partners to choose from than the heterosexuals. They seem obliged to move to the larger city for partners. There are of course lesbian mothers, some living in communes for the support most of us require of our extended families. Raising children, particularly male children, in a homosexual setting presents serious problems and such was my observation of one lesbian commune. Child development studies indicate a need for acceptance from both parents. The loving presence of the opposite sex parent or parent surrogate is necessary in order to achieve a comfortable sense of sexual identity.

Certainly, society's reaction to such behavior adds to the distress of the homosexual. Much of the pain, in the sample that we psychiatrists see, is intra-psychic—

that is within the individual, not just between individuals or the individual and society. The intrapsychic pain is an inner discontent that disrupts the individual's functioning with himself foremost, and then with others. From here I will pass on to some current explanations of homosexuality.

Explanations of Homosexuality

1. Deviant but healthy concept —that homosexuality is simply a statistical concept and only considered pathological in specific societies having taboos against it.

2. Homosexuality is caused by a sexual curiosity, experimental acts, and seduction. These are not considered likely or sufficient cause.

3. Homosexuality is genetic or chromosomal—this is not well supported but may be a contributing factor.

4. The prenatal influence of stress as cited by Money in the N.I.M.H. article.[6] This also may be a contributing factor in some cases.

5. Bieber—Experiential Theory where a seductive mother and underactive father give rise to castration anxiety in the male and homosexual choice. Actually there are several patterns and Bieber seems to describe a limited sample.

6. Freud—dual genetic and psychic-polymorphous perverse theory. Probably the most consistent and workable theory.

Freud's theories of homosexuality were further elaborated by Melanie Klein, Sullivan, Horney, Thompson, Rado and others. (For a brief review see *Comprehensive Textbook of Psychiatry*—Bieber's article and NIMH article.)

From this multiplicity of explanations which attempt to clarify an amazing variety of life styles, it can be assumed that no one concept is likely to be totally adequate. From experience, the most workable theory for the select group of male homosexuals seeking change is the (perhaps simplistic) psycho-analytic concept of castration anxiety. For the female, whose life styles are even more varied, the psycho-analytic concept of penis envy seems even more simplistic. With psychoanalysis 75%-66% of the motivated male homosexuals fail to achieve a satisfactory heterosexual adjustment. I cannot say what percent of these failures are due to the patient not fitting the theory. This would seem an area worthy of research.

Treatment

Before one can speak of treatment, it is necessary to evaluate the patient. I do not think it ethical to search out cases and treat people who are functional and comfortable. Of those who are not functional, the problem must be defined as intra-psychic or inter-psychic. The intra-psychic group responds well to psychotherapy and analysis. The inter-psychic group responds to counseling, role modeling, psychodrama, etc. If the problem is one of sex role confusion as in schizophrenic illness,

the schizophrenia assumes priority and the treatment is for the schizophrenia. With alleviation of the schizophrenia the homosexual behavior frequently disappears. If the problem is the result of situational stress, the treatment may range from simple reassurance to long term therapy, depending on the character and strengths of the person involved. Behavior modification or operant conditioning may change the behavior without improving the feeling tone around this change. Stated another way, if the role assigned by society is not consistent with the subject's intrinsic life style, it may be an assault to his psyche. An example of this is when people are socially conditioned to have children. A significant number of these hate the role and make poor or indifferent parents. Still others are made miserable by not being able to have children after the conditioning.

The choice of intervention or treatment calls for skillful assessment of each case of homosexuality. It is most important that we have the integrity to decide that no treatment may be the best treatment. This decision is most likely to come from those professionals among us who take seriously the Hippocratic Oath.

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Dr. John R. Cavanagh (2nd from left) was the recipient of the Thomas Linacre Award for authoring the best paper in the Linacre Quarterly during 1975 *(Bene Mori: The Right of the Patient to Die with Dignity*, Aug., 1975). The award was presented at the NFCPG annual meeting in Oakbrook, Ill., by Dr. John P. Mullooly (far right), editor of the Linacre Quarterly. Looking on are Dr. Herb Ratner (left), incoming president of the Federation, and Dr. Edward Kilroy, the outgoing president.

Progress in Medical Ethics: How the Physician Can Help

Edwin L. Lisson, S.J., S.T.D.

Father Lisson, of the Texas Institute of Religion, suggests areas where greater cooperation between physicians and ethicists will result in mutual awareness and understanding.

Looking for a good specialist in medical ethics? With the number of medical-moral questions reaching the news media and with increasing demands from medical students for medical-moral seminars and "Ethical Rounds," many institutions are scrambling to come up with an expert in medical ethics.

But who would this rare creature be? If a physician with the personality and impeccable competence of Marcus Welby also held a degree in Moral Theology from the Gregorian in Rome or a degree in Christian Ethics from Harvard, perhaps he would fill the bill. But living, and practicing, in the real world where the demands of being merely competent in either medicine or ethics becomes virtually impossible, the quest for one individual equally competent in both fields may have to be abandoned. Professor K. Danner Clouser accurately and realistically describes this necessary compromise in medical ethics when he asks for a constant and focused interchange which calls for medical people to become familiar with the basics of ethical theory, just as ethicists specializing in medical-moral questions must become familiar with some of the facts of medicine.[1]

The Problems

The root of the problem in finding the ideal medical ethicist lies primarily in the expanding scope of the number and complexity of the questions involved together with the depth of knowledge and skills required of either a physician or an ethicist to remain basically competent, if not up to date.

There is no need here to comment on the complexities of the physician's problems. However, the physician may not be aware that the problems facing the ethicist are expanding in not just one but in two dimensions at the same time. On what might be called a horizontal plane, on the level of concrete practical problems, the number and complexity of the questions confronting the ethicist are becoming virtually overwhelming. At the same time, the ethicist confronts another