Narratives of those who were labeled mentally ill due to sexual orientation

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LOCKED UP FOR LOVE:

Narratives of those who were labeled mentally ill due to sexual orientation

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Homosexuals, like heterosexuals, should be treated as individual human beings, not as a special group either by Law or social agencies or employers... The sexual behavior of individual adults by mutual consent in private should not be a matter of public concern. Some homosexuals, like some heterosexuals, are ill... Probably for a majority of adults, their sexual orientation constitutes only one component of a much more complicated lifestyle... If everybody understood and followed it, we’d have very few problems...

--Joel Fort (Gay and Lesbian Historical Society, 1997)
ABSTRACT

Prior to the printing of the third edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-III) in 1980, mental health practitioners who treated homosexual clients were encouraged by the American Psychiatric Association to define these individuals as mentally ill. The label of mental illness had lasting, damaging effects on many of the people who were categorized mentally ill because of their homosexual orientation. The purpose of this exploratory study was to examine the impact of being labeled mentally ill due to sexual orientation from the perspective of labeling and ecological theories. This researcher used a qualitative approach in seeking to understand more about the effects of being labeled mentally ill because of sexual orientation. The study showed that the ability to resist some of the damaging effects of the label was mediated by resiliency factors such as insight, independent thinking, social support, and a positive sense of themselves in order to resist the label of mental illness. This research may be helpful in framing questions and methods for further exploration of the impact of being labeled mentally ill based upon sexual orientation.
Introduction

Prior to the printing of the third edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-III) in 1980, mental health practitioners who treated clients of homosexual orientation were encouraged by the American Psychiatric Association to define these individuals as mentally ill. The diagnostic option was either “Psychopathic Personality with Pathological Sexuality” in the DSM-I, or “Sociopathic Personality Disturbance” in DSM-II (American Psychiatric Association, 1968). Some people claim that the highly political story behind the removal of homosexuality from DSM-III was “one of the most depressing narratives in the annals of modern medicine,” (Dannemeyer, 1989, p.24) but for those who lived their lives under the cloud of this label there was a sense relief at the instant “cure” (Caplan, 1995).

Though the mental health field has changed its view on homosexuality since the 1970s, it did not quell the debate that has raged for centuries about the way the larger society ought to interpret homosexuality. In 1972, just prior to the publication of the third edition of the DSM, gay and lesbian activists approached the American Psychiatric Association (APA) (Bayer, 1981; Kirk & Kutchins, 1992; Caplan, 1995) and indicated that they would no longer accept the labeling of their same-sex attraction as a mental illness. Approaching the issue of labeling as a political rather than a mental problem, they used political tactics, such as picketing as well as other means of protest, to attempt to remove the category of homosexuality from DSM-III.

Ronald Bayer’s book Homosexuality and American Psychiatry (1981) is widely cited in discussions of the process involved in the removal of homosexuality from the DSM-III. He suggests that “Psychiatry may...act upon society, using its cultural
influences to challenge social values and practices” (Bayer, 1981, p. 14). In 1973, the APA board voted unanimously to delete homosexuality per se from the DSM and to replace it with “Sexual Orientation Disturbance” (later changed to Ego-Dystonic Homosexuality), which stated that only those people who were markedly distressed by their sexual orientation were to be diagnosed mentally ill (Kirk & Kutchins, 1992). Many mental health professionals who did not have a vote in the decision disagreed with the change in nomenclature and they continued to view homosexuality as pathology in need of a cure.

The main justification for the removal of homosexuality from the DSM was that it did not fit under the psychiatric disorder characteristics of self-proclaimed distress and impairment in social functioning (Bayer, 1981). The chair of the board, Russell Monroe, exclaimed, “You don’t devise a nomenclature through a vote” (Bayer, 1981, p.130). Monroe still believed that the diagnosis of mental illness had transcended bias and stereotype. He was concerned that his profession, psychiatry, after working so hard for so long to be accepted as a medical science, had been dragged back into the arena of cultural politics.

The political battle to remove homosexuality from the DSM actually took three years, a convention, and several testimonies from gay men and lesbian women. Finally, the resolution appeared in the DSM-III as, “If one uses the criteria of distress or disability, homosexuality per se is not a mental illness. If one uses the criterion of inherent disadvantage, it is not at all clear that homosexuality is a disadvantage in all cultures or subcultures” (American Psychiatric Association, 1980, p.380).
Paula Caplan, a therapist who has written extensively in favor of eliminating the DSM as a basis for mental diagnosis, reported that gay men and lesbian women, "...Were poignantly glad whether because they believed at some level that the APA actually knew what was normal and what was not, or because they were simply relieved to have one official source of pathology removed, or some of both" (Caplan, 1995, p.180). As a result of the change in the DSM, mental health professionals and family members could no longer legitimately use the category "mentally ill" to classify gay men and lesbian women. Reaction from the gay and lesbian community was mixed; some gay men and lesbian women still saw themselves as "mentally ill," while others resisted this classification.

The purpose of this exploratory study was to examine the impact of being classified mentally ill due to sexual orientation from the perspective of labeling and ecological theories. It was expected that while the experience of being labeled mentally ill was damaging, some individuals would use resiliency techniques to combat societal sanctioning. It was further expected that the extent of damage done by being labeled mentally ill would be indicative of the level of resiliency and the stage of identity development of the gay man or lesbian woman.

**Theoretical Framework**

Ecological, labeling, and sexual identity development theories were used as the framework for this study. These theories help explain different aspects of what happens when people are labeled mentally ill simply on the basis of sexual orientation.
Ecological Theory

The broadest theory is ecological theory. Based in biology and applied to social work practice, this theory states that there is an interaction between the environment surrounding an individual and the individual’s experiences. Two of the main principles of the theory are interdependence and adaptation (Rapp, 1998).

Interdependence is the notion that a change to one part of the system will affect all parts of the system. For example, when a lesbian woman was “caught” by her parents with another woman, she might have been sent to therapy or committed to an institution. As a result, her family would be disgraced in the community. Thus, the perceived challenge to a smaller system, the family interaction, affects the larger system, the community interaction.

Adaptation is defined as the way people change to accommodate each other and the way the environment also adapts to fit the people. However, adaptation is not always life enhancing. There are times when the environment needs to change to accommodate the individual. Often gay and lesbian people adapted to their parents’ wishes to find a “cure” for their “ill” son/daughter. A gay man or lesbian woman may also employ certain adaptations, like remaining “in the closet” or marrying someone of the opposite sex. On the other hand, during the Stonewall rebellion, gay and lesbian individuals changed their public identities as a result of claiming their true sexual identity, as ecological theory would predict.

The Stonewall rebellion, a response to unfair treatment of gay men and lesbian women by the police in 1969, indicated to the larger society that gay and lesbian individuals would no longer be silenced. By demanding a change in the mental health
nomenclature, gay men and lesbian women began a shift in how they were viewed. When the environment accepts the change, adaptation of the larger society has been achieved. If the APA had not accepted the change, people who would have continued to be labeled mentally ill based upon their sexual orientation, creating an unhealthy environment. Germain and Gitterman (1980) explain the power of the environment in the following way:

> When it goes well, reciprocal adaptation supports the growth and development of people and elaborates the life-supporting qualities of the environment. When reciprocal adaptation falters, however, physical and social environments may be polluted... Social environments become polluted by poverty, discrimination, and stigma produced by man's social and cultural processes. (p.5)

According to Wolin and Wolin (1993), resiliency is the coping mechanism that enables people to thrive in a toxic environment given certain adaptations. They suggest that there are seven forms of resiliency: insight, independence, relationships, initiative, creativity, humor, and mortality. In the context of gay men and lesbian women labeled mentally ill due to sexual orientation, resiliency can serve as a buffer from damaging effects. For example, resiliency allowed activist Frank Kameny (Weltge, 1969) to rejoice, “It is a time to live your homosexuality fully, joyously, openly, and proudly, assured that morally, socially, physically, psychologically, and in every other way: Gay is good” (p.145). [Emphasis in original]. Kameny sought to validate homosexuality rather than allow greater society to contribute to his understanding of it.

Cooley (1922) suggested that society provides the mirrors through which people view themselves. Personal friendships and other relationships may serve as reflections that mediate an individual’s level of resiliency. When society maintains that gay and lesbian people are not mentally healthy as a result of their sexual orientation, the looking
glass theory predicts that gay or lesbian individuals would see a “dirty” or “sick” 
reflection of themselves. In order for those gay and lesbian individuals to change their 
perception of themselves in that mirror, a supportive person must hold the mirror. The 
positive reinforcement from the person holding the mirror can counterbalance the 
negative influences in an individual’s environment such as a hostile mental health 
system.

Labeling Theory

Whereas ecological theory provides a framework for reciprocal influence between 
the homosexual and society, labeling theory more clearly explains the costs of labeling 
gay men and lesbian women. Labeling theory provides the elements needed to understand 
discrimination and prejudice. Heterosexuality is the societal norm in the United States. 
Homosexual behavior and persons are, therefore, considered “deviant” and are labeled 
“abnormal.” This tendency to stigmatize certain non-majority attitudes, opinions, and 
behaviors can be explained by labeling theory.

In its simplest form, labeling theory asserts that a person who is defined as having 
an undesirable trait/lifestyle will eventually turn into a person with that particular 
trait/lifestyle (Tannenbaum, 1938), creating a self-fulfilling prophecy (Becker, 1973). 
The theory is persuasive, and over the past sixty years has attracted many followers 
(Lemert, 1951; Erikson, 1962; Goffman, 1963; Becker, 1963; Adam, 1978; Kitsuse, 
1962).

While some labels can be positive, often labels have negative consequences. 
The various strains of labeling theory attempt to help explain why people exhibit so-
called “deviant” and/or “abnormal” behavior (Longres, 1995). While social workers most
often operate from a strengths perspective, the mental health field created the DSM based on “abnormal” behavior. By having a diagnosis for deviance, mental health professionals could prescribe treatments to curb such behavior. Treatments could range from therapy to shock treatment. Plummer (1981) argues, “Labels are destructive devices—they restrict where other choices are possible, they control, and limit possible variety, they narrow human experimentation” (p.108). According to labeling theory, the labeling process conflicts with the goals of mental health professionals in that labeling is not considered helpful, but rather harmful to the people being labeled. Labeling theory has four foundational points (Lemert, 1951; Kitsuse, 1962; Erikson, 1962; Becker, 1963):

1. The original cause of deviance cannot be determined.
2. No one act is actually deviant.
3. Behavior only becomes deviant when someone determines and labels it as such.
4. Once the label has been put in place, it has lasting effects.

Labeling can begin at the onset of a perceived problem. Individuals who “rebel” against society even once may be labeled and categorized by persons in power, such as the authors of the DSM. The original rebellion is known as the “primary deviation” (Lemert, 1951). The continued deviant behavior is called “secondary deviation.” The secondary deviation is the event during which the individual’s identity changes from “normal” to “deviant.” Others begin to treat the individual based on his or her deviance, and the comments and reactions of others then mold the self-esteem of that individual.

According to labeling theory, virtually any behavior could become deviant. The people in power decide who is normal and who is not, and their decisions determine laws, sins, and diagnoses of mental illness. The cultural norms help to set standards for
exclusion of those who do not “fit.” Individuals may be labeled outcasts according to two circumstances:

a. If the person has, in some way, offended others (achieved)

b. If that person is born into a status that is not favorable to society (ascripted)

(Lemert, 1951)

For example, people who are considered criminals are tagged as such because of their actions, while Jews are born into their label.

Homosexuality can be looked at as achieved or ascribed, depending upon the biases of the “labeler.” A gay man or lesbian woman may choose a partner of the same sex, disrupting the “normal” sexual order of heterosexuality, and may be labeled deviant by members of society. Additionally, a gay man or lesbian woman who is born with an “abnormal” sexual orientation may also be labeled deviant. Whether nature or nurture is the cause, the acceptability of homosexuality continues to be debated.

The social stigma attached to homosexuality is difficult to escape (Troiden, 1988). This stigma influences how the gay/lesbian identity is formed, as well as how that particular identity is maintained in the presence of heterosexual people. Troiden claims part of developing a gay or lesbian identity is increasing acceptance of the gay or lesbian label in terms that apply to the specific individual.

The tendency for society to box its members into categories has often created damaging consequences for the individuals who are labeled. A label of “mentally ill” or even “homosexual” has consequences for the individual, the individual’s family, friends, career, and self-esteem. Labeled individuals often become victims of self-hate and guilt because of their “deviant” identity. The deviance is seen as a failure to be normal,
indicating to the individual that he or she may not be able to function normally at all (Gove, 1975).

*Sexual Identity Development*

Trolden (1988) suggests that gay men and lesbian women undergo four stages of development regarding their sexual identity: Sensitization, Identity Confusion, Identity Assumption, and Commitment. Identity development can be best understood as a continuum even though people can vacillate between stages depending upon the environment surrounding them. In the first stage, known as the Sensitization stage, young people receive messages from society about homosexual orientation. “Gender-inappropriate” activities are sanctioned; thus the individual learns anything other than a heterosexual orientation is “inappropriate.” The second stage, Identity Confusion, begins the formation of ownership for one’s sexual orientation. The confusion is brought upon by an internalization of the messages obtained in the Sensitization stage, including inaccurate information regarding homosexuality, and “altered perceptions of self” (Trolden, 1988, p.45).

Depending upon how the individual copes with that insecurity and the forms of resiliency used, he or she may enter into the Identity Assumption stage, where tolerance and acceptance of one’s sexual orientation begins to surface. Often, this tolerance comes after being in the presence of other gay men or lesbian women who have already identified themselves as such. When assuming the identity of a gay man or lesbian woman, the individual begins to practice a stigma management mechanism or a form of resiliency, which may include trying to pass as “straight.” Traditionally, a person who is “in the closet” would operate from this stage. Plummer (1981) asserts that, “Knowing
that one is gay is much more comforting than living with the precariousness of confused sexual identities” (p.108). The Assumption stage is a delicate one in that negative experiences in the gay community could cause the individual to regress in the level of identity development; therefore, this stage is highly determined by the environment surrounding the individual. The quality of interactions within the gay community is important (Troiden, 1988).

The final stage in identity formation is Commitment to the gay or lesbian identification. This commitment may include “coming out” in various forms, and varies depending on the individual’s circumstances. Depending upon the experiences of the individual, the stages of gay and lesbian identity can be repeated, skipped, or may run concurrently with one another (Troiden, 1988).

The dominant societal notion that homosexuality is a “deviant lifestyle” compels some gay men, lesbian women, and heterosexual people to accept it as such. Gay men and lesbian women who remain in the Identity Confusion stage are more likely to accept the deviant label and live shamed lives as sexual beings, by fulfilling others’ negative expectations of what homosexuals are like. By complying with others’ expectations, the individual views himself or herself through the looking glass of stereotypical messages. Labeling theory would suggest that the self-loathing would lead to further deviant behavior, thus creating a self-fulfilling prophecy (Becker, 1973). Gay men and lesbian women, then, might begin to live their lives as stereotypical reflections rather than as themselves. The label becomes a part of how both the individual, as well as society, views that stigmatized individual. In many cases, it may be the only characteristic other
people see (Schur, 1984). Consequently, the “person has experienced a profound and frequently irreversible socialization process” (Gove, 1975, p.7).

The feelings of shame and guilt associated with the development of homosexual identity may be less of an issue if mental health professionals were not so quick to label. Thomas Szasz (1970) has done extensive work on the damaging effects related to labeling people mentally ill, and has concluded that mental illness does not exist. Szasz maintains that mental health professionals prescribe how people should live, becoming “moral policemen.” The culture in which a person lives is highly influential regarding what is considered mental illness. Many people with major mental illness had acceptable roles in other cultures, possibly as clairvoyants (Szasz, 1970), whereas the American culture, eccentrics and odd-thinkers are more readily stigmatized. Similarly, in ancient Greek culture, sexual relations between two members of the same sex were common. However, in America, that same act often elicits the label of “sick.”

Because sexual identity is something that develops over time, the process of acknowledging one’s identity as a sexual being can be an arduous one. Mental health professionals who confirm the status of mental illness upon individuals who identify with a gay or lesbian sexual orientation make this process even more difficult.

**Research Questions**

The questions that guided this exploratory research focused upon the impact of the label of mental illness on gay men and lesbian women. Questions central to this study were:

1. How were people treated according to the label?
2. How did gay men and lesbian women respond to the label of mental illness associated with sexual orientation?

**Methodology**

This researcher used a qualitative, exploratory approach to assist in the understanding of the impact of labeling people mentally ill due to homosexual orientation. The generalizability of such a method is limited; however, the extent to which the label impacted gay men and lesbian women can be better identified through testimonies rather than quantitative data. The framework for this study ecological theory, labeling theory, and sexual identity development theory to examine the individual reactions of being labeled mentally ill based on sexual orientation.

The information for this research was collected through an extensive review of the literature in the WebPALS library system, as well as through a search at the Gay and Lesbian Historical Society of Northern California (GLHS), the nation’s most comprehensive source on gay and lesbian material. The GLHS maintains a comprehensive collection of narratives, letters, photographs, and newspaper clippings featuring gay men and lesbian women across the country. The majority of the archival interview narratives came from the Northern California area. Those that were utilized for this study provided information about the impact of being labeled mentally ill due to sexual orientation. The GLHS Oral History Project collections used for this research came from “Uncles (1989-1996),” “Go West Migration (1995-1998),” and “Shedding a Straight Jacket (1996-1999).”

“Uncles” is a collection of “Life history interviews with gay men who are at least 60 years of age, are retired, and have lived in San Francisco for more than fifteen years”
(Gay and Lesbian Historical Society, 1999). "Go West" is a "series of in-depth interviews conducted by Martin Meeker on the broad subject of gay and lesbian migration to San Francisco in the second half of the twentieth century" (Gay and Lesbian Historical Society, 1999). "Shedding A Straight Jacket" looks at a "wide gamut of individuals who were critical in loosening the confining social constructs that bound queer people of all stripes into the categories of the sick, sinful, and criminal" (Gay and Lesbian Historical Society, 1999).

The interviews from which the narratives came were completed between 1989 and 1998. For those persons who indicated their dates of birth, there was a range from 1921 to 1958. Out of over 150 transcribed interviews from the GLHS, the researcher chose 13 that touched on the issues of mental illness and homosexuality. These 13 spoke specifically about the label of mental illness. Though some of the accounts document only secondary experiences, the majority of interviews used in this piece are primary sources. The researcher had hoped to find more information regarding mental illness in these transcripts, and attributes the minimal number of responses to the following:

1. The interviewees were volunteers. They met with the interviewer on one or two occasions for the sole purpose of the interview. Delving into extremely personal material was likely to have been uncomfortable for the interviewee given the time constraints of the collection process.

2. The researcher only went through those narratives that were accessible to her. Several of the accounts in the collections were restricted, and could not be accessed by the general public until a future date. These restrictions may be a result of an individual's request in a will, or because an individual wished to
have only certain people view the transcript. Perhaps the restricted accounts offered more insight into the mental illness issue.

3. The staff at the GLHS was unaware of specific narratives that might have proved helpful in this research. Willie Walker, head archivist at the GLHS, admitted that his knowledge in this area was limited. Though his interest in this topic had been piqued, Walker regretted that he did not have the time necessary to spend looking in the archives for relevant material.

4. Many people are still not comfortable sharing their experiences of being labeled mentally ill. Joan Biren, a researcher in the San Francisco area, reported that one of her best friends only recently “came out” to her regarding her commitment in an institution. Dr. Bob Cabaj, a psychiatrist who claims he was instrumental in the changing of nomenclature said,

...We tried to see if there was any national data on the use of the anti-gay diagnoses and we could not find any.... We tried to do a national campaign to have such patients come forward and talk about their experiences as we attempted to fight therapists who still tried to change someone's orientation; no patients came forward or were willing to talk about it. Most were embarrassed and ashamed or still confused. (Personal contact, June 16, 1999).

In addition to the 13 narratives from the GLHS, another 28 interviews with gay men and lesbian women were located in the literature, for a total of 41 all together (Berger, 1996; Vacha, 1995; Adair & Adair, 1978; Baetz, 1980; Barrett, 1989; Chesler, 1996). Interviews in the literature were selected based on the presence of testimonies from gay men and lesbian women who had experienced the label of mental illness firsthand. The literature was often more specific than the GLHS material in that the subject of the books was geared toward issues of mental health.
Because the researcher relied on archival interviews, some of the narratives lack the detail necessary to interpret the experience of being labeled mentally ill as a gay man or a lesbian woman. The topic was often touched upon but not explored by many of the interviewers. The researcher would have preferred to have had entire accounts of the impact of being labeled mentally ill, but found that the interviewers in the GLHS collections were mainly concerned with the environment surrounding the individual such as the nightlife, public opinion, and not necessarily the life story of the individual. The 13 narratives from the GLHS contained unsolicited accounts of the experience of the label of mental illness. By looking at non-specific narratives, it is apparent how important the event of the label of mental illness has been for these individuals.

After selecting the most appropriate interviews based upon the discussion of homosexuality as a mental illness, the researcher categorized the experiences of the interviewees into distinct groups. The grouping was based upon patterns of individual responses to being labeled mentally ill because of sexual orientation. Often times, one narrative revealed more than one pattern, creating overlapping themes. In such cases, all relevant material was used.

The researcher determined the criteria for analyzing each narrative based on the presence of the following indicators of the ecological, labeling, and sexual identity development theories: signs of resiliency, method of adaptation used by the individual, and the perceived level of identification as gay or lesbian.

**RESULTS/ANALYSIS**

For those labeled and treated as mentally ill because of their sexual orientation, the effects of the treatment did not diminish after the APA’s 1973 decision to change the
nomenclature associated with homosexuality. In fact, in interviews completed as late as 1998, more than 25 years later, indicate that the trauma of being labeled mentally ill continues to have residual effects. Material from the 13 oral history interviews and the 28 narratives documented in the literature are consistent with the principles of the theories used.

1. How were people treated according to the label?

2. How did gay men and lesbian women respond to the label of mental illness associated with sexual orientation?

How were people treated according to the label?

Clearly, mental health professionals sought to treat gay men and lesbian women because they believed that homosexuality was pathological. What is not as clear, however, are the strategies utilized to combat this "disease." Those people who were labeled mentally ill demonstrate that the treatment methods differ greatly from persuasion to changes in diet to shock treatment.

David Sanders, a psychiatrist who sought therapy for himself in the 1950s, understood the persuasive tactics associated with the label of mental illness:

Very early in the analysis, it became clear...that the goal of the therapist's treatment was to change my sexual orientation, rather than to deal with the troubling relationship. Anything that had to do with homosexuality was defined as disturbed and pathological. Everything that had to do with my friendliness or liking for women was defined as healthy and positive... Instead of being a homosexual, I was slowly defined and defining myself as a latent heterosexual...(Nardi, 1994, p.43).

During his years in therapy, David most likely operated somewhere in between the Confusion and Assumption stages of identity development. Had he been completely in the Confusion stages, the therapy may have prevented him from acknowledging himself
as a homosexual. Similarly, the Assumption stage would have probably kept David out of
"conversion therapy" all together. Mental health professionals who followed the DSM
often attempted to "cure" their patients of their homosexuality. The cure, of course, was
to make the individual heterosexual. The change in attitude David began to exhibit might
have been viewed as successful from his therapist’s perspective. Regardless of the wishes
of the client (also known as self-determination), mental health professionals devised their
own agenda to free the gay man or lesbian woman from his or her sexual orientation.
Mental health professionals dealt with homosexuality as if it were a disease. Therapists
sent messages conveying the negative aspects of homosexuality to their gay and lesbian
clients. The more negative the messages regarding homosexual lifestyles, the more
positive the heterosexual lifestyle would seem.

Like David, Carol also dealt with a mental health professional who insisted that
something about her sexual orientation was wrong. In this case, the mental health
professional attempted to "convert" her patient by removing the label of "lesbian" from
Carol’s identity. The therapist was perhaps trying to shape Carol into believing that she
really was heterosexual:

I became infatuated with my first therapist, who was a woman. She told me that
lesbianism is a sickness. She also told me that I wasn’t a lesbian... The therapist
felt that the feelings I had for women were basically anti-male feelings instead of
pro-woman feelings (Chesler, 1995, p.219).

In this instance, Carol’s right to determine her future was altered, which may have
acted as a barrier in her progression toward the Identity Assumption and/or Commitment
stages. She was not permitted by her therapist to recognize her sexuality, which likely
hindered her acceptance of it. Not only did therapists attempt to remove the label of
“lesbian” or “gay” from the individual, but they also used the label as the sole purpose for committing an individual to a mental institution. Gay men and lesbian women lost their rights as thinking, functioning people because of their sexual orientation. Donna Smith recalled that the mention of the word “lesbian” was reason enough for her mother to lock her up:

My mother was told that I was living a lesbian life with Valerie. All she had to say was that I was living a lesbian life and that was grounds to have you committed to an insane asylum…I was picked up off the streets, thrown in a police car and [they] put me down into the psycho ward of the general hospital (Weiss, 1988, p.16).

Donna’s level of identity development is unknown because of lack of information available to the researcher. Because she was in a lesbian relationship, however, she may have been operating from the Commitment stage. Once again, the stigma associated with the “sickness” of homosexuality created a division between the client and her right to self-determination.

Also aware of her sexuality and accepting of her identity, Marsha endured a similar ethical dilemma with her therapist. As Marsha examined her life as a lesbian woman, her therapist found it necessary to relay all said information to Marsha’s mother. Though Marsha had reached the age of consent, she was treated almost as incompetent and unable to think and reason on her own.

I wound up in Bellevue and was sent to a private hospital where I saw a psychiatrist who was shocked by my homosexuality… He called my mother for an interview (he said he thought he would get a better understanding of me if he met her). In the course of that interview, he told my mother that I was a lesbian and suggested that I be weaned away from this woman (my lover). My mother blew her stack. She called this woman’s parents and family, and said how their daughter was destroying her daughter…I moved out and I didn’t speak to my mother for two years… (Chesler, 1995, p.219).
Another woman named Carol remembers the threat of the label of "lesbian."

Carol is grateful that she was not locked up as a result of the acknowledgment of her sexual orientation:

...When I was in college, I had a friend, probably 20-21-22, who was my age and had spent her adolescence locked up in the Sanitarium...for basically being a lesbian 'cause that's what her parents did when they figured out she was a lesbian, was they put her in the care of a psychiatrist who suggested locking her up. And she spent three years there while I was in high school...Probably '64 or so to '67...So, you know, I feel very lucky none of those things happened to me...(Meeker, 1998, interview).

Those people who were taken from their lives and placed in a mental institution may have been mentally ill, but most likely they were too vulnerable to stand up to their parents and authorities. The messages that these individuals had been receiving from society may have become ingrained in their own minds. Perhaps in some ways, the individuals were waiting for someone to acknowledge their "deviance" so that they could be cured; however, the individuals' perspectives were rarely learned at the time of their commitment. In many cases, it seemed as if the persons committing the individual (usually the parents) were more concerned about returning their families to social normalcy than understanding the challenges faced by the stigmatized individual. Rick learned of his father-in-law's perspective on homosexuality when he was committed:

When I first went to the doctor in the Sanitarium, [the doctor] told me, 'Well, we could castrate you, but let's try some treatments and see what we can do there.' It's a frightening thing to have a man you're going to as a doctor lay that sort of trip on you...I must have been about 23 then. I underwent a fairly lengthy series of shock treatments. That was a very frightening experience--ah, that's the understatement of the year. I mean it was a terrifying experience. You would wait for maybe an hour or two for your turn, and then I remember, with utter terror, how the clock would go, and you'd have people--someone would call the individuals, and you knew when your turn was coming...and how time you would hope against hope that it wasn't your turn yet, that there would be one more time before you had to go into the little room. You would go into a fairly small cubicle which had a gurney--a bed--in it, lay down on the bed, and at what time they were
using Ambytal or Nembutal--my recollection was most clearly of their using always the left arm...lying on the back with the left arm extended, and the nurse would come in her little white suit--uniform--and give you a shot... About the same time that she was giving you the shot, the little machine would be wheeled into the room from where it had been used on some other person. And this little brown box was a frightening, terrifying little thing... I just can't tell you what an utter feeling of terror it was to have that wheeled in and know that they were going to do something to you that you had no control over while you were asleep and out. My mother had bought me a new watch at that time, and I recall one time I had a treatment, and we forgot to take off the watch. We went to the jewelry store, and the watchmaker put the watch on whatever machine it was--he was trying to see what was wrong with it. The sparks flew from it--very visible sparks. The realization that this was happening to your brain while you were out made a real impression on me... (Adair & Adair, 1978, p.34).

Though Rick's experience with the label of mental illness caused him great physical harm, he was able to recover emotionally, as is indicated by his development as a resilient individual. Individuals like Rick who were treated by mental health professionals for their sexual orientation did not often offer their personal stories in such detail. Perhaps part of Rick's resiliency can be attributed to the fact that he tells his story of physical and emotional pain, which have proved to be liberating. The image in the mirror changed from a vulnerable deviant to a confident gay man. Even though he was able to rise above his experience, the trauma of being committed still cost Rick time, anguish, and stress.

Like Rick, Whitey also was able to regain a sense of herself after a demeaning experience in a mental institution. At one time, operating out of the Identity Confusion stage, she believed that she should seek help for her "illness" of lesbianism. After much time and a period of positive sexual identity development, however, Whitey's view in the mirror changed to reflect that of a confident individual who had reached the Commitment stage of sexual identity.
I was full of expectations that going to a psychiatrist was going to solve all my problems; I would be fine, and my mother would be happy. The psychiatrist put me on a diet of green salads. Two green salads a day. What this had to do with anything I don’t know, but I figured she knew what she was doing. I had a schedule of green salads interspersed with prayer but obviously it didn’t do any good (Adair & Adair, 1978, p.5).

[My father found me in the Village]. He grabbed me by the neck, and all of a sudden police cars were pulling up. I don’t know how they go there so fast...My father was more sympathetic; to him these people were perverts, but I don’t think he really thought I was--he just thought I was sick and he wanted me someplace where I could ‘get well again’--which meant hospitals and doctors...I was put in a police car and whisked off to Kings County Hospital, which is--like Bellevue, only in Brooklyn--for observation. At the end of thirty days, they sent me home. It was strange because nothing was settled one way or the other...I went back and forth to Kings County...Finally they considered me incorrigible, and I was sent to a state hospital...I was on tranquilizers; they almost killed me with them. You were given no other treatment of any kind, so I don’t know how they expected you to get any better...It was a shock--something you either adapted to or you went crazy. It was a horrible, horrible experience. I saw things in there that no one who hadn’t been in a state hospital in the fifties could have allowed themselves to believe was happening in this country. But it was like a horror movie...I said to myself, ‘I’m a lesbian, but it isn’t all right.’ I didn’t like [being a lesbian] because of what happened to me--or because from what I could see, it wasn’t going to get any better...By the time I got out of the hospital, I guess I considered myself set off totally from normal life...or what at that time was considered normal life (p.6).

Unlike Whitey, Lil considered her lesbianism to be the reason she was set off from “normal life.” She entered therapy willingly, but later realized that her therapy did nothing positive for her. She received negative messages regarding her sexuality that caused her to believe she was “ill.” Fighting with her identity, Lil probably operated from the Confusion stage of identity development. As a result, she entered therapy:

They were very brutal to me. Asked very specific physical details of what I had done, how many fingers I had used to penetrate her... I was sincere about changing, so they put me into therapy. If you want to be cured, you go through shock treatment. They show you film clips. They monitor your brain waves, and when you react to lesbian and gay scenes, they shock you through your fingertips and armpits. It’s enough of a shock to make you think! (Barrett, 1989, p.144).
After experiencing shock therapy, Lil understood that she was not "curable." She was resistant to accept her lesbianism, but finally did so after many years (Barrett, 1989). She had begun to realize that no one in the mental health field truly knew whether or not homosexuality was a mental illness. Although many were treated for their homosexuality, it seems as if few mental health professionals knew exactly how to treat these gay men and lesbian women. Rick and Lil discussed shock therapy, Whitey mentioned the absurdity of attempted changes in her diet, and Marsha was treated in this way:

[A woman psychiatrist] kept encouraging me to relate to men...I was falling in love with women at the hospital and this was considered "sick."... When they have these dances Saturday night, which you are supposed to go to, you are not supposed to dance with another woman, you are supposed to dance with a man. They encourage you to have dates and to go to the movies (Chesler, 1995, p.219).

The inconsistencies in treatment when dealing with sexual orientation give evidence that mental illness can be interpreted in many ways. Perhaps the environment surrounding the mental health professionals led them to believe that treatment needed to be prescribed for the illness of homosexuality.

* How did gay men and lesbian women respond to the label of mental illness associated with sexual orientation?

There were varied reactions to being labeled mentally ill due to sexual orientation, forms of resiliency used, and the level of sexual identity development. Some of the narratives showed a pattern of resiliency for people in the Commitment stage of identity development. Others, in the Confusion and Assumption stages of identity development, experienced shame and guilt.
Reactions of people in the Commitment Stage of Identity Development

Those persons most resilient with regard to the pathological labeling of their sexual orientation were most likely operating from the Commitment stage. In the Commitment stage of identity formation, the individual has established stability regarding his or her sexual orientation (Trodden, 1988). The results indicated that individuals’ experiences change over time. This shift may be attributed to the growth and development an individual goes through as a result of a crisis or trauma. Evident in many of the narratives was the tendency for gay men and lesbian women to continue their intimate relationships with same-sex partners. They were aware of the label by the American Psychiatric Association, but chose not to believe that they were mentally ill or to pursue conversion to heterosexuality. Low levels of vulnerability may have been a result of positive validation of sexual orientation in social circles or an unwavering sense of self.

Further evidence of the Commitment stage is exhibited in personal attitudes toward sexual orientation. The dedication an individual has toward his or her sexual orientation affords a certain sense of confidence regarding challenges to sexuality. For example, Don, born in 1907, believed that treating homosexuality as an illness was outdated. He said, “We have to reexamine the fundamental things and say, ‘A lot of it I don’t accept anymore, put it in the social garbage can. Put a lid on it that’s riveted tight’” (Vacha, 1985, p. 10). Don continued, “It’s not that many years ago that the great authorities of the American Psychiatric Association believed that a homosexual was a mentally ill person. I never believed it as a child, nor as a man. Now I see them reversing themselves, and I say, ‘Just chalk one up for us’” (Vacha, p.10). Don’s resiliency
stemmed from insight at an early age. Because he had chosen not to believe that the label of mental illness applied to homosexual people, he might have been able to maintain his belief system despite the societal pressures toward heterosexuality.

An individual is more apt to reach the Commitment stage of identity development if he or she has a significant other. Former military personnel Pam exclaimed, “Honey, if I’m abnormal, I love it. I’ve never worked so hard in my life to make something work. I’ve never been happier” (Adair & Adair, 1978, p.52). Pam’s attitude reflects the resiliency patterns of humor and relationships as well as the result of a positive image in the looking glass. She was seeing herself as her partner did, which created acceptance despite the negative social response of the mental health professionals.

Similarly, Laverne Jefferson was able to confront her therapist as a result of her coping mechanisms. She told the following story:

I told this one therapist that I was gay, and she goes, ‘Oh, honey, oh no!’ She would try to cure me, and I said, ‘Look, I don’t want to be cured. It ain’t no disease; it’s what I want to do.’ She’d say things like, ‘It’s not normal.’ I’d say, ‘What do you know about normal with the kind of life you lead?’ (Baetz, 1980, p. 200)

Laverne demonstrated the subjectivity of a label as she challenged the term “normal.” While her therapist insisted that a “cure” would improve her state of mental health, Laverne chose to follow her own feelings, demonstrating independence, a form of resiliency. It is difficult from this narrative to determine, but her relationships with women seem to have been the source of her resiliency, in that she was not persuaded by her therapist to “become mentally ill.”

As a result of developing the pattern of resiliency by insight, George came to this conclusion about the purported pathology of his sexual orientation:
Why should I judge my life on what society expects of me? On what a psychologist expects of me? I've got my life to lead... It works all right for me, and I really don't give a damn whether people like it or not... Happiness is a relative thing that you make for yourself, and I've made my happiness for myself. I feel like I'm a very well-adjusted person, but probably someone else stepping into my life with all their judgments would say I'm a very screwed up individual (Adair & Adair, 1978, p.78-79).

George's attitude indicates that mental illness is more of a perspective than an absolute diagnosis. George's statement further identifies the subjectivity of what is considered normal, and sets his own standard for happiness. He did not deny the reality that society was judgmental of his sexual orientation, but insight and independence allowed him to refrain from viewing himself as a "deviant."

The reality of societal sanctioning existed for these individuals; however, their coping mechanisms such as insight and independence did not allow the negative reactions to permeate their beliefs. One woman articulated her insight that she had a choice about giving in to society: "[There's this] process that you go through as a young lesbian. You have a choice to become sick and mentally ill or to trust yourself and fly with that. Well, I decided to trust myself and fly with that!" (Scaglioni, 1994, video). A pattern of awareness emerged that there was a choice to abandon the label given by the mental health field and actively participate in self-determination when the person had reached the Commitment stage.

Another part of developing the Commitment to a gay or lesbian identity is the ability to connect the emotional and sexual spheres of one's life (Troiden, 1988). At the Commitment stage the identity is an authentic one, a realization that tends to bring a sense of happiness to the individual. Rick, a man hospitalized by his parents for his sexual feelings, articulated this level of identity development by stating:
But a realization— I'm not sure exactly what caused it—made me suddenly say, 'What are you doing to me? And what's the price that I'm paying? What am I supposed to get out of this, for blocking out what's positive, pleasant, and a delightful part of life? And what are you giving me in return?'... The thing that caused me to have [the treatments] wasn't the gayness... It was other people's inability to deal with the fact—to accept the fact—that Rick happens to be gay, and happens to like men (Adair & Adair, 1978, p. 36-37).

Rick realized that his feelings toward men did not need to be curbed, but rather, they needed to be understood by society. Societal views of homosexuality precipitated the rejection of gay men and lesbian women, not the inability of the gay or lesbian individual to accept himself or herself.

Tonya’s narrative provided another example of the freedom that comes in the Commitment stage of identity development. She expressed her ability to accept her lesbianism even when she was encouraged to think otherwise. She found that the unsettling issues in her life were not addressed because her sexual orientation became identified as the main issue.

I was in therapy with a man who really messed me over. I’d already had sexual relationships with women, and I popped out with, ‘You know, I think I’m a lesbian.’ He said, ‘Well, don’t worry, I’ll cure you.’ I said, ‘I really enjoy my relationships with women, and I don’t think I want to be cured by you. I’m not happy with myself, with my life, but I am happy with the woman friends I know, and I don’t want that taken care of.’ It had taken me a long time to get to the point of telling him, and he came up with that ‘cure you’ bit... Every time he’d talk about homosexuals, he’d say how much he cured them, how well he brought them back into the world as normal people. After that time, I just walked out of the office and never went back. It wasn’t worth my while to fight him on that (Baetz, 1980, p. 203).

Tonya’s image of herself as a lesbian woman was healthy, stable, and committed; yet, her therapist insisted on trying to change her perspective. As she explained, Tonya struggled to identify herself as a lesbian woman to her therapist and her level of identity development enabled her to maintain that identity.
Lois, also operating at the Commitment stage of identity development. She sought personal counseling for matters other than her sexual orientation and experienced the following:

One female therapist got scared when I became 'gay.' 'I can't treat homosexuals. There's nothing you can do with them.' She made it sound like terminal cancer... One male therapist kept insisting that I wasn't gay, but he told me it's something I'll outgrow... He told me I'd end up alone and bitter in the gay scene, and that didn't appeal to me. It still doesn't... Another woman therapist said, 'But men are so marvelous to sleep with! Lesbianism isn't necessary, it's absurd!' In a sense, being psychiatrically hospitalized helped me. I'd hit bottom. Now I could be a lesbian, that's not as bad as crazy... (Chesler, 1995, p. 219).

The attitudes shared by people in the Commitment stage were perhaps part of the catalyst that led to the removal of homosexuality from the DSM. They had insight, independent thinking, social support in the form of a partner or a peer group, and a positive sense of themselves in order to resist the label of mental illness. The societal pressures to live a heterosexual life were great, so those who trusted themselves to challenge the mental health system took significant risks.

Confusion and Assumption Stages of Identity Development

Perhaps factors such as low self-esteem, negative self-images, or scarcity of social support caused some gay men and lesbian women to lack the confidence obtained by those who had reached the Commitment stage. The identity development of some individuals may be arrested in the Identity Confusion or Identity Assumption stages, which have been defined as "...inner turmoil and uncertainty" (Troiden, 1988, p. 45). According to the research done for this study, gay men and lesbian women who were unsure of the validity of their feelings of attraction toward people of the same sex often struggled with feelings of shame and/or guilt during at least a portion of their lives.
This inner struggle is fueled in part by the mirror through which an individual sees himself or herself. The mirror may have challenged an individual's self-esteem, ability to trust oneself, and the ability to trust others because of the adverse responses to minority sexual orientation. Negative images bring shame and guilt, whereas positive images elicit acceptance and worthiness. Many gay men and lesbian women faced being stigmatized because they were labeled mentally ill. Whitey, a lesbian woman, said this of shame:

If you do anything that isn't right, you are terrified you'll be struck by lightning or go to hell. It caused a lot of fear. It's a pretty heavy trip to put on a kid...I was pretty well brainwashed...I prayed a lot because I believed if I had enough faith I would get over this...this sickness...As I developed as a human being, I felt I was somehow stunted because I spent all that time grappling with that problem when I could have been learning how to live...In grammar school—even though I didn't know what being gay was. I was enjoying crushes, until I found out they were considered abnormal (Adair & Adair, 1978, p.3-4).

Whitey’s environment was telling her that her feelings were “wrong.” Instead of society changing its views regarding Whitey’s attraction to women, Whitey’s views began to parallel society’s. Prior to her knowledge of the word “lesbian,” Whitey had not thought her feelings abnormal. The stigma from her environment regarding her feelings caused her to repress that attraction toward women.

Similarly, Ron received negative messages from his environment, which provided the shame regarding his sexuality:

I think there is a certain amount of guilt... about sexuality and stuff like that... I did feel some shame and stuff over sexuality when I was a little young, like nine or ten. And I had gotten caught with another little kid playing around in the woods and stuff and, you know, it was just, it definitely came down as heavy, you know, Christ will never forgive you and all those kind... What happened was one of the kids told his mother and his mother came to my grandmother...It was one of my first experiences with guilt around being gay... I knew somewhat that what we were doing was probably wrong but I didn’t really grasp the concept of it being gay...I suddenly started to become more and more aware ...that queer was bad
and that it was not the right thing to do. Then I developed all this guilt around it, and from the time I was 14-15, somewhere around in that area, until I came out of the closet, I carried around a lot of guilt and shame and stuff on being queer. But I didn’t really know (GLHS, 1998, interview).

In addition to the shame that is usually associated with sexuality in general, Ron was further challenged by the idea of his “deviant sexuality” as a result of the messages from the environment surrounding him. Ron was most likely operating from the Identity Confusion and Assumption stages. Because he was receiving societal indicators that did not validate his experience as a gay youth, he was unable to transcend the stigma placed on homosexuality. Furthermore, not understanding the implications of what it meant to be gay might have hindered his ability to challenge his beliefs regarding homosexuality.

Perhaps as vulnerable as Whitey and Ron when it came to societal/familial influence, Philip claimed that:

...There were times when I felt very alone, very frustrated, even condemned myself for being psychologically sick... I mean, it comes with, you know, you hear the homophobic jokes, you hear you can’t be gay, you hear everything negative about being gay, which kids today don’t, even though it’s not anywhere near where we as gay people want it... But, you know, I was a victim of homophobia and worrying about am I sick. And in some, to a certain level, believing it... I did seek psychiatric help which is a whole other story (Meeker, 1998, interview).

Philip heard from those around him that his identity as a gay man would not be received well by society. The label of mental illness caused him to begin to feel like he was mentally ill.

Some gay men and lesbian women were unable to escape labeling. Those individuals who expressed shame and guilt in their experience with the label of mental illness also struggled with the tag “homosexual.” Labeling theory and the concept of the looking glass self would suggest that an individual becomes the person that is seen in the
reflected societal mirror, in this case, a sick homosexual. When others in society discover that an individual is homosexual, they change their perception of that individual. For example, Whitey’s interview in Adair & Adair’s (1978) book, *Word is Out*, explained how the stigma associated with the homosexual label inhibited her behavior and her comfort level in expressing herself honestly:

I realized I could not say to somebody, ‘I am a homosexual,’ because they then no longer related to me as they had before—which made me think it was something to be ashamed of and to hide. I had no idea what type of life homosexuals led. I just knew my parents’ reaction to me and the psychiatrist’s...people's reactions just to the word. The word ‘pervert’ was always attached to it, and this meant something horrible for me (Adair & Adair, 1978, p.5) [Emphasis in original].

Society’s reaction “just to the word” homosexual implies that positive identity formation and reaching the Commitment stage would be difficult. Positive interaction within the gay and lesbian community typically precedes entrance to the Assumption stage of identity formation (Troian, 1988). Because homosexuality was perceived so negatively in both the mental health profession and society, it might seem almost impossible to reach this third identity stage. An individual would be less likely to self-identify with a population that is treated as “perverts.”

Roger explained his frustration with self-identification in the following way:

It's hard, by the way, as a homosexual, to use any of the words such as 'homosexual' without being conscious of the weight. Every time I say 'sissy,' every time I say 'faggot,' every time I say 'homosexual,' it's weighted with all that I'm thinking about. Isn't that odd—that you should even have to think about it at all? It's a pain in the ass (Adair & Adair, 1978, p.221).

The labels of “mentally ill” and “homosexual” had detrimental effects for those who had not reached the Commitment stage of their sexuality. It seemed difficult for the more vulnerable to cope with these labels and with others’ opinions regarding sexual
orientation than for those who would be considered operating from the “resilient”
Commitment stage. Perhaps the most vulnerable of all gay men and lesbian women
dealing with the label of mental illness were those clients treated by mental health
professionals who believed their therapist’s DSM diagnosis.

Though many the individuals had mortifying, shameful experiences with mental
health professionals, not all did. The DSM was interpreted by each mental health
professional differently, and some chose not to accept the label of mental illness with
regard to sexual orientation. These therapists’ views were in the minority in their
profession, yet their beliefs and the accompanying treatment were life giving, healing,
and supportive. The study’s narratives showed that the opposite approach, also called
“treatment,” used a coercive approach resulting in damage to the development of a
healthy sexual identity. The contrast between these two types of approaches certainly
created a division in mental health circles.

Even those individuals whose self-images were tarnished by the negative societal
view of homosexuality were able to redefine themselves through positive role modeling.
William wanted to explore his feelings for men in a therapeutic setting, and got a
therapist who was not swayed by the diagnosis of mental illness for homosexuals in the
DSM. For William, having a therapist who acknowledged the client’s right to his sexual
orientation helped him understand himself better.

I felt that life was passing me by, that I was not getting out of it what other people
did... So I went to see a psychiatrist. I don’t remember how long I saw him, but it
was a long time. I spent $10,000 on that psychiatrist. But it was worth it. It was
the psychiatric help that made me understand, finally, that I was gay, and that this
wasn’t any great tragedy. I really believe that if it hadn’t been for the psychiatrist
I would not have come out again in my middle age. Talking to the psychiatrist
was like a dam bursting open; it sort of loosened me up inside and made me more
relaxed so all of those feelings that I had pushed down for so many years could finally come up (Berger, 1996, p.69).

William’s story can act as a model for sensitive mental health professionals. Because of the mental health professional’s approach, William was able to begin to release his repressed feelings of same-sex attraction. Prior to the treatment with his therapist, William was in one of the earliest stages of sexual identity development, Confusion. After seeking therapy, however, he was able to move ahead toward acceptance of his sexual orientation and into the Commitment stage.

Through the examination of narratives like William and the others used for this study, it was found that the level of sexual identity of a gay or lesbian individual predicted the response of the individual to the label of mental illness associated with sexual orientation. For those individuals who had chosen to see their orientation in a positive light despite the label of mental illness, patterns of resiliency emerged. Often, the individuals who exhibited this resiliency were in the Commitment stage of their development as a gay man or lesbian woman. Others, however, had not yet reached the Commitment stage. Those individuals were more vulnerable to the societal definitions of homosexual people. Their malleability often caused them to question their identities, or to seek conversion. Influential individuals in these gay men and lesbian women’s lives tried to find “cures” in asylums or therapist’s offices. As a result, these gay men and lesbian women lost self-esteem, faith in others, and trust in themselves.

Mental health professionals’ opinions of homosexuality and of mental illness had a definite impact on the way gay and lesbian individuals perceived themselves. When an individual was treated as a mentally ill person because of his or her sexual orientation, that individual had to find sources of strength to combat the guilt and shame attached to.
being labeled mentally ill. When an individual was treated by a therapist who did not
ascibe to the DSM label, his or her sexual identity was validated.

**IMPLICATIONS**

1. *Current Applications.* The general public has been slow to accept
homosexuality as a variation of sexual expression, as is indicated by the numerous hate
crimes such as Matthew Shepard's death and regressive legislation like the Defense of
Marriage Act (American Civil Liberties Union, 1999). Referring to homosexuality,
former President Ronald Reagan said in a speech while president, “I happen to subscribe
to the belief that it is a tragic illness. A neurosis like any other illness” (Scagliotti, 1994,
video).

One cannot expect that a decision made in the mental health field will have
instantaneous effects on the public; however, one would think such a decision should
significantly change the climate within the mental health field, putting an end to
involuntary conversion therapies. Unfortunately, this is not the case. In 1979, a notable
psychiatrist was featured in an article by *People* magazine discussing homosexuality. One
of the responses he received was from a young man who was being hospitalized for his
homosexuality:

I am a patient in a mental hospital in Iowa and homosexuality is not talked about.
I have known that I was gay since I was 17 years old. When I realized that I
couldn't change, I accepted it and told my parents and close friends. My parents
could not understand, and they thought I was sick. So here I am, committed to this
institution, and feeling like I'll never get out. There is nobody to give me support
to something that I strongly believe in. There are very few understanding staff
members—and my doctor thinks that my homosexual feelings are no good. He
wants to change me! I once had a relationship with a girl and I felt out of place
(not right). There is no one that will even try to understand me, let alone give me
support. Iowa is backwards—and there are not too many people that really
understand. I have even felt suicidal because my parents could not accept me. I
am 21 and stuck in this slump. What should I do? (In the P.S.) I would appreciate
it if you could give me some advice. I am tired about nobody caring (Confidential letter, GLHS, 1979).

For whatever reason, this young man was committed to a mental institution six years after the APA changed the nomenclature in the third edition of the DSM. The researcher was initially interested in doing a historical piece; however, examples like the previous one relay that this issue is not entirely in the past. Though most mental health professionals appeared to readily label homosexuality as a mental illness, they have not been as willing to abandon the label once the change occurred in the DSM-III.

To combat the hesitation of some mental health professionals to adhere to the removal of pathology from homosexuality, the American Psychological Association recently released their “Guidelines for Psychotherapy with Gay, Lesbian and Bisexual Clients” (American Psychological Association, 2000). The document, consisting of 16 points, includes practice advice for attitudes toward homosexuality and bisexuality, among other facets of psychotherapy. The American Psychological Association claims, “Practice guidelines differ from practice standards in that standards are mandatory and are often accompanied by an enforcement mechanism. In contrast, these guidelines are designed to be educational and aspirational.”

Those pieces that specifically address the mental health of the individual are the following:

Guideline 1: Psychologists understand that homosexuality and bisexuality are not indicative of mental illness.

Guideline 2: Psychologists are encouraged to recognize how their attitudes and knowledge about lesbian, gay, and bisexual issues may be relevant to assessment and treatment and seek consultation or make appropriate referrals when indicated.
Guideline 3: Psychologists strive to understand the ways in which social stigmatization (i.e., prejudice, discrimination, and violence) poses risks to the mental health and well-being of lesbian, gay, and bisexual clients.

Guideline 4: Psychologists strive to understand how inaccurate or prejudicial views of homosexuality or bisexuality may affect the client's presentation in treatment and the therapeutic process (American Psychological Association, 2000).

Although these are guidelines and not standards, they provide an outline for the treatment of gay and lesbian individuals by psychologists, and may assist in shaping the development of such a statement by other mental health organizations.

2. Implications for Social Work practice. As a result of the hesitation from some mental health professionals with regard to the pathology of homosexuality, the field of mental health may not appear to be a place for gay men and lesbian women to turn for help. The effects of the labeling may challenge an individual’s ability to trust mental health professionals seeking future therapy. Those people treated as mentally ill based on their sexual orientation prior to the changes in the DSM may be hesitant to seek therapy because of their prior experiences with the mental health field. Mental health professionals have the potential to be an ally or an oppressor. If mental health professionals want to bolster the resiliency and positive identity formation of gay and lesbian people they must reassure them that their experiences as gay or lesbian people will be validated, at least within the counseling session.

Though this study examines the effects of the label of mental illness prior to the change in the DSM, this information has relevance today. Men and women are currently being committed into institutions by their parents and guardians under the diagnosis “Gender Identity Disorder” (GID). This disorder, which is found in the fourth edition of
the DSM, indicates that men who display characteristics “typical” of a female and women
who display characteristics “typical” of a male have a mental disorder (American
Psychiatric Association, 1994). The similarities between the labels of GID and its
predecessor in the DSM, homosexuality, might predict that a similar series of events
would unfold to remove GID from the manual.

Daphne Scholinski provides a narrative that exhibits both resiliency and a
reluctance to accept the label of mental illness associated with GID. Daphne was
hospitalized in both Illinois and Minnesota between the years 1981 and 1984 for GID.
During her time in the hospital, Daphne was observed and questioned about her sexuality,
as though the possibility of her being a lesbian woman was also pathological. In her
book, The Last Time I Wore A Dress, Daphne notes the precautions her therapists took
with regard to her sexual orientation. Within the pages of her book, Daphne includes the
observations from her record at the institution: “She still continues to meet with her
female companion on another Unit but she has not escalated her contacts with her much
more, if any, than when we were limiting their periods of visiting with each other”
(Scholinski, 1997, p.188). This type of treatment by the mental institution further implies
that sexual orientation is pathological.

Like some of the individuals examined in this study, Daphne also experienced the
trauma of being treated for a fixed aspect of her life. She discusses her therapy in the
following way:

I can’t change what happened. I still wonder why I wasn’t treated for my
depression, why no one noticed I’d been sexually abused, why the doctors didn’t
seem to believe that I came from a home with physical violence. Why the thing
they cared the most about was whether I acted the part of a feminine lady. The
shame is that the effects of depression, sexual abuse, violence: all treatable. But
where I stood on the feminine/masculine scale: unchangeable. It’s who I am. I
can’t get the time back (Scholinski, 1997, p.197)…When you’ve had your sanity challenged, you always have something to prove. But I did fine. I told about the hospitals, about putting on eye shadow…about being locked up for being an inappropriate female (Scholinski, 1997, p.199).

The cycle of people being committed against their will appears to be continuing again with GID. The information gathered in this study can help to pave the way for additional research with regard to the potential consequences of labeling people with a diagnosis of GID, and perhaps other “Sexual Dysfunctions” found in the DSM.

3. Implications for social policy. When examining the larger picture, it seems as if those populations who do not fit the arbitrary “norm,” lose out on many social privileges. The legal rights of people with mental illness as well as gay, lesbian, bisexual, and transgendered individuals are limited. The law does not recognize those gay and lesbian individuals as full citizens, by denying them the right to marry or to receive partner benefits, among other commonly held heterosexual rights. In the case of people with mental illness, they are deemed incompetent, and their power to make decisions is awarded to the state. As indicated by this research, being labeled mentally ill does not necessarily deem a person incompetent.

4. Implications for further research. Since the research completed for this study is exploratory, the potential for a more in-depth look at the connection between mental illness and homosexuality is great. Face-to-face interviews with gay men and lesbian women might yield more specific experiences and a better understanding of sexual identity development and resiliency. By tracking the experiences of gay men and lesbian women over a long period of time to understand the development of sexual identity might also better predict environmental influence. A snowball sampling would further assist in reaching a large number of participants anonymously, and could be fashioned to locate
quantitative trends that might be more generalizable than the qualitative research used for this study.

The use of pre-existing interviews and literature limited the scope of this research, since historical narratives were not specifically focused on addressing the experience of being labeled mentally ill. In addition to more first hand accounts obtained in current interviews, a study on the individuals who have been “converted” through mental health treatment might further reveal the effects of the removal of the label of homosexuality. By identifying the motivation for the conversion, the reasons conversion occurred, and the quality of life post-conversion, a researcher might discover the effects of retarded/stalled sexual identity development and the impact on resiliency.

Furthermore, information gathered from mental health professionals who perform “conversion therapy” might also provide insight into the reasoning behind treatment approaches for gay men and lesbian women. Perhaps an even more insightful piece of research would be a qualitative collection of those mental health professionals who once treated gay and lesbian clients as mentally ill, and then altered their approaches following the change in the DSM. The motivation behind their decision to conform to the manual might reveal interesting results. There exist many possible avenues for research, which indicate that perhaps the topic of mental health and homosexuality have not been addressed adequately thus far.

**CONCLUSION**

The initial expectations of the study were supported, in that some individuals were able to combat the damaging effects of labeling with forms of resiliency. According to the narratives of the individuals used for the study, the response of a gay man or
lesbian woman to the labeling was dependent upon the stage of identity development from which that individual operated and the resiliency factors attached with that stage. People who reached the Commitment stage of identity development were most likely to challenge the label of mental illness. Other contributing factors were the resiliency factors of an accepting peer group, the initiative to move away from the disease model, and independence from negative influences. Those who only reached the Confusion or Assumption stages were more likely to experiment with conversion therapy. This division in responses can be attributed to the difference in characteristics of the Confusion and Assumption stages, which center on validation of and immersion into homosexual experiences, and the Commitment stage which focuses on celebrating the gay or lesbian identity.

Furthermore, individuals were labeled mentally ill due to sexual orientation when they acknowledged their homosexuality and/or there was evidence of same-sex attraction, regardless of their stage of identity development. In fact, those who had reached the Commitment stage were assumed to be more “deviant” by some therapists than their peers in the Confusion and Assumption stages, but their high self-esteem with regard to their sexual orientation counterbalanced that negativity.

In addition to those findings on individuals’ responses, the methods of treatment were also examined for this study. It was found that those gay men and lesbian women who were treated by mental health professionals experienced a wide range of therapy, from attempts at conversion toward heterosexuality through counseling to physical methods of persuasion, such as shock therapy. Lack of consistency in mental health approaches may exhibit the influence society has on the mental health field.
In a more recent context, society continues to label individuals with mental illnesses, such as Gender Identity Disorder, which is currently present in the DSM-IV. Research such as this might provide a rationale for challenging other sexual dysfunctions found in the manual. Furthermore, this type of exploratory research could be expanded through face-to-face interviewing of gay men and lesbian women as well as the mental health professionals who provide service to them.
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