Homosexuality as a criterion predictor of psychopathology and emotional adjustment in non-patient males expressing varying degrees of homosexual behavior and preference as compared to exclusively heterosexual males.

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HOMOSEXUALITY AS A CRITERION PREDICTOR OF PSYCHOPATHOLOGY
AND EMOTIONAL ADJUSTMENT IN NON-PATIENT MALES EXPRESSING
VARYING DEGREES OF HOMOSEXUAL BEHAVIOR AND PREFERENCE AS
COMpared TO EXCLUSIVELY HETEROSEXUAL MALES

by

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A.B., Greenville College, 1965
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Dissertation
submitted in partial fulfillment of the requirements
for the degree of Doctor of Philosophy in the Department of Psychology
at the University of Windsor, Ontario, Canada

1972
ABSTRACT

The relationship between homosexuality and psychopathology was investigated, using a well-known personality and self-concept measure in current clinical and research use with 140 college-educated, socially functioning, non-patient males expressing varying degrees of homosexual behavior and exclusive heterosexuality in seven matched groups. The results indicate no significant differences between mean performance scores of the homosexual groups and the exclusively heterosexual comparison group (Hypotheses I and II) or between any of the groups and the established norms of the test in regard to self-concept, self-criticism, defensiveness, general emotional maladjustment, psychosis, personality-character disorder, neurosis, and overall personality integration. The data also make clear that homosexuality, per se, is not a criterion predictor of psychopathology (Hypothesis III). There was no trend toward the homosexual groups being even slightly more pathological as level of homosexuality increases, and no evidence emerged to suggest that homosexuality and heterosexuality are differentially related to emotional adjustment or disturbance. By correcting for the error of past studies which were based on skewed samples of homosexuals already selectively loaded with psychopathology, the present data indicate that the traditional school of thought regarding homosexuality may be incorrect. The fact that non-patient homosexual Ss did not show signs of emotional disturbance in the present research is taken as an indication that the sweeping generalization, in the clinical literature, that homosexuality is always a symptom of psychopathology, may be in need of qualification or revision.
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* * * * *

Thomas R. Clark
HOMOSEXUALITY AS A CRITERION PREDICTOR OF PSYCHOPATHOLOGY AND EMOTIONAL ADJUSTMENT IN NON-PATIENT MALES EXPRESSING VARYING DEGREES OF HOMOSEXUAL BEHAVIOR AND PREFERENCE AS COMPARED TO EXCLUSIVELY HETEROSEXUAL MALES
CHAPTER I

INTRODUCTION

One of the most challenging problems in the field of clinical psychology is that of homosexuality. However, despite its prevalence and the magnitude of the social-societal and psychological conflicts it creates, there has been little controlled research dealing with this area and only a handful of legitimate studies. Treatises on homosexuality undoubtedly number in the hundreds, but most of them are on a subjective, speculative level rather than the scientific, empirical level. To be sure, the majority of past studies in this area, while being pretentiously scholarly, are in reality little more than stated opinions in which the essential preliminary statement of bias is omitted. Homosexuality thus remains a subject beset by misunderstanding, prejudice, repression, and dishonesty; and there is a great need for further research in this area where so many unanswered questions remain. The present Doctoral study represents a specific attempt to clarify experimentally some of the basic issues surrounding this highly controversial area that has so many widespread social and psychological ramifications.

The fact that in our society homosexual behavior is subject to legal and social taboos has contributed in a major way to the relative paucity of research involving groups of subjects who are not to be found through clinics or other therapeutic or correctional agencies. When the taboo exists, access to a population
sample that would provide an optimum opportunity for study of the collective sub-
cultural aspects of the phenomenon is difficult. Consequently, our knowledge of
homosexuality and the variables involved in it is based mainly on clinical exper-
ience, individual case studies of patients (in psychotherapy or under incarcera-
tion), and various theoretical conclusions drawn from these sources. It has
been next to impossible for most researchers to gain entrance into the homo-
sexual subculture itself, and, to be sure, the majority of them have deemed it
even unnecessary and unimportant to do so. Therefore, as Churchill (1968)
suggests, most psychological and psychiatric studies up until now have dealt in
stereotypes, since they have involved only mentally disturbed subjects and then
inappropriately generalized the psychopathology found in these individuals to the
whole homosexual population at large. This, in turn, has given rise to the pri-
mary assumption and assertion among clinicians that homosexuality is always a
sign or indication of marked emotional maladjustment, personality disorder,
aberrant self-esteem, and/or other serious psychopathology. Despite recent
evidence to the contrary (in the form of a wealth of data from other realms of
the biological, behavioral, and social sciences), this assumption equating homo-
sexuality with psychopathology still rules the day among clinical researchers
and practitioners, as the vast majority of the literature clearly attests.

With Churchill's (1968) criticism of past studies firmly in mind, the writ-
er wishes to emphasize here, at the outset, that the rationale for the present
study (and the group of experimental subjects thus sought) stemmed from an awareness of the necessity of going directly into the homosexual subculture itself to reach a nonpathological segment of that population for accurate research, thereby negating some of the effects of bias, prejudice, stereotyping, and certain other selective factors so prominent in the plethora of past studies in this area. One does not go into prisons and mental hospitals or clinics to study normal heterosexuality and then generalize to the whole heterosexual population at large; therefore, to do so with homosexuals, as has been done so often in the past, is to study a sample already selectively loaded with psychopathology that may not be truly representative of the whole homosexual population, thereby committing a gross methodological error at the outset which may contaminate and predispose the resultant data to support the assumption of the psychopathology of homosexuality, perhaps erroneously, in a circular manner not unlike that of a self-fulfilling prophecy.

Hence, the present writer agrees with Churchill (1968) that what is needed now, in order to get a more representative appraisal and profile of the homosexual population, is a study based upon a large sample of nonpathological subjects, including not only exclusive homosexuals and heterosexuals, but also persons who express varying degrees of homosexual preference along with heterosexual desires. Consequently, the present study "zeros in," as it were, on this nonpathological element of the homosexual population in an attempt to examine a
primary theme or assumption that runs through the clinical psychological literature on homosexuality; this assumption (phrased in somewhat varied terminology reflecting the various theoretical positions of its researcher adherents) holds that homosexuality is always a pathognomic sign or symptomatic indicant of psychopathology, mental illness, personality disorder, general emotional maladjustment, and/or abnormal or unfavorable self-concept (Fenichel, 1945; Sears, 1953; Bieber, 1962; Bandura and Walters, 1963; Socarides, 1971; et. al.). Although this assumption is discussed in greater depth and detail in the sections to follow, suffice it to say at this point that the purpose of the present research was to experimentally study and operationally test this across-the-board hypothesized relationship between homosexuality, on the one hand, and emotional maladjustment (or psychopathology), on the other, using a well-known personality adjustment and self-concept scale in current clinical and research use with 140 college-educated, socially functioning, admitted overt male homosexual subjects (who expressed varying degrees of homosexual behavior and preference) and heterosexual comparisons, all of whom were matched for age, educational background, and lack of a history of significant psychological disturbance.

CRITICAL REVIEW OF THE LITERATURE

A variety of etiological explanations have been offered for the development
of homosexuality. These range from simple genetic or constitutional factors (Kallman, 1952; Klintworth, 1962) to very complex psychosocial factors (Mead, 1949). In an excellent brief summary of the accumulated evidence on homosexuality, Thorpe and Katz (1968) concluded that the genetic and hormonal theories are lacking in support and that the extended study of environmental influences offered the better possibility of understanding the conditions. Until the advent of psychoanalysis, however, homosexuality was believed to be a biological or constitutional abnormality (Ellis, 1928); following Freud, emphasis shifted to the psychogenic side of the problem, and homosexuality has since been viewed by most clinicians as a form of psychopathology (i.e., a form of abnormal behavior resulting from psychological disturbance) rather than a biological abnormality. In the past five years though, a more divergent view has also developed, based on evidence gleaned from recent behavioral, cross-cultural, and cross-species studies, which questions the psychopathology of homosexuality; this view holds that homosexuality, per se, is not necessarily pathological.

The Biogenic Theories

Seward (1964) has reviewed the evidence for biological abnormality, and it is not particularly impressive. The most important finding has to do with the androgen–estrogen balance in male homosexuals. Androgen (the male sex hormone) and estrogen (the female sex hormone) are both present in the human
body, the former predominating in males and the latter in females. Several studies have shown that in a majority of male homosexuals tested, the balance is somewhat shifted in the direction of estrogen. Some investigators further claim to have shown a certain association between homosexuality and feminine body characteristics in men. Taken together, these findings suggest that men of a somewhat feminine biological make-up are a little more likely than others to have homosexual inclinations, but the relation is a very slight one and does not go far toward explaining the homosexual object choice. One might also question the limited sample of homosexuals used. A great number of men with somewhat feminine bodily physique are quite free from homosexual tendencies and interests, and many male homosexuals are of distinctly rugged and powerful physique.

Modern cytological methods have administered a coup de grace to all theories of "intersex" or "third sex" as the somatic basis of homosexuality; the sex chromatin of homosexual men is invariably masculine (Pare, 1956; Raboch and Nedoma, 1958). Hormonal aberrations likewise have been disproved as a causative factor in homosexuality (Hemphill, et al., 1958; Swyer, 1954). In fact, when male hormones were used in the treatment of male homosexuality, the resultant effect was an increase in intensity of the homosexual desires and activity rather than a change in the direction of heterosexual object choice (Swyer, 1954). Therefore, it would appear that looking for the roots of homosexuality in chromo-
somal or hormonal disturbances seems a futile task based on the assumption
that molecular chemistry can somehow give us a direct answer to the problems
of personality development. It disregards the remarkable plasticity and variabil-
ity of the psychic life as well as its social roots. The heterogeneity of homo-
sexuality can thus derive very little, if any, support from cytology or biologi-
cal genetics.

Jones (1955) points out that Freud did not attach much importance to the
presence of somatic changes in the direction of the opposite sex; he did not
think there was any close correlation between them and homosexual tendencies,
and he regarded the concept of an inborn biological "third sex," along with what
was believed at that time to be an important distinction between innate and ac-
quired homosexuality, as being "antiquated as the last century and unsupported
by the evidence." He did feel that the presence of secondary somatic charac-
teristics of the other sex might be conducive to the homosexual object-choice
becoming manifest in some cases, but it was by no means decisive, even in
these cases; hence, he insisted that "biological factors may be influential only
in a few isolated cases, if at all."

The Prevailing Psychogenic View—Homosexuality as Psychopathology

The psychoanalysts who came after Freud have been the most prolific pro-
ponents in the literature of the view that homosexuality is an abnormal form of
behavior resulting from psychological disturbance, without reaching any semblance of complete agreement. Saul and Beck (1961) reviewed the psychoanalytic literature and summarily grouped the psychodynamic theories concerning the etiology and psychopathology of male homosexuality into four basic categories:

1) homosexuality as a neurotic mode of expression of pregenital drives;  
2) faulty or inadequate, fixed identification;  
3) unusual infantile fixation; and  
4) homosexuality as a pathological defense or adaptive mechanism.

Fenichel (1945), for example, views homosexuality in this way:

"Pregenital fixations, especially anal ones, and the readiness to substitute identifications for object relationships are the necessary prerequisites for homosexuality. This readiness must be combined with a special intensity of secondary narcissism. In the Oedipal phase, the probability of homosexual orientation is increased the more a boy tends to identify with the mother and when this identification is made as an identification with the aggressor (where boys are frustrated in crucial things by their mothers)."

Bergler (1957), on the other hand, interprets homosexuality as an "ego disturbance of pathological proportions which is the resultant product of the vicissitudes of an 'unresolved breast complex' (oral regression) and/or fixation stemming from early babyhood." Despite his extremely limited and skewed sample, he presents his therapy sessions with homosexual patients as "proof for the thesis that the substitute of the penis for the breast (the breast-penis equation)
and the narcissistic blow of weaning provide the essential basis for all manifestations of the personality disorder known as male homosexuality." What Fenichel and Bergler do not point out, however, is that these same disordered dynamics may be present, and indeed are often found, in patients who are not homosexual (Churchill, 1968).

The simplest psychogenic explanation of homosexuality would be that the homosexual person became pathologically fixated upon this object choice because of abnormal gratifications and/or sexual experiences happening in childhood or early adolescence (White, 1964). However, Cappon (1965) reports that there is a great deal of evidence pointing to the fact that even quite extensive homosexual experience in childhood and adolescence often does not interfere with later normal heterosexual development. It becomes necessary for many clinicians to assume, therefore, that the preference for objects of the same sex must be based on a hidden incapacitating fear of, or distaste for, objects of the opposite sex; some emotional obstacle, as it were, prevents the person from feeling a sexual interest in members of the opposite sex. White (1964) elaborates on this as follows:

"In cases of enduring homosexuality there is a strong connection of some kind between heterosexual interest and anxiety. Childhood punishments of a terrifying character elicit the defense of repression; thereafter the person is unable to become aware of heterosexual feelings and he may even fortify his defense by experiencing disgust at such dangerous inclinations. Under
these circumstances an interest in the same sex becomes the most available substitute for the repressed inclinations.

White (1964) goes on to state that his psychoanalytic study of homosexual patients shows that the repression of heterosexual interest often goes back to anxiety over the anatomical differences between the sexes. He discusses the issue in this manner:

"The little boy may be led to fear that his penis will be cut off as a punishment for sexual play. If this preoccupation is active at the time he discovers anatomical differences, his fear may be abruptly increased. Women's genitals become phobic objects because they remind him too strongly of the danger of castration. Thus the possibility of being interested in them for pleasure, curious about them, or even seeing them, becomes firmly repressed into the unconscious. The anticipation of nonpleasure may still affect conscious behavior, however. In this case, the fear of punishment causes sexual interest to be deflected from heterosexual objects, and homosexual ones become the only safe ones, for they are not apprehended as entailing anything like the same dangers. The assertion of homosexual inclinations thus serves as a protective defensive denial of the dangerous heterosexual ones."

White (1964) thus points out that his homosexual patients are under the influence of a strong castration complex; that is to say, for them the sight of being without a penis is so terrifying that they avoid it by rejecting any sexual relationship with such a partner. He then goes on to assert later that "all homosexuals
are so determined on the existence of a penis that they refuse to do without it in their sexual partners." (Note the ease with which White generalizes inappropriately from his small sample of emotionally disturbed patients to the whole homosexual population at large without evidence to back up such a generalization.)

Bieber (1962) takes an entirely different approach. In a systematic, organized, painstaking study of differences between pathological heterosexuals and homosexuals, which was statistically as well as psychoanalytically oriented, he attempted to derive diagnostic formulations from the variants of intrafamilial relationships; he examined the constellations of patients' life events flowing from the mother-son, father-son, and triangular mother-father-son relationships. His investigation showed that most of the homosexual male patients he studied had been exposed to maternal overseduction (resulting in positive Oedipal strivings of great intensity) coupled with a restriction of heterosexual strivings; most fathers, on the other hand, were weak, detached, and passive. Bieber wrote: "The homosexual son emerges as the interactional focal point upon whom the most profound parental psychopathology was concentrated." He also observed how frequently in the cases of his patients the homosexual trends were reinforced by maternal physical overstimulation extending into puberty; at the same time, mothers of homosexual men had been, and continued to be, disparaging of their husbands and critical of girls and warned their sons of the "dangers" of heterosexual involvements. Simultaneously, the
detached, passive attitude of the weak father further subverted the traces of male identification and served to consolidate the homosexual trends through adolescence. Bieber thus defined homosexuality as "a form of neurosis incompatible with a reasonably happy life of personality integration and a high level of self-esteem."

In the present writer's opinion, Bieber's (1962) classic study is helpful in assessing the determinants of sexual object and of sexual behavior, for his perspective is the broader life patterns on which homosexuality may develop. The dilemma is that because of his lack of definition of variables involved, limited sampling techniques (using only 106 male homosexual patients who had undergone psychoanalysis), and his proceeding directly from patients' life stories, he ends up with a cluster of epics which are incomplete, difficult to follow, and which cannot be validly generalized to the whole homosexual population at large. Evans (1969), in fact, failed to find strong supporting evidence that such disturbed family relationships are necessary and sufficient conditions for male homosexuality, for they are found also in heterosexuals, thus casting further doubt on Bieber's findings. The writer noted, also, that there was a tendency on Bieber's part toward forcing the true-life stories into predetermined patterns and cubby holes, thereby making them smaller than life and devitalized.

Other psychogenic theorists not holding to the psychoanalytic views expressed heretofore have assumed homosexuality to develop according to social
learning principles. Litin, Giffin, and Johnson (1956) and Bandura and Walters (1963) suggest that homosexuality may be "an emotional disturbance and personality disorder resulting from pathological parental encouragement and reinforcement of inappropriate sexual behavior," and they illustrate this point with a number of studies and cases. With few exceptions, the case studies of patients they examined definitely involve deviant sexual behavior that appears to be the result of pairing positive reinforcement in the form of close physical intimacy with sexual responses that are inappropriate for the sex or age of the child.

One drawback though, in connection with such evidence concerning the effects of reinforcement patterns on deviant sexual behavior, is that once again it comes mainly from a selectively loaded sample of interview and clinical studies of emotionally disturbed persons; these studies, however, do provide some evidence that exclusive homosexuality, at least in some cases, may result from the reinforcement of socially disapproved sexual responses, often in conjunction with nurturant parental modeling of atypical patterns of sexual behavior and the development in the child of an expectancy for negative reinforcement from female figures (Sears, 1953).

A multitude of studies done in the last twenty years have further suggested a higher incidence of mental illness within the homosexual population, but this relationship is by no means conclusive, since precisely these results might be anticipated considering the biased sampling techniques used. For example,
Doidge and Holtzman (1960), in comparing homosexuals who had been arrested for sexual offenses while in the Air Force with normal heterosexuals, obtained test results for the homosexual group which were significantly different from the heterosexual groups and which, in their opinion, indicated that "severe personality disorder, significant emotional disturbance, and poor overall self-concept were more likely to be present in homosexual individuals." It should be pointed out though that Doidge and Holtzman's homosexual sample consisted entirely of patients and individuals arrested for sexual offenses while in the Air Force; both selective loading factors and incarceration effects probably were at work to distort the results. Lambert (1954) found a history of attempted suicide and severe depression much more common among a group of homosexual soldiers than among their heterosexual comrades, and O'Connor (1958), studying a small series of suicides and attempted suicides, identified homosexual trends in about half of the cases. In an analysis of a hundred cases of male homosexuality, Curran and Parr (1957) pointed to a large proportion of the sample which was apparently neurotic and concluded that "homosexuality is an abnormal form of sexual behavior based in psychological disturbance" (i.e., it is psychopathological).

Cattell and Morony (1962), studying 100 incarcerated Australian homosexuals convicted of homosexual offenses, again obtained test results which differed significantly from those of normals. On the 16 PF Test the homosexuals were
very similar to anxiety neurotics and somewhat similar to psychopaths, similarity being indicated by a high pattern similarity coefficient; but once more, it would seem that selection factors and incarceration effects cannot be ruled out here as grossly affecting the results. In Bieber's (1962) study mentioned previously, results were obtained supporting the psychopathology of homosexuality using 106 male homosexuals undergoing psychoanalysis. The conclusion drawn was that "homosexuality in general is a diffuse personality disorder and a pathological ego disturbance, an illness and emotional maladjustment which is the defensive result of hidden but incapacitating fears of the opposite sex." Again, however, it should be noted that by using homosexual patients undergoing psychoanalysis, selective factors probably were operating that tended to load the sample with cases having moderate to severe personality disturbance.

The foregoing studies, despite their inherent methodological deficiencies, exemplify the prevailing and traditional psychogenic view of homosexuality as a sign of psychopathology; they are typical examples of the vast majority of the clinical literature on homosexuality presented as conclusive evidence supporting (in somewhat varied terminology reflecting the various theoretical positions of its clinical and researcher adherents) the position and assumption that homosexuality is always synonymous with, or at least a symptomatic indicant of, psychopathology (conscious or unconscious). In a recent joint session of the National Institute of Mental Health and United States Public Health Service,
Socarides (1971) summarized this view as follows:

"The rise of homosexuality to almost epidemic proportions makes it imperative for parents of the young, and for the public, to understand its nature. Currently the pathological affliction is surpassing four major illnesses in this country: heart disease, arthritis, rheumatism, and impairments of the back and spine. The homosexual personality is one who consistently and from inner needs and necessity compulsively engages in homosexual acts, and this pattern comes from faulty sexual identity and emotional disturbance in the earliest years of life. Typically we always find a pathological family in which there is a domineering, crushing mother who will not allow her child to achieve independence, and an absent, weak, or rejecting father. The acts of all homosexuals are caused by unconscious fears of heterosexual relationships or childhood psychological traumata. A person does not become a true homosexual if the initial psychopathological pattern is not laid out by three years of age. Like the Committee on National Public Health of the New York Academy of Medicine reports, homosexuality is a form of psychiatric and emotional illness and should be treated as such. It is a psychopathological disease of social proportions, national significance, and serious portent. The homosexual always must be treated as one who is suffering from marked emotional maladjustment, severe personality disorder, poor personality integration, and an extremely abnormal and aberrant type of self-concept. In short, the homosexual is essentially a mentally ill personality."

The connection of this primary trend in the literature, as epitomized by Socarides' (1971) view, with the specific hypotheses of this research study will become clear in the pages that follow.
A Divergent View—Homosexuality as Not Necessarily Pathological

Unlike most of the psychoanalytic and learning theorists who came after him, Freud did not always view homosexuality as a sign of psychopathology. For example, in his "Letter to an American Mother" (1935), he wrote:

"Homosexuality is assuredly no advantage in our culture, but it is nothing to be ashamed of, no vice, no degradation, and it cannot be classified as an illness, perversion, or disorder in and of itself; rather we consider it to be merely a variation of the sexual function."

Additionally, in his 1920 work, Freud speaks of overt homosexuality when the homosexual object is predominantly cathexed in the conscious psychic life of the individual, but he also maintains that the dynamics of homosexuality may be present in lesser form in non-homosexuals:

"A very considerable measure of latent or unconscious homosexuality can be detected in all normal people. Everyone, even the most normal person, is capable of making a homosexual object-choice, and has done so at some time in his life, and either still adheres to it in his unconscious or else protects himself from or against it by vigorous counter-attitudes or defenses."

Following Freud's reasoning, Pasche (1964) elaborates that we may frequently observe an occasional breakthrough of homosexual fantasies, dynamics, and behavior in the heterosexual person, although this takes place in our culture
under exceptional circumstances in many people—e.g., under the influence of alcohol when the repressing forces of the ego are weakened. He goes on to state that, in reality, homosexuality can show itself in four forms: repressed, fantasied, sublimated, and manifest; the first three may be latent (but nonetheless important from an internal motivational standpoint), while the fourth is overt (directly observable or acted out in external behavior).

In Three Essays on Sexuality, Freud (1905) describes homosexuality as essentially a displacement in the choice of the sexual object. He emphasizes, however, that a multiplicity of factors determines as individual’s development towards sexual maturity and capacity for heterosexual relationships, and the exclusive heterosexual outcome is "a rather precarious one at best based on a delicate balance of factors." Such a view seems to be implicit when he expresses the opinion in his 1920 work that a heterosexual development requires just as much explanation as a homosexual one, and that in principle the prospects for converting a confirmed homosexual into a heterosexual are not different from those of changing a heterosexual into a homosexual.

Freud repeatedly stated that homosexual behavior, in and of itself, is a manifestation and expression of the fundamental bisexuality of every human being, stemming from a biologically-rooted bisexual predisposition—a universal trend in all humans and a concept which has recently received cross-cultural and cross-species support from the biological and cultural anthropological re-
search of Ford and Beach (1961). This concept of homosexuality in Freud's theoretical system is not only linked to overt sexual behavior per se, but is also related to a conglomerate system of feelings, motivations, attitudes, and reactions that exist in varying degrees in all persons, although they are most evident in those whose behavior is overtly homosexual. Hence, anyone considering the status of homosexuality as one among many sexual maladjustments, or alternatively as a condition different in quality from the psychopathological perversions, is bound to give careful attention to the concept of universal human bisexuality, as put forth by Freud, for he felt that homosexuality may well be essentially different from the perversions. It will be recalled that he preferred the use of the term "inversion" in conjunction with homosexuality rather than "perversion," since the latter term, connoting as it did the cathexis of partial drives to parts of objects, would be inappropriate when used to describe homosexuality (which, like heterosexuality, more often than not manifests itself in a full cathexis of the love object with complete libidinal drives). Pasche (1964) uses the same line of reasoning, following Freud (and accepting the concept of universal human bisexuality), that the word "perversion" is not suitably used when applied to homosexuality. He says:

"As the main aspect of perversions applies to partial drives directed towards part-objects, the perverse attitude cannot imply by itself a full cathexis of the object, that is to say, feelings of tenderness, pro-
tectiveness, admiration, etc. toward the partner. Such feelings may, of course, exist in the pervert, but they are always incompatible with his specific desire. Fetishistic, exhibitionistic, masochistic, and sadistic regressions appear in homosexuals, but they do not describe them as such, for they appear also in heterosexuals."

Taking his cue from Freud and Pasche, Gillespie (1964) further discusses the knowledge and theories relating to homosexuality in an inquiry as to whether or not they can be actually accommodated easily and naturally in the general theory of sexual perversion. It might be, he hypothesizes, that homosexuality is a different kind of state or behavior pattern from other conditions that are considered to be psychopathological perversions and indications of severe personality disorder or emotional maladjustment. He argues:

"Perhaps the old discarded distinction which was once drawn by Freud between 'perversion' and 'inversion' might be really justified. What we call 'homosexuality' may be very far from homogeneous, so that some of the manifestations we include under this label may be properly classified with the perversions, others not. Thus, we have the hypothesis that homosexuality is not a homogeneous category, just as heterosexuality is not a homogeneous grouping. The possibility remains, and indeed it is a distinct probability, that what we lump together and call 'homosexuals' are actually made up of more than one personality group, some pathological and some not, and that these groups differ from each other in a fundamental way."

However, most traditional psychoanalytically-influenced theorists, clini-
ciens, and researchers do not accept either Gillespie's views, the theory of psychological bisexuality, or the assumption that homosexuality is a normal phase of libidinal development as put forth by Freud. Rather, as seen from the preceding section, they view it as a pathological ego disturbance and adaptation to certain environmental vicissitudes, which results in an emotional maladjustment and sexual perversion caused by "hidden but incapacitating fears of the opposite sex" (Bieber, 1962; et al.). There seems to be little doubt that most modern psychoanalytic research supports this thesis; in view of the highly selective nature of the psychoanalysts' clinical material on homosexuality though, it still remains to be demonstrated that such fears are always at the bottom of the homosexual symptom. Certainly, in numerous instances of behavioral bisexuality, the evidence of fear of women is less obvious than in cases of exclusive homosexuality.

If sexuality operates adaptively, as most of these psychoanalytic authors agree it does, then it would appear to the present writer that researchers in this area must concede at least the possibility that a homosexual object-choice can be determined on the basis of a natural, innate bisexual predisposition and early learning or persistent positive conditioning to objects of the same sex, rather than solely by pathological fears of the opposite sex. It has been reported, for example, that many previously heterosexual men who resort to homosexual practices during long periods of isolation or confinement with other males find
it difficult, or do not choose, to resume heterosexual relations when released simply because they have learned to enjoy the homosexual experiences (Karpman, 1958; Wilson and Pescor, 1959). This finding is reminiscent of an experiment reported by Jenkins (1958) where he found that, some time after previously heterosexual rats had been segregated sexually and all other factors kept normal and constant, homosexual behavior would commence as a matter of course. On being returned to the company of rats of the opposite sex, a number would remain homosexual or at least bisexual, depending on the length of time they had been segregated, although all other aspects of their behavior appeared normal. This behavior is apparently also characteristic of other animals under similar circumstances.

More recent scientific investigations into the sexual behavior of human and subhuman animals have also demonstrated that homosexual responsiveness is a normal component of mammalian sexuality; that is to say, in the absence of negative conditioning, any animal (human beings included) appears to be capable of fully responding normally and naturally to any adequate sexual stimulus—heterosexual or homosexual. In other words, the stimulus is a necessary and sufficient condition in and of itself to motivate the behavior, regardless of the sex of the object. For example, the biological and cultural data offered by Ford and Beach (1961), in their ten year study of hundreds of species of primates and mammals, support Freud's conclusion that bisexuality is a
normal tendency inherent in the human species. They state:

"The cross-cultural and cross-species dimensions and comparisons presented combine to suggest that a normal, natural tendency for inversion of sexual behavior is inherent in most if not all mammals including the human species. The capacity for homosexual, as well as heterosexual, response is a basic part of our mammalian heritage. Cultural pressures and social conditioning determine the final sexual object choice for human beings in many cases, however. Thus, it would appear that exclusive heterosexuality in our society and time may be little more than a culturally-imposed restriction."

The behavioral fact of "homosexuality"--or better, of "ambisexuality" (deemed a more appropriate term than "bisexuality" by many newer researchers in this area because the latter is loaded with too many unwarranted biological implications)--in lower animals presents several theoretical facets that have implications for human beings. Normally occurring socially conditioned homosexual behavior is almost universal among animals, according to Denniston (1965), and frequent natural homosexual activity has been described for all species of mammals of which recent careful observations have been made. Such homosexual activity is never found to the full exclusion of heterosexual behavior, however, at least under normal circumstances. Denniston further adds:

"Homosexual behavior, for example, is so common in domestic stock as to attract little notice from the husbandman, unless he chooses to use it for some
specific purpose. Cows in heat so frequently mount other cows that the behavior is considered diagnostic of the oestrus condition. Young bulls or steers are often used as 'teasers' to arouse mature bulls in preparation for the collection of ejaculates to be used in artificial insemination, since it has been discovered that a bull will react more readily sexually to a 'teaser' of his own sex than to a female heifer. Even as lowly an organism as the common fish shows homosexuality related to social dominance subordination conditioning."

The recent research surveys of homosexual activity among lower animals should thus serve to explode several widely held myths and misconceptions. First, homosexual behavior is certainly not a uniquely human practice; it occurs under normal conditions in every type of animal that has been carefully studied. Secondly, such activity has little or no relation to behavioral, hormonal, or structural abnormality.

The foregoing data also serve to counter an argument frequently raised against the significant likelihood of non-pathological homosexual behavior in humans, at least in Western society, by most traditional clinicians and researchers when they assert, as does Bieber (1962), that "heterosexuality is the natural biologic norm," as it were, and that "homosexuality is thus a sexual perversion and personality disorder that cannot occur without some psychopathological basis and/or anxiety-provoked inhibition of heterosexuality." This argument, it seems to the present writer, does not withstand careful scrutiny. All of the evidence from more recent comparative zoology or cross-species and
and cross-cultural studies indicates that, on the contrary, bisexuality or "ambisexuality" is the natural biologic norm and that exclusive heterosexuality is a societally-imposed cultural restriction. Patterns of homosexuality are normally displayed concurrently among primates, for example, even, it should be noted, where heterosexual opportunities and behavior exist alongside. Exclusive homosexuality though is also a rarity in the animal world, and its relative frequency in man must therefore be due to specific features of human life; however, the same may be said for exclusive heterosexuality. Thus, while it might be theorized by many traditional researchers for our time and culture that exclusively homosexual behavior might be associated with unconscious fears of heterosexual relationships, it might be equally justifiable to assert the converse, that exclusive heterosexual behavior (which sometimes verges on the compulsive in modern Western society) may also be associated with unconscious fears of homosexual relationships (Churchill, 1968). Hampson and Hampson (1968), in their investigation of the acquisition of gender role in humans, point strongly to the presence of psychosexual neutrality in humans at birth— a neutrality that permits the development and perpetuation of diverse patterns of psychosexual orientation and functioning in accordance with the normal, as well as pathological, life experiences each individual may encounter and transact. The work of Stoller (1965) corroborates these findings. If we recognize, as the work of the Hampsons clearly indicates, that the objects of human sexual
drives are experientially and culturally determined rather than biologically determined by the drives themselves, then it must be concluded that there is nothing inherently "unnatural" about life experiences that predispose an individual to a preference for homosexual object-relations except insofar as this preference represents a socially condemned form of behavior in our culture and consequently carries with it certain sanctions or handicaps.

Many of the efforts by clinicians to explain homosexual behavior among the higher animals and man tend to become rather complicated and unnecessarily speculative. In many cases, this seems to result from an anthropocentric and ethnocentric bias on the part of the observers who find it difficult to imagine that homosexual stimuli could of themselves provide sufficient motivation for sexual behavior. Consequently, many theorists search for elaborate and often extraneous explanations of homosexual behavior when it may be sufficient to realize that any animal, in the absence of negative conditioning, is capable of responding to any adequate sexual stimulus, heterosexual or homosexual, regardless of the sex of the object (Ford and Beach, 1961). The data on homosexual behavior among infrahuman animals indicate that such behavior constantly and normally occurs among the lowest as well as the highest mammals, but as one ascends the phylogenetic scale both the frequency and complexity of this behavior increase; and among the subhuman primates one gets a clearer inference and indication of the type of homosexuality that exists at the level of human
life. The complexity of any animal's behavior is a function of the complexity of its nervous system. As Ford and Beach (1961) say:

"Exclusive preferences and patterns of sexual behavior, heterosexual or homosexual, come only with experience, or as a result of social pressures which tend to force an individual into an exclusive pattern of one or the other sort. Psychologists and psychiatrists, reflecting the mores of the culture in which they have been raised, have spent a good deal of time trying to explain the origins of homosexual activity in psychopathological or abnormal conditions; but considering the physiology of sexual response and the mammalian backgrounds of our human behavior, it is not so difficult to explain why a human being does a particular thing sexually. It is more difficult to explain why each and every individual is not involved more in every type of sexual activity."

The phylogenetic basis of homosexuality is often denied by most clinicians and others advocating the view that all human homosexuality is psychopathological and that it is always a "symptom of fear and inhibition of heterosexual expression" or "a personality disorder and emotional maladjustment resulting from hidden incapacitating fears of the opposite sex and/or an abnormally high expectancy for negative reinforcement from female figures." These authors and researchers do not believe that there is any connection between infrahuman homosexuality and the homosexuality of human beings, "where cognitive and highly complex patterns of motivation are involved and where, at least in our society, fear of heterosexuality is salient" (Bieber, 1962). However, the fact
that human homosexuality involves "cognitive" and "highly complex patterns of motivation," of course, is a function of the complex central nervous system of human beings and only demonstrates the obvious; namely, that human beings humanize every type of behavior in which they become involved. Churchill (1968) points out:

"Authors and researchers who are dedicated to the clinical interpretation of homosexuality are often forced to disparage the significance of human homosexual behavior outside our own culture, because such behavior usually does not meet with the criteria emphasized in their clinical theories. But they have no right to elaborate theories on the origin and meaning of homosexuality that ignore or disparage the homosexual behavior of infrahuman individuals or the behavior of other human beings in other cultures simply because their attitudes do not conform to what we have come to regard as 'normal' in our own sex-negative, sexerophobic culture. On the basis of the phylogenetic data as well as the cross-cultural and cross-species data, it becomes obvious that homosexual behavior seems to arise from some deep-seated and deep-rooted natural urge, and thus cannot be always so easily written off as an indication of psychopathology, ego disturbance, mental illness, aberrant self-concept, emotional maladjustment, or personality disorder."

An Attempt at Consolidation and Synthesis

To dichotomize the problem, is homosexuality always a sign or indication of personality disorder, general emotional maladjustment, lack of personality integration, or any other psychopathology traditionally ascribed to it; or is it
merely a different way of life? Bieber (1962), in his psychoanalytic study, clearly views homosexuality as "a sign of psychopathology and perversion" and as "an emotional illness incompatible with a good psychological adjustment, a reasonably happy life, and a healthy high level of self-esteem and self-acceptance." Hooker (1967), on the other hand, argues that, apart from the specific difference in sexual orientation, many of the homosexuals she has intensively interviewed reveal no "clinically observable or demonstrable pathology" that would differentiate them in any way from a group of relatively happy, normal heterosexuals with healthy self-concepts; indeed, she found no more evidence of personality deviation or mental illness "than one would expect to find in any random sample of the population." In the first of only three research studies to have been done using subjects other than clinical patients, she reported on a group of 30 homosexuals and 30 heterosexual controls, both groups having been selected for good adjustment and functioning in the community and lack of indications of psychological disturbance. Absence of significant differences between the groups led her to conclude that "homosexuality may be a deviation in sexual pattern or object which is within the normal range psychologically." Following Hooker, Chang and Block (1970), in reporting on identification in male homosexuals from urban communities, stated that in the homosexual and heterosexual groups they studied (who were not incarcerated or in psychotherapy at the time, but rather functioning adequately in society— in contrast to so many
of the past studies), they did not notice in their interviews any tendency for the
two groups to differ in the degree of their self-acceptance, level of self-concept,
and ego-ideal and that there was no obvious trend for the heterosexual groups
to be more self-accepting. In addition, Clark and Epstein (1972) found that the
sweeping generalization presented in the psychological literature—that homosexu-
als always have a preference for objects of the same sex and a distaste for
the opposite sex based on a high affective expectancy for negative reinforcement
(conscious or unconscious) from female figures, which is learned from emo-
tional interactions with parents—may be in need of qualification or revision.
Their data, using 100 college-educated, socially functioning, overt homosexual
males (many of whom were professional people) and a heterosexual comparison
group, suggested that such an expectancy for negative reinforcement from fe-
males in homosexuals, if and when present at all, is very heavily dependent
upon important stable personality dispositions and differences, notably variations
in self-concept, and thus varies considerably from person to person. Indeed,
the expectancy for negative reinforcement from females (as measured by a per-
ceptual task involving an affective probability learning experimental paradigm)
was evidenced only in homosexual groups at the level of low self-concept in
Clark and Epstein's study and not at all at the level of high self-concept.

One possible explanation for these widely varying views concerning whether
homosexuality is necessarily always a symptom of emotional maladjustment or
personality disorder comes immediately to mind. The concepts of traditional researchers such as Bieber (1962) are all derived from the study of homosexuals who have sought psychoanalysis or other types of psychotherapy or else have been referred because of external legal or behavioral difficulties. Hooker’s case material, on the other hand, includes many non-patient homosexuals who appear to be emotionally and interpersonally well-adjusted and who have felt no need or motivation whatever to seek psychotherapy. As a result, a strong possibility exists that traditional studies and concepts about the characterological and personality defects of homosexuals are based on a skewed sampling of mentally disturbed individuals and may not accurately represent or portray the spectrum of personalities truly present in the total homosexual population. To be sure, the three recent studies just presented offer data that lends credence to the possibility that sexual deviance in and of itself may not necessarily mean social and psychological maladjustment, despite earlier evidence to the contrary. Although extensive homosexual behavior may reflect a functional limitation in the capacity for heterosexuality, the possibility must be granted that under certain circumstances this limitation may not necessarily interfere with a reasonably satisfactory normal life adjustment and personality integration. As Churchill (1968) points out, if the judgments of clinicians about heterosexuals were based only on the ones they see as patients, they would have the same skewed impression of heterosexuals as a group as they have of homosexuals.
Some Suggestions for Further Research

The value of the three foregoing studies becomes apparent when they are generally seen not only as a start toward a more realistic view of homosexuality, but also when they are more specifically viewed as the first studies to ever make use of seemingly well-adjusted (non-patient) homosexuals in countering the primary trend in the clinical literature which asserts across-the-board that homosexuals always present a picture of psychopathology and mental illness as compared to normal heterosexuals. A shortcoming of both Hooker's (1967) and Chang and Block's (1970) studies, however, is that they involved only clinical interviews of non-patient homosexual subjects and no empirical data.

The next step for scientific research, in the opinion of Churchill (1968) and the present writer, has to be an experimental study utilizing data from reliable and valid psychological tests to more deeply study and suitably portray, from an operational standpoint, the particular patterning of personalities (if present), the psychodynamics, and level of self-concept characterizing a non-patient segment of those individuals involved in homosexual activity to see if they do, in point of fact, always present a picture of psychopathology, general emotional maladjustment, personality disorder, and a low level of self-concept, self-esteem, and personality integration when compared to exclusive heterosexuals, as the overwhelming majority of the clinical literature would insist.

It is appropriate that any further research study in the area of homosexuality
should include a measure of self-concept as well as performance on other personality variables, since it has been found that certain internal personality dispositions—notably the self-concept—may mediate the influence of affective value on the learning of emotional expectancies (Klein and Schlesinger, 1949; Rosenhan and Messick, 1966; Clark and Epstein, 1972; et al.). Fitts (1955) also points out that a personality disposition such as the self-concept serves as a perceptual frame of reference, as it were, in social perception (the way one perceives oneself and others), which is an important factor in human behavior, adjustment, and adaptiveness. The individual's concept of himself has been demonstrated to be highly influential in much of his behavior and also to be directly related to his overall personality adjustment and integration, motivations, expectancies, and state of mental health (Berg, 1965). A knowledge of how an individual perceives himself (his self-concept) is thus very beneficial in making evaluations of the level and state of his psychological functioning.

Additionally, any proposed further research should deal with the matter of definition of the homosexuality variable. Should subjects only be divided into groups of homosexual and heterosexual on an "either-or" basis as has been done in the past? It would simplify matters considerably if all males learned a pattern of mutually exclusive sexual preferences so as to make it possible to divide them into distinct classifications, one heterosexual and the other homosexual. However, as Kinsey, Pomeroy, and Martin (1948) point out:
"Our research concerning sexual behavior in the human male indicated that, in reality, males do not represent two discrete populations, heterosexual and homosexual, despite cultural mores and myths to the contrary. The world is not to be divided dichotomously into sheep and goats. Not all things are black nor all things white. It is a fundamental law of taxonomy that nature rarely deals with discrete categories; only the human mind invents categories and tries to force facts into separated pigeon-holes. The living world of nature is a continuum in each and every one of its aspects, and the sooner we learn this fact concerning human sexual behavior and forget the myth of a mutually exclusive either-or dichotomy, the sooner we shall reach a sound understanding of the realities of sex."

Accordingly, then, it must be understood that the homosexuality of most males is not actually an all-or-nothing proposition. This is not to say that the existence of individuals with a history of exclusive heterosexuality or homosexuality can be overlooked. On the contrary, the existence of exclusive heterosexuality and homosexuality has always been recognized, to be sure, and for the most part over-emphasized in the literature; what is important to understand also, though, is that there is always a considerable portion of the male population in any culture whose members have learned to respond to both heterosexual and homosexual stimuli (Kinsey, et al., 1948; Churchill, 1968). This important variable has not been taken into account in past studies. There are some individuals in whom heterosexuality predominates, some in whom homosexuality predominates, and others in whom the two types of responsiveness
are more or less balanced have been traditionally referred to as "bisexual" (or more recently, "ambisexual"), with the remainder of this group being called either heterosexual or homosexual. This method of classification, however, proves to be rather misleading, because it provides for only a three-point scale or tri-partite division; whereas in nature, according to Kinsey, et al. (1948) and the wealth of recent animal, cross-species, and cross-cultural studies discussed earlier, there is a much more gradual transition between exclusive heterosexuality and exclusive homosexuality.

The transitional continuum of sexuality is better described by a seven-point "Heterosexual-Homosexual Rating Scale" devised by Kinsey, et al. (1948). In this Scale (see Appendix), 0 represents individuals with a history of exclusive heterosexuality, 6 represents individuals with a history of exclusive homosexuality, and 1 through 5 represent all those individuals with a history of varying combinations of heterosexual and homosexual experience. In the present research, the writer is interested in all those individuals who rate from 1 through 6, rather than only those ratable as 5 and 6. Heretofore it has been only those at the upper extreme of the continuum who have been the center of attention in most books, monographs, research studies, and experiments on homosexuality. The serious neglect of those ratable from 1 through 4 has tended to obscure the full significance of homosexuality in the life of the adult human male. Thus, in many cases statistical estimates of homosexuality in our
culture have been misleading because they have tended to refer at most only to those with the highest rating on the sexual continuum scale. Indeed, it is presumably those ratable as 5 and 6 whom most people and clinicians have in mind when they speak of the "homosexual." Yet it is impossible to be sure of what is meant by this elusive expression, since many people regard any person who has any homosexual experience whatsoever as a "homosexual." However, as Kinsey, et al. (1948) observe, "All such judgments are the product of the tendency to categorize sexual activities under only two heads, and of a failure to recognize the endless gradations that actually exist." Following this same line of reasoning, Churchill (1968) denies that the "homosexual" can be defined, since homosexual behavior occurs to some extent in such a wide variety of persons. Most often homosexual responsiveness occurs among males who also respond vigorously to heterosexual stimuli, and he states that it is entirely misleading to discuss it as if it were always, or even usually, a distinct phenomenon isolated from other aspects of mammalian sexuality. In a personal communication (1970) with the writer, Churchill amplified this view even further, as follows:

"I am especially impressed by the fact that your research is directed toward 'non-patient, socially functioning homosexual and bisexual (or better ambisexual) males,' for these are the males that the conventional literature tells us least about, and there seems little doubt that
they are the males who form the overwhelming majority within the group rated from 1 through 6. It is important to realize that homosexual and heterosexual propensities are by no means polarities and that, as may be seen through the cross-species and cross-cultural data, most males who are homosexually responsive, even to a high extent, remain heterosexually responsive as well. This point is often obscured by culturally derived attitudes and beliefs, and such attitudes and beliefs may even foster the development of a larger number of exclusively heterosexual and exclusively homosexual males. But in cultures where such attitudes are minimal, or even almost totally absent, an ambisexual orientation seems to be much more common. In fact, as a long-time resident of Italy, I have become especially aware of this because the sex-culture of Italy, as in most Mediterranean countries, tends to be far more ambisexual than, for example, in America or Western Europe. To be sure, there is far more overt and covert ambisexuality than the mores, myths, and verbalized ideals of the group would ever suggest."

Agreeing with Kinsey et. al. (1948) and Churchill (1968), the present writer feels that the only valid approach to researching homosexuality is to distinguish degrees of homosexual orientation on the basis of frequency and preference of homosexual activity. Therefore, the present study was based upon a large sample in which the appropriate proportion of all males rated as 1 through 6 on the "Heterosexual-Homosexual Rating Scale" was included. Such a sample represents the entire population which has any history of homosexuality. The present research is the first study of homosexuality to utilize
in an experimental setting the "Heterosexual-Homosexual Rating Scale" as devised by Kinsey, et al. (1948); in addition, it is only the fourth study in this area to use a non-patient sample of those individuals involved in homosexual behavior.

Hypotheses

Given the foregoing approach for distinguishing degrees of homosexual orientation, the writer decided to obtain psychological test scores from groups of individuals ratable 1 through 6, and compare the results with a heterosexual group comprised of an equal number of males ratable as 0. On this basis, the writer would be better able to make an estimate of the effects of homosexuality on the entire group concerned rather than, at most, its effects upon a subpopulation at the upper extreme of the continuum (the latter having been the case with all past research in this area). Would there be, as Socarides (1971) insists, "definite demonstrable pathology, emotional maladjustment, personality disorder, and lowered self-esteem and personality integration that can always be predicted and found in those groups of individuals involved in homosexual behavior" revealed on a reliable and valid psychological test that would differentiate such groups psychologically in any way from a group of normal heterosexuals, all groups (not just the exclusive heterosexuals) being chosen on the basis of their socially functioning, non-patient status and all other variables
held constant except for that of sexual behavior and preference?

In view of the preceding discussion, the following first hypothesis is suggested:

**Hypothesis I.** Groups of subjects involved in varying degrees of homosexual behavior and preference (Groups 1-6) will not differ significantly in levels of psychopathology from a group of matched heterosexuals (Group 0), as revealed by total group mean scores across a battery of the following eight personality scales on a standard psychological measure: self-concept, self-criticism, defensiveness, general emotional maladjustment, psychosis, personality-character disorder, neurosis, and overall personality integration; that is, the groups will not differ significantly in total mean scores across all personality measures.

In other words, it is hypothesized that there will be no significant differences between groups for total scores across all measures.

**Hypothesis II.** Groups of subjects involved in varying degrees of homosexual behavior and preference (Groups 1-6) will not differ significantly in pattern of individual psychopathology scores on the same personality measure from a group of matched heterosexuals (Group 0); that is, the pattern of group mean scores upon individual measures across all groups will not be significantly different.

In other words, it is further hypothesized that there will be no significant differences in pattern of scores upon individual measures across groups.

From the preceding discussion in the Introduction, it was pointed out that the present study differs from others in that a socially functioning, non-patient sample of males who express varying degrees of homosexual behavior and pref-
erence is being used. Since past studies were criticized for not controlling this variable and thus contaminating and distorting the results, the writer proposes Hypothesis III:

Hypothesis III. Homosexuality, per se, will not be a criterion predictor (or predictive criterion) of psychopathology; that is, there will be no significant prediction of psychopathology from level of homosexuality.

In other words, it is further hypothesized that there will be no statistically significant degree of relationship between level of homosexual behavior and preference (as indicated by group position on the Kinsey Scale) and any of the types of psychopathology emphasized in the clinical literature (as measured by psychological test scores of psychopathology).
CHAPTER II

METHOD

Materials

The first step of this experimental study made use of the seven-point "Heterosexual-Homosexual Rating Scale" devised by Kinsey, Pomeroy, and Martin (1948) to better describe the gradual transitional continuum of sexuality between exclusive heterosexuality and exclusive homosexuality. In this rating scale (see Appendix), 0 represents individuals with a history of exclusive heterosexuality (0% homosexual), 6 represents individuals with a history of exclusive homosexuality (100% homosexual), and 1 through 5 represent all those individuals with a history of varying combinations of heterosexual and homosexual experience and preference. Those rated 1 (1–19% homosexual), for example, "have only incidental homosexual contacts which have involved physical or psychic response, or psychic responses without physical contact," and "the great preponderance of their sexual experience and psychic reaction is directed toward members of the opposite sex." Those rated 3 (40–59% homosexual activity) "stand midway on the heterosexual-homosexual scale," and "they accept and equally enjoy both types of contacts and have no strong preferences for one or the other." Those rated 5 (80–99% homosexual activity and preference) "are mostly homosexual in their overt activities and/or psychic
reactions," but "they do have incidental experience with the opposite sex and
do on occasion react physically to individuals of the opposite sex." Since this
is a seven-point scale, 3 is the midpoint of the classification; and, therefore,
0 is the opposite of 6, 1 is the opposite of 5, and 2 is the opposite of 4. These
ratings take into account not only the individual's overt experiences but also
his psychosexual reactions, mental preferences, motivations, and fantasies.
In those few instances in which actual behavior and psychosexual reactions are
not in accord, the rating of an individual is based upon an evaluation of the rel-
ative importance of the overt and the psychic in his history, the final rating
being an average of the separate overt behavior and mental preference ratings.
In addition, the position of an individual on this scale is determined not just by
the absolute numerical amount of overt experience or psychic reaction alone,
but by the relation or ratio of the heterosexual to the homosexual in his history.
In other words, all of the individuals in each classification or group show the
same approximate balance between the heterosexual and homosexual elements
in their history. Every person, therefore, may be graded or rated at some
point on this scale in accordance with a reasonable representation of his sexual
orientation.

The second step of this experiment utilized the Tennessee (Department of
Mental Health) Self-Concept Scale developed by Dr. William E. Pitts, hereafter
referred to as the Tennessee Self-Concept Scale or more simply the TSCS, and
its Clinical and Research Form answer sheet. Other measures of psychopathology could have been used, but the TSCS was selected for several reasons: it is widely recognized, is in current clinical and research use, it is simple for the subject, well-standardized, corrected for social desirability, correlates well with other known personality measures (Berg, 1965), and is applicable to the whole range of psychological adjustment from well-adjusted people to psychotic patients. It also proved to be an excellent instrument in the author's previous work (Clark and Epstein, 1971). Furthermore, the Scale is multi-dimensional both in its description of the self-concept and in other important personality characteristics which reflect the individual's state of mental health and psychological adjustment.

For the purposes of this study, the experimenter was interested in one particular self-concept summary score on the TSCS—the Total Positive + Negative (P+N) Score (test-retest reliability coefficient .88). This is the most important self-concept score on the Clinical and Research Form, as it reflects the overall level of self-esteem, and high scores uniformly mean positive self-concept. Persons with high scores tend to like themselves, feel they are persons of value and worth, have confidence in themselves, and act accordingly. People with low scores are doubtful about self-worth; see themselves as undesirable; often feel anxious, depressed, and unhappy; and have little confidence in themselves.

In addition, there are six psychopathology scales on the Tennessee Self-Concept Scale that were of special interest to the experimenter, for they deal
directly with the individual's state of mental health and the presence or absence of significant psychological disturbance. The scores on these scales are purely empirical, and cut across the basic classification scheme of the TSCS, having been derived by item analysis, with a resulting selection of those items which differentiated one group from all other groups. The seven empirical psychopathology scales are as follows:

1. The Self-Criticism Score - SC. This scale is derived from a scale composed of 10 items from the L-Scale of the MMPI and are all mildly derogatory statements that most people admit as being true for them. Its interpretation is identical to that of the MMPI's Lie Scale in terms of level of defensiveness and attempts to present a favorable picture of oneself (but is more gross a measure than DP).

2. The Defensive Positive Scale - DP. This scale composed of 29 items is a subtle measure of defensiveness; it stems from a basic hypothesis of self theory: that individuals with definite and established psychological and psychiatric difficulties do have negative self-concepts at some level of awareness (overt or covert), regardless of how positively they describe themselves on an instrument of this type.

3. The General Maladjustment Scale - GM. This scale of 24 items differentiates psychiatric patients from non-patients on the basis of emotional maladjustment but does not differentiate one patient or psychological disorder group from another. Thus it serves as a general index of emotional adjustment-maladjustment but provides no clues as to the nature of the psychopathology; this is an inverse scale on the Profile Sheet, and low scores result in high T-scores on the Profile Sheet (which means high similarity to the group from which the scale was derived).

4. The Psychosis Scale - PSY. This is a scale based on 23 items which differentiates pre-psychotic individuals and psychotic patients from other groups.
(5) The Personality Disorder Scale - PD. This is another inverse scale composed of 27 items that differentiates those people with character disorders or other basic personality defects and weaknesses in contrast to psychotic states or the various neurotic reactions.

(6) The Neurosis Scale - N. This is an inverse scale of 27 items differentiating neurotics from normals.

(7) The Personality Integration Scale - PI. This scale consists of 25 items and measures the degree of personality integration and level of overall adjustment.

The Tennessee Self-Concept Scale itself consists of 100 self-descriptive items or statements (see Appendix) which the subject uses to portray his own picture of himself; each statement can be answered on a semantic differential ranging from response #1 (completely false) to response #5 (completely true). The TSCS is self-administering and requires no instructions beyond those on the inside cover of the test booklet. It is well, however, to note one point which needed special attention by the experimenter. The Clinical and Research Form (C & R Form) answer sheet is arranged so that the subject responds to every other item on the answer sheet (an attempt to help eliminate response sets), and some subjects were momentarily confused at this point; thus, it was helpful for the experimenter to be aware of this possibility. The majority of subjects completed the TSCS in less than 20 minutes.

The test-retest reliability coefficients of all major TSCS scores are reported in Table I of the Manual (Fitts, 1965). In addition, several other evi-
dences of reliability are seen in the similarity of profile patterns found via repeated measures of the same individuals over long periods of time presented by numerous researchers, with reliability coefficients for the various profile segments falling in the .80 to .90 range. Four types of TSCS validation procedures were used (with some excellent resultant coefficients): (1) Content validity; (2) discrimination between groups; (3) correlation with other personality-mental health measures; and (4) personality changes under particular conditions.

Procedure

Over 200 subjects were interviewed by the experimenter over an 18 month period, with the homosexual Ss being contacted through persons in the homosexual subculture and the heterosexuals coming from a similar college and professional population, both in various parts of the United States and in Canada. These interview sessions with each S were to determine the extent of the Ss sexual preferences from both an overt and psychic standpoint. (A sample of the interview question topics is given in Appendix III). Each S gave the experimenter an estimate of the percentage ratio of his overt homosexual and/or heterosexual behavior and an estimate of the percentage ratio of his homosexual and/or heterosexual fantasies and mental preferences. Only one interview with each S was possible because of the exclusive, intimate nature of the information given. Due to extenuating circumstances relating to subject accessibility and availability, only 140 subjects
actually participated in the final experimental task, giving an $n=20$ size for each group (which was the largest that could be used); the remaining subjects, then, did not participate further in the study.

On the basis of the interview findings, each subject's percentage ratio of heterosexual-to-homosexual behavior and preference was calculated, with each of the 140 Ss then being assigned on the basis of this percentage ratio to the appropriate one of seven possible group ratings on the "Heterosexual-Homosexual Rating Scale" which was in accord with, and most correctly reflected, his specific sexual behavior and desires. These assigned ratings, in turn, produced seven matched groups, each group having an $n=20$ and varying from every other group only in the percentage of homosexual desire, preference, and behavior expressed by its members (which was constant only among members within a particular group); all Ss were otherwise matched for age, educational background, and a lack of clinical or patient history of significant psychological disturbance.

Thus, in accordance with Kinsey's, et al. (1948) designations, Group 0 represented one end of the sexual continuum scale and had only those individuals in it who expressed no homosexual tendencies at all; hence, they formed the completely exclusive heterosexual comparison group for this experimental study. Groups 1 through 5, on the other hand, were experimental groups composed of subjects espousing varying degrees of both heterosexuality and homosexuality, with the percentage of homosexual activity and preference of the group members
increasing (and heterosexual behavior decreasing) accordingly as the group's numerical designation on the "Heterosexual-Homosexual Rating Scale" gets larger. The upper end of this continuum of sexuality was represented by Group 6, which contained only those subjects who are completely homosexual in behavior and preference and who respond to no heterosexual stimuli. (See Appendix for more detailed descriptions and percentages.)

After all subjects had been rated in terms of sexual preference and assigned to the appropriate group, all seven groups were administered the Tennessee (Department of Mental Health) Self-Concept Scale. Next, the Clinical and Research Form answer sheets were sent to Counselor Recordings and Tests in Nashville, Tennessee, for computer scoring of all self-concept and personality adjustment- psychopathology scales.

Subjects

The subjects that participated in the entire experiment were 140 college-educated, socially functioning adult males, chosen on the basis of admitted homosexual or heterosexual preference mainly through contacts in the homosexual subculture over a period of eighteen months. The subjects' ages varied between 20 and 39 years, with a mean age of 29.2 years and a median age of 30 years. Several subjects had been awarded the Master of Arts and/or the Doctor of Philosophy or Doctor of Medicine degrees, while others were still college under-
graduates or recently graduated with baccalaureate degrees. The academic and occupational background of the subjects was extremely heterogeneous, with approximately 20 different academic majors represented. Occupations included medicine and other health professions (31), law (10), education (16), business (29), professional athletics (17), the ministry (4), the armed forces (5), and the acting profession (28). All of the subjects were either employed or continuing their education and thus were functioning at least adequately in society; in addition, none were in any form of psychotherapy or in legal difficulty because of their homosexual behavior.

**Statistical Treatment of Data**

In order to test Hypotheses I and II, mean performances of the seven groups on the seven scales of the TSCS were compared and appropriately analyzed for significant differences (our hypothesis predicting no such differences) using a two-way analysis of variance (ANOVA), $8 \times 7$ statistical design, for a two-factor experiment with repeated measures on one factor (Winer, 1962). Additionally, to analyze the data obtained from the experiment in a manner consistent with Hypothesis III of this study, a Multiple Regression analysis was utilized as the appropriate statistical technique. Its two principal and functional advantages were: 1) it yielded the optimum weighting for combining a series of variables in predicting a criterion while providing an indication of the accuracy of subse-
quent predictions; and 2) it permitted the analyzing of variation into its component parts.

For the purposes of this study, the seven TSCS measures of psychopathology and self-concept for each S were used as the predictor (X) variables; these predictors were selected on an a priori basis from a larger group of 29 possible scores in the Clinical and Research (C & R) Form profile for each S. The criterion (Y) measure was the particular position on the Kinsey Heterosexual-Homosexual Rating Scale for each S; although this scale was based upon a self-report and is an ordinal scale, it could still be legitimately used in the regression analysis.

It should be pointed out here that Hypothesis III proposed that homosexual behavior, per se, will not be a predictor of psychopathology; however, multiple regression has no statistical analysis procedure which allows one to predict multiple criterion (TSCS measures of psychopathology and self-concept) from a single predictor (amount of homosexual behavior and preference as measured by the Kinsey H-H Scale). Thus, it became apparent that to some degree multiple regression was not completely congruent with Hypothesis III as set forth earlier; nevertheless, since there were no intentions of pointing the causal arrow in one direction or the other, the relationships obtained could be turned around, as it were, and be interpreted as correspondences between the predictor variables (TSCS measures) and the criterion (level of homosexuality) for
the sake of the analysis.

The experimenter's interest, then, was in the form of the relation that might occur between the criterion (level of homosexual behavior and preference) and the predictor variables (TSCS measures of psychopathology and self-concept) and specifically whether this relation could be approximated well by some kind of function rule. In other words, to test Hypotheses III of this study, an attempt was made to set up a multiple regression equation which predicted the level of homosexuality (\(Y\) or criterion variable) from a battery of TSCS scales of psychopathology and self-concept (\(X\) or predictor variables). This involved taking the best possible weighting of the number of predictor variables in order to give the best function to predict position on the Heterosexuality-Homosexuality continuum (0-6), although Hypothesis III predicted that this could not be done to any statistically significant degree.

Upon completion of the multiple regression analysis, the reliability or significance of the multiple correlation was determined by an F-test. The relative contributions of each predictor variable were obtained by further investigation of each Beta weight (partial correlation coefficient) in conjunction with its respective variable's correlation with the criterion. An indication of the accuracy of future predictions was obtained from the coefficient of determination \((R^2)\), which gives the proportion of variance in the criterion explained or accounted for by that particular combination of predictor variables. (It should
also be kept in mind that the Beta weights themselves were standard partial regression coefficients and thus aided in the interpreting of the relative contributions of each predictor.)
CHAPTER III

PRESENTATION AND ANALYSIS OF RESULTS

The basic data of the study can be summarized in a table of mean performance scores and standard deviations for all seven experimental groups on each of the eight TSCS personality measures. These results are shown in Table 1, Page 53a.

Hypotheses I and II (which predicted no significant differences between groups for total scores across all TSCS personality measures and no significant differences in pattern of scores upon individual personality measures across groups, respectively) were tested by means of a two-way analysis of variance (ANOVA) with repeated measures on one factor, the results of which are summarized in Table 2, Page 53b.

Hypothesis I would be established if a non-significant F for main effect A (between groups main effect) could be obtained, while Hypothesis II would be confirmed if no significant A x B (group level x mean score) interaction effect could be obtained. Table 2 reveals no significant main or interaction effects,
<table>
<thead>
<tr>
<th>Homosexuality level</th>
<th>TOTAL</th>
<th>SC</th>
<th>DP</th>
<th>GM</th>
<th>PSY</th>
<th>PD</th>
<th>N</th>
<th>PI</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>P+N</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Group 0</td>
<td>385.75</td>
<td>45.60</td>
<td>60.00</td>
<td>107.90</td>
<td>40.80</td>
<td>76.20</td>
<td>91.60</td>
<td>14.55</td>
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<tr>
<td></td>
<td>(31.08)**</td>
<td>(6.05)</td>
<td>(7.03)</td>
<td>(6.63)</td>
<td>(6.26)</td>
<td>(11.10)</td>
<td>(8.79)</td>
<td>(2.64)</td>
</tr>
<tr>
<td>Group 1</td>
<td>382.75</td>
<td>44.20</td>
<td>61.35</td>
<td>105.50</td>
<td>40.15</td>
<td>79.30</td>
<td>92.45</td>
<td>14.40</td>
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<td>(31.35)</td>
<td>(6.99)</td>
<td>(5.91)</td>
<td>(8.68)</td>
<td>(5.64)</td>
<td>(10.37)</td>
<td>(7.63)</td>
<td>(2.69)</td>
</tr>
<tr>
<td>Group 2</td>
<td>383.65</td>
<td>42.25</td>
<td>58.30</td>
<td>106.80</td>
<td>39.50</td>
<td>80.20</td>
<td>89.65</td>
<td>15.75</td>
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<tr>
<td></td>
<td>(32.21)</td>
<td>(6.14)</td>
<td>(8.34)</td>
<td>(7.06)</td>
<td>(5.14)</td>
<td>(8.48)</td>
<td>(8.52)</td>
<td>(2.67)</td>
</tr>
<tr>
<td>Group 3</td>
<td>381.75</td>
<td>46.90</td>
<td>57.95</td>
<td>105.55</td>
<td>38.45</td>
<td>77.80</td>
<td>88.40</td>
<td>16.70</td>
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<tr>
<td></td>
<td>(32.17)</td>
<td>(5.30)</td>
<td>(5.65)</td>
<td>(8.95)</td>
<td>(5.40)</td>
<td>(9.75)</td>
<td>(8.46)</td>
<td>(2.66)</td>
</tr>
<tr>
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<td>386.60</td>
<td>46.15</td>
<td>58.25</td>
<td>107.20</td>
<td>39.80</td>
<td>78.00</td>
<td>91.75</td>
<td>17.95</td>
</tr>
<tr>
<td></td>
<td>(31.29)</td>
<td>(4.20)</td>
<td>(7.81)</td>
<td>(7.11)</td>
<td>(4.91)</td>
<td>(10.21)</td>
<td>(7.14)</td>
<td>(2.87)</td>
</tr>
<tr>
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<td>43.25</td>
<td>59.55</td>
<td>108.55</td>
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<td>79.90</td>
<td>89.25</td>
<td>14.50</td>
</tr>
<tr>
<td></td>
<td>(31.87)</td>
<td>(7.01)</td>
<td>(6.87)</td>
<td>(8.66)</td>
<td>(9.05)</td>
<td>(8.87)</td>
<td>(8.16)</td>
<td>(3.24)</td>
</tr>
<tr>
<td>Group 6</td>
<td>385.25</td>
<td>46.65</td>
<td>58.50</td>
<td>105.90</td>
<td>38.10</td>
<td>76.10</td>
<td>91.45</td>
<td>15.45</td>
</tr>
<tr>
<td></td>
<td>(32.34)</td>
<td>(6.53)</td>
<td>(7.02)</td>
<td>(7.47)</td>
<td>(5.11)</td>
<td>(13.85)</td>
<td>(7.86)</td>
<td>(2.61)</td>
</tr>
</tbody>
</table>

*Standard deviations are enclosed in parentheses.*
TABLE 2

RESULTS OF TWO-WAY ANALYSIS OF VARIANCE
FOR SIGNIFICANT DIFFERENCES BETWEEN GROUP
MEANS ON TSCS PSYCHOPATHOLOGY MEASURES

<table>
<thead>
<tr>
<th>Source</th>
<th>df</th>
<th>MS</th>
<th>F</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Between subjects</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>A (homosexuality level)</td>
<td>6</td>
<td>6.434</td>
<td>0.014</td>
</tr>
<tr>
<td>Subjects within groups</td>
<td>133</td>
<td>437.786</td>
<td></td>
</tr>
<tr>
<td><strong>Within subjects</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>B (TSCS measures)</td>
<td>7</td>
<td>1940701.0</td>
<td>14651.848</td>
</tr>
<tr>
<td>AB</td>
<td>42</td>
<td>23.952</td>
<td>0.1808</td>
</tr>
<tr>
<td>B x subjects within groups</td>
<td>931</td>
<td>132.454</td>
<td></td>
</tr>
</tbody>
</table>

A  \( F_{6,133} \)  
\( p < .05 = 2.26 \)  
\( p < .01 = 2.99 \)

AB  \( F_{42,931} \)  
\( p < .05 = 1.39 \)  
\( p < .01 = 1.59 \)
a result consistent with and supporting both hypotheses. This means the analysis revealed that mean performances of the seven experimental groups on the eight TSCS measures of psychopathology were not significantly different. More specifically, groups of subjects involved in varying degrees of homosexual behavior and preference (Groups 1–6) did not differ significantly in levels or indications of psychopathology from a group of matched heterosexuals (Group 0), as revealed by group mean scores on TSCS measures of self-concept, self-criticism, defensiveness, general emotional maladjustment, psychosis, personality-character disorder, neurosis, and overall personality integration.

Hypothesis III, which stated that homosexuality would not be a criterion predictor (or predictive criterion) of psychopathology, was tested by means of a multiple regression analysis, the results of which are summarized in Tables 3, 4, and 5 on Pages 54a, 54b, and 54c, respectively. Table 3 gives the correlation coefficient matrix for all intercorrelations of all nine variables (eight TSCS psychopathology measures plus homosexuality level). The relative contributions of each predictor variable (TSCS measure) were also obtained by further investigation of each Beta weight or partial correlation coefficient (see Table 5) in conjunction with its respective variable's correlation with
TABLE 3
CORRELATION COEFFICIENT MATRIX FOR ALL INTERCORRELATIONS OF TSCS PSYCHOPATHOLOGY MEASURES AND HOMOSEXUALITY LEVEL

<table>
<thead>
<tr>
<th>VARIABLE</th>
<th>Homo-</th>
<th>TOTAL P+N</th>
<th>SC</th>
<th>DP</th>
<th>GM</th>
<th>PSY</th>
<th>PD</th>
<th>N</th>
<th>PI</th>
</tr>
</thead>
<tbody>
<tr>
<td>Homosexuality Level</td>
<td>1.00</td>
<td>-0.01</td>
<td>0.05</td>
<td>-0.08</td>
<td>-0.01</td>
<td>-0.06</td>
<td>-0.01</td>
<td>-0.06</td>
<td>0.09</td>
</tr>
<tr>
<td>TOTAL P+N</td>
<td>-0.01</td>
<td>1.00</td>
<td>0.47</td>
<td>0.72</td>
<td>0.91</td>
<td>-0.59</td>
<td>0.79</td>
<td>0.89</td>
<td>0.01</td>
</tr>
<tr>
<td>SC</td>
<td>0.05</td>
<td>0.47</td>
<td>1.00</td>
<td>0.02</td>
<td>0.55</td>
<td>-0.66</td>
<td>0.04</td>
<td>0.25</td>
<td>0.06</td>
</tr>
<tr>
<td>DP</td>
<td>-0.08</td>
<td>0.72</td>
<td>0.02</td>
<td>1.00</td>
<td>0.52</td>
<td>-0.19</td>
<td>0.56</td>
<td>0.68</td>
<td>-0.01</td>
</tr>
<tr>
<td>GM</td>
<td>-0.01</td>
<td>0.91</td>
<td>0.55</td>
<td>0.52</td>
<td>1.00</td>
<td>-0.60</td>
<td>0.65</td>
<td>0.76</td>
<td>0.02</td>
</tr>
<tr>
<td>PSY</td>
<td>-0.06</td>
<td>-0.59</td>
<td>-0.66</td>
<td>-0.19</td>
<td>-0.60</td>
<td>1.00</td>
<td>-0.23</td>
<td>-0.54</td>
<td>-0.22</td>
</tr>
<tr>
<td>PD</td>
<td>-0.01</td>
<td>0.79</td>
<td>0.04</td>
<td>0.56</td>
<td>0.65</td>
<td>-0.23</td>
<td>1.00</td>
<td>0.71</td>
<td>-0.11</td>
</tr>
<tr>
<td>N</td>
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<td>0.89</td>
<td>0.25</td>
<td>0.68</td>
<td>0.76</td>
<td>-0.54</td>
<td>0.71</td>
<td>1.00</td>
<td>0.03</td>
</tr>
<tr>
<td>PI</td>
<td>0.09</td>
<td>0.01</td>
<td>0.06</td>
<td>-0.01</td>
<td>0.02</td>
<td>-0.22</td>
<td>-0.11</td>
<td>0.03</td>
<td>1.00</td>
</tr>
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TABLE 4

RESULTS OF ANALYSIS OF VARIANCE FOR SIGNIFICANCE
OF THE MULTIPLE LINEAR REGRESSION OF TSCS PSYCHO-
PATHOLOGY MEASURES AND HOMOSEXUALITY LEVEL

Coefficient of Determination ($r^2$) = .04

Multiple Correlation Coefficient ($r$) = .21

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<tr>
<th>Source</th>
<th>df</th>
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</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Due to regression</td>
<td>8</td>
<td>3.106</td>
<td>0.760</td>
</tr>
<tr>
<td>Deviation about regression</td>
<td>131</td>
<td>4.085</td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>139</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

$F_{8,131}$ p<.05 = 2.02
p<.01 = 2.66
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>TOTAL P+N</td>
<td>384.59</td>
<td>30.92</td>
<td>.07</td>
<td>.05</td>
<td>1.43</td>
<td>.12</td>
</tr>
<tr>
<td>SC</td>
<td>45.56</td>
<td>6.06</td>
<td>-.06</td>
<td>.06</td>
<td>-.93</td>
<td>-.08</td>
</tr>
<tr>
<td>DP</td>
<td>59.27</td>
<td>6.92</td>
<td>-.09</td>
<td>.06</td>
<td>-1.43</td>
<td>-.12</td>
</tr>
<tr>
<td>GM</td>
<td>106.77</td>
<td>7.70</td>
<td>-.07</td>
<td>.07</td>
<td>-1.05</td>
<td>-.09</td>
</tr>
<tr>
<td>PSY</td>
<td>39.93</td>
<td>6.04</td>
<td>-.01</td>
<td>.05</td>
<td>-.26</td>
<td>-.02</td>
</tr>
<tr>
<td>PD</td>
<td>78.21</td>
<td>10.39</td>
<td>-.03</td>
<td>.05</td>
<td>-.62</td>
<td>-.05</td>
</tr>
<tr>
<td>N</td>
<td>91.36</td>
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<td>.06</td>
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<tr>
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<td>.07</td>
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<td>.08</td>
</tr>
<tr>
<td>Homosexuality Level</td>
<td>3.00</td>
<td>2.01</td>
<td></td>
<td></td>
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</tbody>
</table>
the criterion (homosexuality level); all were low and not significant (See Table 5).

Hypothesis III would be confirmed by the obtained nonsignificant A x B interaction from the two-way analysis of variance (see Table 2) and a nonsignificant multiple regression coefficient predicting homosexuality level from the battery of TSCS psychopathology measures (or vice-versa). It can be seen from Table 4 that the regression analysis did, in fact, reveal a multiple correlation coefficient that was not statistically significant, a result consistent with Hypothesis III. Recall that the experimenter's interest was in the form of the relation that might occur between the criterion (level of homosexual behavior and preference) and the predictor variables (TSCS measures of psychopathology) and specifically whether this relation could be approximated well by some kind of function or regression rule; that is, an attempt was made to set up a multiple regression equation which predicted level of homosexuality (Y or criterion variable) from a battery of TSCS psychopathology measures (X or predictor variables)—or vice-versa—although Hypothesis III predicted that this would not be done to any statistically significant degree. The data support this hypothesis, and the nonsignificant multiple correlation (see Table 4) means that there is no best possible weighting of predictor variables that can be taken in order to give the best function to predict position on the Heterosexuality-Homosexuality continuum or scale (0 through 6); or, in another way, it means that
level of homosexuality, per se, is not a criterion predictor (or predictive criterion) of psychopathology, at least for the subjects in this study.

In addition, an indication of the poor accuracy level of future predictions was obtained from the coefficient of determination (see Table 4), which reveals clearly the very low proportion of variance in the homosexuality level criterion (Y) variable that can be explained or accounted for by the particular combination of TSCS predictor (X) variables, or vice-versa. This means that the especially low coefficient of multiple determination obtained from the regression analysis represents the lack of strength of linear relationship in the data, and hence it points up again the lack of "goodness" of the linear regression rule for prediction.

All three hypotheses, therefore, were borne out by the experimental evidence. The data indicate that there were no significant differences between groups on any of the TSCS measures of psychopathology, and there was no trend toward the homosexual groups being even slightly more pathological as level of homosexuality increases. The mean performances of all seven groups also fall within, and thus are not significantly different from, the established norms of the TSCS as given by Fitts (1965).
CHAPTER IV

DISCUSSION OF RESULTS

The present research was concerned with investigating the relationship between homosexuality and psychopathology, using eight measures of personality adjustment and psychopathology from the Tennessee (Department of Mental Health) Self-Concept Scale (TSCS) with 140 college-educated, socially functioning, non-patient males expressing varying degrees of homosexual behavior and exclusive heterosexuality in seven matched groups. The results presented in the previous chapter indicated no significant differences between mean performances of the homosexual groups and the exclusively heterosexual comparison group (or between the homosexual groups and the established norms of the TSCS) in regard to self-concept, self-criticism, defensiveness, general emotional maladjustment, psychosis, personality-character disorder, neurosis, and overall personality integration (Hypotheses I and II). The data also make clear that homosexuality, per se, is not a criterion predictor of psychopathology (Hypothesis III). There was no trend toward the homosexual groups being even slightly more pathological as level of homosexuality increases, and no evidence emerged to suggest that homosexuality and heterosexuality are differentially related to emotional adjustment or disturbance.

Certainly the most striking finding of this study is the confirmation of all three of our hypotheses. Indeed, according to TSCS indications of personality
adjustment, there were no important differences between matched groups of males expressing varying degrees of homosexual behavior and exclusively heterosexual males in the present study and thus no psychopathology. Moreover, as far as the present TSCS measures are concerned, no evidence was deduced from any of the analyses to indicate a predictive relationship between amount of homosexuality and psychopathology. While the present results do not prove positively that there is no psychopathology present or that we cannot predict psychopathology from homosexuality, the data do make clear that the sweeping generalization concerning homosexuality so often found in the literature may be in need of qualification or revision. To be sure, because there were no differences between groups found in the present study via the TSCS measures used, the foregoing evidence seriously questions the validity of clinical theory, research, and practice in the former literature which defines homosexuality as a symptomatic indicant of psychopathology, at least for the subjects of our study. The author recognizes the possibility that other instruments may possibly produce varying results, especially with respect to differences between groups; one may speculate that perhaps there is another instrument that might produce differences between the groups, but this does not necessarily mean that these would be psychopathological differences.

The results of the present study are thus in conflict with and contradict the findings of Bieber (1962), Socarides (1971), Doidge and Holtzman (1960), et al.; on the other hand, our data tend to support the position of Hooker (1967) and Churchill (1968). This disparity is likely due to a number of factors, not the least of which are difficulties in the definition of emotional health and pathology and diverse methods of evaluating both homosexuality and personality adjustment. However, one particular explanation does come immediately to mind. The concepts of traditional researchers such as Bieber (1962)
are, without exception, derived from studies employing samples consisting of male homosexuals who have sought (or are undergoing) psychoanalysis or other types of psychotherapy, or else have been referred because of external legal or behavioral difficulties. In Bieber's study, for example, selective factors probably were operating that tended to load the sample with cases having moderate to severe personality disturbance; furthermore, objective measures of personality characteristics were not used and criterion contamination may have resulted. It will be recalled that Doidge and Holtzman's (1960) homosexual sample consisted of individuals arrested for sexual offenses while in the Air Force; both selective factors and incarceration effects probably were at work to distort the results. The present writer though, like Hooker (1967), used a non-patient sample of men involved in homosexual behavior who appeared to be socially functioning at least adequately in society and who felt no need, compunction, or motivation whatever to seek psychotherapy. Hence, a strong possibility exists that the traditional studies and concepts about the characterological and personality defects of homosexuals are based on a skewed sampling of mentally disturbed individuals which does not accurately represent or portray the spectrum of personalities actually present in the total homosexual population. From the critical review and survey of the literature presented earlier, it seems highly probable that few clinicians and researchers have ever had the opportunity to examine homosexual subjects who came neither for psychological help nor were found in
mental hospitals, disciplinary barracks in the Armed Services, or in prison populations. There is no doubt in the author's mind that the homosexual population has its share of mentally disturbed individuals, as does the general population; however, as Churchill (1968) points out, if the judgments of clinicians about heterosexuals were based only on the ones they see as patients, they would have the same skewed impression of heterosexuals as a group as they have of homosexuals. By correcting for the error of past studies which were based on biased samples of homosexuals already selectively loaded with pathology, the present study indicates that the traditional school of thought regarding homosexuality may be incorrect. It can be speculated that had this variable been controlled for in past studies (thus eliminating a gross methodological error at the outset), results such as those reported by Bieber (1962), et. al., may not have been obtained; rather, similar results to the present study might be predicted.

It would appear, then, that the point of view of men like Churchill (1968) is substantiated and upheld by the present study. To be sure, the data lend credence to the probability that homosexuality in and of itself may not necessarily mean social and psychological maladjustment or psychopathology. Indeed, although extensive homosexual behavior may reflect a functional limitation in the capacity for heterosexuality, the results from the present research do grant the possibility and suggest that this limitation may not necessarily interfere
with a reasonably satisfactory or normal psychological life adjustment and personality integration. In general, our data indicate that the homosexual groups were not at all seriously neurotic, pre-psychotic, or otherwise psychopathological as compared to matched exclusive heterosexuals, and—considering the apparent effective functioning of all the groups, heterosexual and homosexual—the lack of significant differences indicates no psychopathology and no atypicality from the TSCS norms reported by Fitts (1965); that is to say, the mean performance scores of each of the homosexual groups was not significantly different or deviant from (but rather was well within) the established "norms" of the TSCS as given by Fitts (1965) and not significantly different from the exclusively heterosexual comparison sample group who were matched for similarity in age, educational level, and heterogeneity of academic background. Moreover, the homosexual groups did not show a greater tendency than the group of matched heterosexual comparisons to have defensive, nonconformist, or deviant attitudes toward themselves and others. The fact that significant differences were not obtained on any of the TSCS measures (see Table 2) strengthens our results bearing out a lack of definite indications of psychopathological personality aberrations in the homosexual sample studied.

A limitation of the present research is that it deals exclusively with men and is a further investigation of the personal adjustment only of male homosexuals and matched heterosexuals; the author knows of no similar evidence for
female homosexuals. Adjustment information about the seldom studied female homosexual is rarely considered and is an area that is still much in need of further research. A question might also be raised concerning the use of self-report personality measures such as the TSCS involving semantic differentials which are subject to social desirability biases; this bias would be expected across all Ss, however, and not only or even primarily from the homosexual Ss. Furthermore, the TSCS has built-in corrections for both social desirability and response sets, and hence this question is not really relevant for this study. The use of the TSCS was to allow for data collection from large numbers of Ss, and this measure was chosen because of its widely known, generally accepted high reliability and validity in clinical and research circles. Additionally, it seemed of particular interest to ask persons to describe themselves in a straightforward manner without the complicating influences and implications of projective techniques and searching questions about pathology. Although the absence of significant differences between groups in our study might lead one to question the adequacy of the TSCS as a good measure of psychopathology (or whether it measures anything at all), its validity and reliability can be attested to by the present author (Clark and Epstein, 1971) and a wealth of other researchers who have used it in the past (Berg, 1965); very high correlations with other known personality measures in various areas have also been found (Fitz, 1965).

What are the psychological implications of the hypotheses confirmed in this study that homosexuality is not necessarily a symptomatic indicant of psychopathology? Several speculations can be made, and the present investigation suggests at least four possibilities:

1) Homosexuality may be a deviation in sexual pattern and object choice which is within the normal range psychologically. This has been suggested at the biological level by the work of Ford and Beach (1961) and also by Hooker (1967).
2) Homosexuality as a clinical entity or unitary concept may not exist, for its forms, manifestations, and meanings in various personality types may be as varied as those of heterosexuality. Recent data (including the present study) definitely question the validity of the necessarily psychopathological "homosexual personality" concept as it has emerged from the literature, and it would appear that there may be as wide a personality variation among homosexuals as among heterosexuals, with some being pathological and others not.

3) The role of particular forms of sexual desire and expression in personality structure, development, and adjustment may be less important than has frequently been assumed. Even if one assumes that homosexuality is a severe form of maladjustment to society in the sexual realm, this does not necessarily mean that those involved in such behavior are or must be severely maladjusted in other sectors of their adjustment and behavior.

4) The present study raises as many questions about heterosexuality as it does about homosexuality, and few would question the statement that to describe a man as heterosexual tells little or nothing about his intrapsychic processes or his mode of adaptation to social and psychological pressures. The same is true for describing a man as homosexual.

Summarily speaking, there are enough unanswered questions raised by the present study so that closure should not be brought on the question of whether homosexuality is always a symptom of psychopathology or rather a deviation in sexual object choice within an otherwise "normal" personality. The clinical literature concerning this area is still mostly of the "homosexuality as disease and psychopathology" genre, and there is a scarcity of research that deals with homosexuality as a normal, personal characteristic. However, the data obtained in this study indicate that for matched groups of socially functioning, well-educated, non-patient subjects involved in varying degrees of homosexual
behavior and preference, no evidence emerged to suggest that homosexuality and heterosexuality, per se, are differentially related to emotional adjustment or psychopathology. The homosexual groups did not show signs of psychopathology or emotional disturbance on the TSCS and in no way differ from comparably exclusively heterosexual males. Moreover, it was found that homosexuality is not a criterion predictor of psychopathology.
CHAPTER V

SUMMARY

Despite the prevalence of homosexuality and the magnitude of the social and psychological conflicts it creates, there has been little controlled research dealing with this area and only a handful of legitimate studies. Our knowledge of homosexuality and the variables involved in it is based mainly on clinical experience and individual case studies of patients in psychotherapy or under incarceration. Therefore, as Churchill (1968) maintains, most psychological and psychiatric studies up until now have dealt in stereotypes, since they have involved only mentally disturbed subjects and then inappropriately generalized the psychopathology found in these individuals to the whole homosexual population. This has given rise, in turn, to the primary assumption and assertion among clinicians that homosexuality is always a symptomatic indicant of emotional maladjustment, aberrant self-esteem, and/or other serious psychopathology. Despite recent evidence to the contrary (in the form of a wealth of data from other realms of the biological, behavioral, and social sciences), this assumption equating homosexuality with psychopathology still rules the day among clinical researchers and practitioners, as the vast majority of the literature clearly attests. What is needed now, then, in order to get a more representative appraisal and profile of the homosexual population, is research based upon a large sample of non-patient subjects, including not only exclusive homosex-
uals and heterosexuals, but also persons who express varying degrees of homosexual preference along with heterosexual desires. Consequently, the purpose of the present study was to "zero in," as it were, on the non-pathological element of the homosexual population in an attempt to experimentally study and operationally test the hypothesized relationship between homosexuality and psychopathology so rampant in the literature, using eight personality adjustment and psychopathology scales from the Tennessee (Department of Mental Health) Self-Concept Scale with 140 college-educated, socially functioning, non-patient overt male homosexual subjects (expressing varying degrees of homosexual desire, preference, and behavior) and heterosexual comparisons in seven matched groups, all of whom were matched for age, educational background, and lack of a history of significant psychological disturbance.

The results of the study indicate no significant differences (as revealed by a two-way analysis of variance) between mean performance scores of the homosexual groups and the exclusively heterosexual comparison group (or between the homosexual groups and the established norms of the TSCS) in regard to self-concept, self-criticism, defensiveness, general emotional maladjustment, psychosis, personality-character disorder, neurosis, and overall personality integration (Hypotheses I and II). The data also make clear (via a multiple regression analysis) that homosexuality, per se, is not a criterion predictor of psychopathology (Hypothesis III). There was no trend toward the
homosexual groups being even slightly more pathological as level of homosexuality increases, and no evidence emerged to suggest that homosexuality and heterosexuality are differentially related to emotional adjustment and disturbance.

The most important finding of this study is the confirmation of all three hypotheses, for such results are in conflict with the findings of Bieber (1962), et al., while supporting Churchill's (1968) position. By correcting for the error of past studies, however, which were based on skewed samples of homosexuals already selectively loaded with psychopathology, the present study indicates that the traditional school of thought regarding homosexuality may be incorrect. The fact that non-patient homosexual subjects did not show signs of emotional disturbance on the TSCS is taken as an indication that the sweeping generalization, in the clinical literature, that homosexuality is always a symptom of psychopathology to be cured or corrected through behavior modification or other types of psychotherapy, may be in need of qualification or revision. There are enough unanswered questions raised by the present research so that closure should not be brought on the question of whether homosexuality is always a symptomatic indicant of psychopathology or rather a deviation in sexual object choice within an otherwise "normal" personality. One can speculate on the basis of the present data that homosexuality, per se, may be a deviation in sexual pattern which is within the normal range psychologically; this has been suggested at the biological level by the work of Ford and Beach (1961) and also at the psy-
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APPENDIX I

THE HETEROSEXUAL–HOMOSEXUAL RATING SCALE
(From Sexual Behavior in the Human Male by Alfred C. Kinsey, Wardell B. Pomeroy, and Clyde E. Martin)

0----(0% homosexual activity) Individuals are rated as 0s if they make no physical contacts which result in erotic arousal or orgasm, and make no psychic responses to individuals of their own sex. Their sociosexual contacts and responses are exclusively with individuals of the opposite sex.

1----(1–19% homosexual activity) Individuals are rated as 1s if they have only incidental or situational homosexual contacts which have involved physical response, or incidental psychic responses without physical contact. The great preponderance of their sociosexual experience and reactions is directed toward individuals of the opposite sex. Such homosexual experiences as these individuals have may occur only a single time or two, or at least infrequently in comparison to the amount of their heterosexual experience. Their homosexual experiences never involve as specific psychic reactions as they make to heterosexual stimuli. Sometimes the homosexual activities in which they engage may be inspired by curiosity or may be more or less forced upon them by other individuals, perhaps when they are asleep or when they are drunk, or under some other unusual circumstances.

2----(20–39% homosexual activity) Individuals are rated 2s if they have considerably more than incidental or situational homosexual experience, and/or if they respond rather definitely to homosexual stimuli. Their heterosexual experiences and/or psychic reactions still surpass their homosexual experiences and/or psychic reactions. These individuals may have only a small amount of homosexual experience or they may have a considerable amount of it, but in every case it is surpassed by the amount of heterosexual experience that they have within the same period of time. They usually recognize their quite specific arousal by homosexual stimuli, but their responses to the opposite sex are still stronger. A few of these individuals may even have all of their overt experiences in the homosexual, but their psychic reactions to persons of the opposite sex indicate that they are still predominantly heterosexual. This latter situation is most often found among younger males who have not yet ventured to have actual intercourse with girls, while their orientation is definitely heterosexual. On the other hand, there are some males who should be rated as 2s because of their strong reactions to individuals of their own sex, even though they have never had overt relations with them.
3—(40–59% homosexual activity) Individuals who are rated 3s stand midway on the heterosexual-homosexual scale or continuum. They are about equally homosexual and heterosexual in their overt experience and/or psychic reactions. In general they accept and equally enjoy both types of contacts and have no strong preference for one or the other. Some persons are rated 3s even though they may have a larger amount of experience of one sort, because they respond psychologically to partners of both sexes, and it is only a matter of circumstance that brings them into more frequent contact with one of the sexes. Such a situation is not unusual among single males, for male contacts are often more available to them than female contacts. Married males, on the other hand, find it simpler to secure a sexual outlet through intercourse with their wives, even though some of them may be as interested in males as they are in females.

4—(60–79% homosexual activity) Individuals are rated as 4s if they have considerably more overt activity and/or psychic reactions in the homosexual, while still maintaining a fair amount of heterosexual activity and/or responding rather definitely to heterosexual stimuli.

5—(80–99% homosexual activity) Individuals are rated 5s if they are mostly homosexual in their overt activities and/or psychic reactions. They do have incidental or situational experience with the opposite sex and do on occasion react psychologically to individuals of the opposite sex.

6—(100% homosexual activity) Individuals are rated as 6s if they are exclusively homosexual, both in regard to their overt experience and in regard to their psychic reactions.
APPENDIX II

THE TENNESSEE SELF-CONCEPT SCALE
INSTRUCTIONS

On the top line of the separate answer sheet, fill in your name and the other information except for the time information in the last three boxes. You will fill these boxes in later. Write only on the answer sheet. Do not put any marks in this booklet.

The statements in this booklet are to help you describe yourself as you see yourself. Please respond to them as if you were describing yourself to yourself. Do not omit any item! Read each statement carefully; then select one of the five responses listed below. On your answer sheet, put a circle around the response you chose. If you want to change an answer after you have circled it, do not erase it but put an X mark through the response and then circle the response you want.

When you are ready to start, find the box on your answer sheet marked time started and record the time. When you are finished, record the time finished in the box on your answer sheet marked time finished.

As you start, be sure that your answer sheet and this booklet are lined up evenly so that the item numbers match each other.

Remember, put a circle around the response number you have chosen for each statement.

<table>
<thead>
<tr>
<th>Responses</th>
<th>Completely false</th>
<th>Mostly false and partly true</th>
<th>Mostly true</th>
<th>Completely true</th>
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<td>2</td>
<td>3</td>
<td>4</td>
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</table>

You will find these response numbers repeated at the bottom of each page to help you remember them.

© William H. Fitts, 1964
1. I have a healthy body......................................................... 1

3. I am an attractive person.................................................. 3

5. I consider myself a sloppy person..................................... 5

19. I am a decent sort of person.......................................... 19

21. I am an honest person.................................................... 21

23. I am a bad person.......................................................... 23

37. I am a cheerful person................................................... 37

39. I am a calm and easy going person................................. 39

41. I am a nobody............................................................... 41

55. I have a family that would always help me in any kind of trouble........... 55

57. I am a member of a happy family..................................... 57

59. My friends have no confidence in me................................ 59

73. I am a friendly person.................................................... 73

75. I am popular with men.................................................... 75

77. I am not interested in what other people do..................... 77

91. I do not always tell the truth......................................... 91

93. I get angry sometimes.................................................... 93

Responses— Completely Mostly Partly Mostly Completely
false false false true true
1 2 3 4 5
2. I like to look nice and neat all the time............................................ 2
4. I am full of aches and pains.............................................................. 4
6. I am a sick person............................................................................. 6
20. I am a religious person................................................................. 20
22. I am a moral failure......................................................................... 22
24. I am a morally weak person......................................................... 24
38. I have a lot of self-control.............................................................. 38
40. I am a hateful person....................................................................... 40
42. I am losing my mind......................................................................... 42
56. I am an important person to my friends and family................. 56
58. I am not loved by my family......................................................... 58
60. I feel that my family doesn't trust me........................................ 60
74. I am popular with women.............................................................. 74
76. I am mad at the whole world....................................................... 76
78. I am hard to be friendly with....................................................... 78
92. Once in a while I think of things too bad to talk about............. 92
94. Sometimes, when I am not feeling well, I am cross................. 94
7. I am neither too fat nor too thin.

9. I like my looks just the way they are.

11. I would like to change some parts of my body.

25. I am satisfied with my moral behavior.

27. I am satisfied with my relationship to God.

29. I ought to go to church more.

43. I am satisfied to be just what I am.

45. I am just as nice as I should be.

47. I despise myself.

61. I am satisfied with my family relationships.

63. I understand my family as well as I should.

65. I should trust my family more.

79. I am as sociable as I want to be.

81. I try to please others, but I don't overdo it.

83. I am no good at all from a social standpoint.

95. I do not like everyone I know.

97. Once in a while, I laugh at a dirty joke.

Responses—

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<tr>
<th>Completely false</th>
<th>Mostly false</th>
<th>Partly false and partly true</th>
<th>Mostly true</th>
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8. I am neither too tall nor too short
10. I don't feel as well as I should
12. I should have more sex appeal
26. I am as religious as I want to be
28. I wish I could be more trustworthy
30. I shouldn't tell so many lies
44. I am as smart as I want to be
46. I am not the person I would like to be
48. I wish I didn't give up as easily as I do
62. I treat my parents as well as I should (Use past tense if parents are not living)
64. I am too sensitive to things my family say
66. I should love my family more
80. I am satisfied with the way I treat other people
82. I should be more polite to others
84. I ought to get along better with other people
96. I gossip a little at times
98. At times I feel like swearing

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<tr>
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<th>Completely false</th>
<th>Mostly false</th>
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</table>
13. I take good care of myself physically.................................
15. I try to be careful about my appearance..............................
17. I often act like I am "all thumbs"....................................
31. I am true to my religion in my everyday life........................
33. I try to change when I know I'm doing things that are wrong....
35. I sometimes do very bad things......................................
49. I can always take care of myself in any situation..................
51. I take the blame for things without getting mad..................
53. I do things without thinking about them first.....................
67. I try to play fair with my friends and family......................
69. I take a real interest in my family...................................
71. I give in to my parents. (Use past tense if parents are not living)
85. I try to understand the other fellow's point of view............... 
87. I get along well with other people..................................
89. I do not forgive others easily......................................
99. I would rather win than lose in a game.............................

Responses - Completely false Mostly false Partly false Mostly true Completely true
1  2  3  4  5
14. I feel good most of the time ........................................ 14
16. I do poorly in sports and games ........................................ 16
18. I am a poor sleeper ........................................ 18
32. I do what is right most of the time ........................................ 32
34. I sometimes use unfair means to get ahead ........................................ 34
36. I have trouble doing the things that are right ........................................ 36
50. I solve my problems quite easily ........................................ 50
52. I change my mind a lot ........................................ 52
54. I try to run away from my problems ........................................ 54
68. I do my share of work at home ........................................ 68
70. I quarrel with my family ........................................ 70
72. I do not act like my family thinks I should ........................................ 72
86. I see good points in all the people I meet ........................................ 86
88. I do not feel at ease with other people ........................................ 88
90. I find it hard to talk with strangers ........................................ 90
100. Once in a while I put off until tomorrow what I ought to do today .......... 100

Responses— Completely Mostly Partly Mostly Completely
false false false true true

1 2 3 4 5
APPENDIX III

A SAMPLE OF INTERVIEW QUESTION TOPICS USED WITH SUBJECTS
A SAMPLE OF INTERVIEW QUESTION TOPICS USED WITH SUBJECTS

I. Age, educational background, and occupation of subject.

II. Amount or extent of homosexual or heterosexual preferences.

   --Subject's estimate of the percentage ratio of his homosexual and/or heterosexual behavior.

   --Subject's estimate of the percentage ratio of his homosexual and/or heterosexual dreams, fantasies, and mental preferences.

   --Optional: Subject's preferences for specific sexual acts in overt behavior.

III. Subject's history of psychological disturbance and legal difficulty, if any (including seeking professional help if necessary).
VITA

Born October 30, 1943, to Mr. and Mrs. Edward Rolfe Clark, Dearborn, Michigan. High School Diploma from Edsel Ford High School, Dearborn, in June, 1961. Graduated from Greenville College, Greenville, Illinois, with Bachelor of Arts in biology in June, 1965, magna cum laude, with departmental honors in biology, course honors and research in parasitology, genetics, and abnormal psychology, class academic honors all four years, Full Tuition Scholarship all four years, election to Beta Beta Beta (national honor society in biology), Alpha Kappa Sigma (national honor society for scholarship and leadership), Phi Beta Kappa, President of college fraternity, Vice-President of the Student Body, and election to WHO'S WHO IN AMERICAN AMERICAN UNIVERSITIES AND COLLEGES (1965); summer scholarship to National Music Camp, Interlochen, Michigan. Granted Master of Arts (major field clinical psychology) from Wayne State University, Detroit, Michigan, in December, 1968, with United States Public Health Service Fellowship and Graduate Teaching Assistantship, and election to Psi Chi (national honor society in psychology). Presently completing requirements for the Ph.D. in clinical psychology at the University of Windsor, Ontario, Canada (originally on Robards Doctoral Fellowship and Graduate Teaching Assistantship); internship at Wayne County General Hospital, Eloise, Michigan. Presently organist of the large First United Methodist Church of Dearborn, Michigan, with AAGO degree from the American Guild of Organists; also lecturer in psychology at Henry Ford College.