



Gendered Neutral? Medical Representations of Senescent Sexuality

by Sarah Goodfellow

In 1956, physician William H. Masters, of Masters and Johnson renown, addressed the International Association of Gerontology, and referred to people over sixty as “a third sex or neutral gender” (Anonymous). Was he truly proposing that there are three sexes?

First, one should note that “third sex” and “neutral gender” are not the same thing. Historically, the term “third sex” was used throughout the nineteenth and early twentieth century, most notably by German sexologist Magnus Hirschfeld, to refer to individuals then believed to possess the sexual characteristics of *both* males and females--for example, hermaphrodites and homosexuals.¹ More recently, historian and developmental biologist Ann Fausto-Sterling stirred some waters by proposing that biological sex encompasses at least five sexes.² And on a more popular level, *Hedwig and the Angry Inch* has revived Plato’s idea that there were originally three human sexes: male, female, and a third sex that was half male and half female. “Neutral gender,” on the other hand, would seem to imply a different sort of sexual status--one which is neither male *nor* female.

Returning to 1956, though it is doubtful that Masters meant to imply that the elderly are either homosexuals or hermaphrodites, his word choice merits examination. The very ambiguity of Masters’ statement illustrates the various and sometimes contradictory ways in which senescent sexuality has been represented. What, then, have been the beliefs about the aging process that have made medical authorities cast about for terms different from those generally used to describe the two sexes and genders?

Historically, the threat that old age has posed to gender identity has been profound, and the sexual status of the aged has been problematic. For a number of social and cultural reasons, the elderly have not been supposed to have or to want to have sex. As a result, popular and medical literature has widely prescribed an end to sexual activity for the elderly--ostensibly for their own peace of mind and physical well-being. As French physician Louis Noirod observed in 1873, in old age “like our hair, our desires should wither” (Noirod quoted in Stearns, 243). The prescriptive flavor of this statement is telling: he is stating not that desire does wither, but that it should. For theories about sexuality being deeply embedded within a paradigm of reproduction, there has seemed to be no biological reason for the elderly to be sexual at all. Menopause has thus been interpreted as a “natural” mandate for women to cease all sexual activity, and aging men have been assumed to follow a parallel course into impotence and infertility. It was, therefore, a common observation in medical literature throughout the nineteenth and early twentieth centuries that aging women lose their “feminine grace” and grow more “masculine.” The corresponding belief that old men become more “feminine” in behavior, if not also in appearance, was also a mainstay. The fact that echoes of these ideas can still be heard in the twenty-first century speaks to the enduring power of preconceptions of old age as sexless.

The de-sexing of the aged body was often quite literal in descriptions of senescent physiology: the genital and reproductive organs were said to shrink, shrivel, and atrophy. Interestingly, there have been two schools of thought with regard to the physiological transformation of the male in old age. One maintained that both sexes display stronger masculine characteristics. The other held that men become more like women. At the turn of the last century, for example, popular advice author Sylvanus Stall cited the greater “tenderness” and lack of zeal that rendered old men “unfit for war.” Drawing on contemporary medical authorities, Stall was explicit about the androgynous nature of late life:

When the period of reproduction is passed and the climacteric period of life has been attained, there are again numerous physical changes. Instead of assuming more marked sexual characteristics, each of the sexes then seems to tend measurably to assume the characteristics of the opposite sex.

In contrast to the male, there was no lack of agreement about the transformation of the aging female. Medical writers unanimously agreed that she grew physically more masculine. Menopausal changes, including fat deposits at the lower part of the back and neck, flat and hard breasts, facial hair, and a deepening voice, were supposedly a direct consequence of the cessation of menstruation: no longer taxed by monthly blood loss, the body grew stronger, but also, more mannish (Stall). As Edward Tilt, a pioneer in menopause research remarked in 1857, “the invigoration of health is bought at some sacrifice to feminine grace.”

The blurring and fading of sexual characteristics was said to be manifest not only in the body but also in the mind. This meant that masculinization could be insidious--an aging woman who appeared perfectly feminine could yet experience a masculinization of her inner psychology. One authority claimed that post-menopausal women “feel the ground grow steadier underfoot,” and are consequently less prone to flights of fancy and passion. In the 1930s, sexologist Havelock Ellis also noted the advantages of menopause, including “clarity, objectivity, a sense for conceptions of abstract justice, toleration, business aptitude, [and] general social as well as political aptitudes” all supposedly typical masculine characteristics.

The ambiguous and supposedly non-reproductive sexuality of the elderly has also been reflected in discourse about their sexual behavior. With nothing to limit post-menopausal women’s desires to reproduction, they were believed to be likely to exhibit any number of transgressive behaviors, from sadism to campaigning for the right to vote.³ I maintain that, because of its non-reproductive nature, senescent sexuality was often equated with “perversions,” such as masturbation and homosexuality, or with the immature and objectless sexuality of children. According to one authority from the 1920s, for example, a woman who had led a “serene and monogamous sexual life” might at menopause be plagued with an “extraordinary hyperexcitability” of “the delicate and numerous nerves in the external genitals,” compelling enough to launch her “upon evil courses” (Marañón). He hinted that she may even resort to masturbation.

Around the same time, Sigmund Freud described how the post-menopausal woman loses her “womanliness,” and either reverts to an infantile, anal-erotic stage, or to deviance:

It is a well-known fact . . . that after women have lost their genital function their character often undergoes a peculiar alteration. They become quarrelsome, vexatious and overbearing, petty and stingy; that is to say, they exhibit typically sadistic and anal-erotic traits which they did not possess earlier, during their period of womanliness.

The “masculine” sexual behavior of aging women included increased sexual aggressiveness. This might go so far as to cause them to be attracted to other women. Such sexually aggressive older women were sometimes described as suffering from sexual virilism or labeled viragos. Viragos occupied a sexually ambiguous position between male and female sexuality--masculinized women, they were lesbians or lesbian-like in their behavior and appearance--in other words, Hirschfeld’s “third sex.”

The idea of a sort of sexual inversion or reversal of gender roles among the elderly remained current throughout the twentieth century. A 1962 study paved the way by suggesting that a lessening of sex-role differentiation was related to “successful aging,” meaning adaptation to a time of life when gender roles are not as rigidly defined. Building on this work, a 1977 paper examined the varying importance of sex-role differentiation over the life span. Betraying an assumption that gender identity is unimportant in late life, the author expressed dismay that the aged to cling to traditional sex roles, “in spite of their general lack of relevance” (Sinnot). Relevance to whom?

The champion of androgyny in old age, however, has been gerontologist David Gutmann, whose model remained popular into the 1990s. Basing his work on cross-cultural studies, Gutmann demonstrated in 1958 that middle-aged people perceive men as becoming passive with age (Gutmann 1961). In 1976, he proposed that older men have a more diffuse and less phallic sexuality, taking more pleasure in things like food, pleasant sights, and human association. Aggression, as well as pleasure, played a significant role in Gutmann’s conception of gender. He found that in the U.S., Italy, and Japan, male aggression declines after about age 55 to a level below that of the average female, and that these men then cultivate a previously undeveloped capacity for cherishing, appreciating, and bringing together. In contrast, Gutmann posits to a universal “sergeant virility of the older woman” who, according to him, ages “psychologically in the reverse direction.” By this he means becoming more aggressive, less sentimental, and “more managerial” (Gutmann 1979). Gutmann not only speaks specifically of androgyny in late life, but he refers to the process by which it is reached as “involution.”⁴

Thus, over time and across sex lines a massive transcultural involution takes place: during the post-parental years the husband comes to be more dependent on the wife; he tends to defer to her wishes and requirements. . . . The older wife becomes something of an authority to the husband; and through these various sex-role changes the normal androgyny of later life is ushered in. (Gutmann, emphasis added)

The idea that life follows a curve, or even a circle, is far from unique to the biomedical perspective. The similarities between youth and old age that medical authorities have emphasized, however, is revealing of the way in which they have theorized old age, and these in turn have repercussions in the conceptualization of late-life sexuality. “Involution” began to be used in biomedical literature during the mid-nineteenth century to refer to the physical process of aging. It was used to describe the time when an organism ceases to grow or develop, and begins to turn in on itself, or “involute.” Involution reflects a nineteenth-century tendency to conceive of physiology as a closed system with limited energy; in the beginning, an organism’s energy went to growth, then reproduction, and finally to simple survival. Involution in senescence, therefore, implied a turning inward or even reversal of direction.

Not unrelated to the idea of involution, it is significant that old age has often been referred to as a “second childhood.” This phenomenon deserves specific attention within a discussion of

androgyny and old age. The idea that old age represents a return to childhood is one of the ways in which the elderly have been theoretically de-sexed. The infantilization of the elderly portrays them in such a manner that it is very difficult to imagine them as fully gendered, sexual adults. I propose that one underlying reason for the perceived androgyny of late life has been a formulation of senescent sexuality that echoes a pre-Freudian model of childhood sexuality: dormant, immature, and of little import. Because they are (theoretically) not reproductive, the sexuality of both the elderly and children have been seen as undifferentiated and insignificant. Herein too can be found a source of the confusion as to whether the elderly constitute a “third sex,” or no sex at all.

Before the general acceptance of Freud’s theories, children, though clearly sexed and gendered, were not perceived as sexual beings in the sense of having a definite (hetero)sexuality, experiencing sexual desires, and partaking in sexual behavior. It was supposedly the physiological changes of puberty and the arrival of fertility that rendered one sexual in any meaningful way. Thus, comparing the aged with the very young not only infantilized the former, but bestowed upon them a particular (pre-Freudian) childish sexuality. Gutmann, for example, claimed in 1976 that older men seek pleasure in “pregenital directions” such as food and pleasant sights and sounds (1979, 152).

The trajectory of life has been seen as linear, and also as curved, and though it goes in only one direction temporally, this does not mean that it cannot involute physiologically and psychologically. The rhetoric of the “curve of life,” however, is one of simile, not metaphor. The elderly were said to be like children, not to be children. In the post-Freudian era, the elderly continued to be infantilized, with the addition that their “second childhood” was no longer seen as a harmless, dottering return to the beginning of life, but rather a “regressive” or even neurotic state.

What, then, would constitute age-appropriate sexual behavior for the elderly? While ideas about childhood sexuality changed dramatically after the dissemination of Freud’s psychoanalytic theories, this change in sexological thought did not inspire a (re)examination of the theoretical model for sexuality in old age. Late-life sexuality remained, and to a large extent remains, critically unexplored, and the elderly continue to inhabit an ambiguous sexual space describable as, indeed, “a third sex or neutral gender.”

Notes

1. Interestingly, according to the Oxford English Dictionary, an even earlier usage of the term “third sex” referred to eunuchs. The reference cited is from the poet Byron in 1820: “A black old neutral personage Of the third sex stept up.” I would note, however, that though the Oxford English Dictionary claims that this quotation illustrates a use of “third sex” in reference to a eunuch, this is not necessarily obvious. Is a person who is “old” and “neutral” a member of the “third sex” because literally castrated, or can this phrase refer to a more general desexing of the aged as discussed in this paper?
2. Fausto-Sterling argued that along with male and female, the medical term “intersex” is a catch-all category that encompasses at least three distinct other sexes: herm, merm, and ferm (hermaphrodites, male pseudohermaphrodites, and female pseudohermaphrodites, respectively).
3. Marañón attributes the activities of the English suffragists to “the influence of a sexual disturbance of a hypogenital type.”
4. The Oxford English Dictionary defines involution as a biological term referring to “a retrograde process of development; the opposite of evolution; degeneration” and in physiology as “the retrograde change which occurs in the body in old age.”

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Psychiatry, Homosexuality, and U.S. Postwar International Leadership

by Naoko Wake

The well-known psychiatrist Harry Stack Sullivan received severe criticism of his work on the world stage after World War II. He was known as a founder of an interpersonal theory of mental illness and a leader of the liberal reform of psychiatry between the wars. He defined mental illness not as a biological defect, but as dysfunctional “interpersonal relations” embedded in broader socio-cultural circumstances, helping to remove the stigma from patients. But his approach to an international commission on mental health in 1948 contradicted this liberal view. The goal of the commission was to issue a statement on the worldwide advancement of mental health, but many conferees felt that the commission was “unsuccessful” and they had to leave in “bewilderment.” Moreover, they believed that Sullivan had tenaciously excluded minority opinions, and thus was the person most responsible for the commission’s failure.

In this essay, I examine how Sullivan’s work on an international stage after the war contradicts the well-known image of him as a liberal psychiatrist, in order to shed light on American liberalism’s important limitations. It is at first surprising that many members of the commission found Sullivan intolerant to disagreements, considering that his prewar theory emphasized the ethics of including social minorities. Past studies have stressed how his interpersonal approach helped de-stigmatize mental illness.¹ Also we are now appreciating that he was dedicated to the treatment of homosexuals because, as a gay psychiatrist, he was a strong critic of the social prejudice against them.² True as this may be, this view heavily focuses on Sullivan in the 1920s when his liberal agenda was at its peak. Sullivan’s career after the 1930s clearly shows a decline of this agenda. Thus it is misleading to see him as simply bringing the best of American liberalism into a postwar international program. As a vivid way to show the limits of his liberalism, I will first look at Sullivan’s failure to defend homosexual men during the war. Working for Selective Service from 1939 to 1942, he maintained that certain types of mental “problems,” including homosexuality, worked against the nation’s interest. Then, I will suggest how this earlier narrow view, which also ran counter to his prewar ethics of inclusion, played a role in shaping U.S. isolation in international projects after the war. Sullivan, in postwar years, drew a parallel between heterosexuality and homosexuality on the one hand, and “mature” and “immature” nations on the other. In so doing, Sullivan and his professional associates had a significant impact on the shrinking liberalism in the 1930s and 1940s. Psychiatrists’ attitudes toward homosexuality were a crucial component of American liberalism in these decades, and I hope that this essay begins to better integrate the issue of homosexuality into our understanding of the changing liberalism in the interwar period and beyond.

Screening Out Homosexuals

Sullivan attempted and failed to protect gay men from medical and social stigma in wartime. As is well known, the U.S. military during WWII tried to keep gay men out of the armed forces,

using psychiatric examination as its device. A fair number of psychiatrists, including Sullivan himself, who created the screening criteria, were conflicted. They understood that exclusion from the army was often considered a disgrace, and that it might cause psychological damage for gay men whom they knew as patients. This was a serious compromise of medical ethics in general and the ethics of inclusion that liberal psychiatrists upheld in particular. But Sullivan and other psychiatrists were unable to discuss their concern persuasively with government and military officials. They lacked an ability to make their opinions heard in discussions of public policy, and this confirmed the military's bias against gay men as "unfit" for service. How did this happen?

Sullivan's work on psychiatric screening between 1939 and 1941 helps us understand how liberal psychiatrists failed to make their opinions heard. When he drafted the screening criteria in 1939 and 1940 as a member of a civilian committee advising the military on selection of soldiers, he made a list of major psychiatric problems to be screened out, such as mental retardation, mood disorders, and psychotic personalities. He did not make a direct reference to homosexuality, but instead mentioned "impression of queerness" that certain psychotic personalities might make on examiners (Sullivan 1940, 625-627). The term "queerness" could mean an unspecific strangeness in a person, but it could also mean homosexuality when it is used in specific contexts (Chauncey 13-14). Psychiatrists during the 1920s and 1930s also used this term in both ways. Sullivan, because he worked intensively with homosexual patients during these decades, surely knew the ambiguous and possibly less-stigmatizing character of the word "queerness" compared to "homosexual." In 1941, however, the advisory committee revised the screening criteria and spelled out that individuals with "homosexual proclivities" must be rejected.³

Sullivan's role in this revision is unclear, but evidence suggests that it was troubling to him. For one thing, Sullivan avoided the word "homosexual" in his professional writing, claiming that the term "has accumulated so great a freight of misunderstanding" that a better term was needed (Sullivan 1935, 1954). He continued to insist on this *even* as he lectured psychiatric examiners on how to screen out homosexual men. In a 1941 seminar in Chicago, for example, he pointed out that medical examiners must reject homosexuals, because it is so required; but psychiatric examination is not at all dependable in detecting an examinee's sexual preference, and thus the cause of rejection should remain as unspecified as possible.⁴ When he acknowledged the "inadequacy" of examination, he came close to disqualifying the screening that he himself had created. He attempted to keep homosexual men away from medical stigma, without fully challenging the system of stigmatization itself.

He also tried to use screening to benefit individual gay men. Sometime in 1940, for example, he helped a patient of his friend psychoanalyst Clara Thompson out of the army. As this patient recalled, Thompson believed that "it would be disastrous [for the patient] to go in the army." She talked to Sullivan and he used his "influence" to get the patient a rejection "*without saying he was homosexual*" (Biele, my emphasis). The apparent intention of Sullivan was to protect the patient without putting a "diagnosis" of homosexuality on him. As in his attempt to keep the language of rejection unspecific, Sullivan tried to obscure the borderline between rejection and admission--or to put it more specifically, the borderline between homosexuality and heterosexuality--in order to minimize the distress of those who were denied military service.

Why didn't Sullivan resist discrimination based on sexual preference itself, rather than attempting to lessen its adverse consequences? There is no simple answer. Certainly, the prevailing homophobia, particularly in the medical profession and in the military, played a part, as did Sullivan's fear that if his own sexual preference came to light he would lose both social and professional standings. What needs to be addressed in addition to these reasons is the gradual exclusion of homosexuality as an issue from public debate among scientists, a process beginning

in the early 1930s. Well before the war, as historian George Chauncey has argued, “[a] powerful campaign to . . . exclude [homosexuals] from the public sphere . . . gained momentum,” as the economic recession undermined traditional gender and sexual roles (331). There is some evidence suggesting that Sullivan and his associates were influenced by or even contributed to this trend of exclusion.

For one thing, there was a considerable gap between what Sullivan pursued in his treatment of homosexual patients and what he claimed about them in public. Sullivan continued to see homosexual patients in the 1930s, as he had in the 1920s, encouraging them to be more comfortable with their own sexual preference, a rather radical approach at the time. In his public lectures and articles, in contrast, he continued to stress that a certain kind of homosexual men are “immature.” In 1939 at Georgetown University, for example, Sullivan discussed “individuals who have [never] progressed to the stage of pre-adolescence. [These] immature people . . . [or] immature personalities . . . are incapable of love, [because their personalities] have never gotten to the point of developing love” directed toward a person of the opposite sex. Sullivan’s circle of professional associates was careful not to make his radical approach in the clinical setting a public issue or a matter of public policy. When one of his male patients in the 1930s had a doubt about Sullivan’s approach, the patient consulted with the referring psychiatrist. This psychiatrist suggested that the patient discontinue seeing Sullivan, but made it clear that she did not want to openly criticize Sullivan’s approach. Even as she supported Sullivan, then, she contained the issue of homosexuality within the private arena. The discussion never got outside of a small group of doctors and patients, thus it did not challenge the official view of homosexual men as “immature” personalities.

Sullivan’s use of unspecific diagnoses and unspecific reasons for rejection of gay men during wartime, therefore, was of a piece with his and his profession’s propensity in the preceding decade to deal with the issue of homosexuality mostly in the private arena. Psychiatrists created the ethics of inclusion in private, but they were not willing to use it to make a difference in the public sphere. I do not argue that this had only negative consequences. Indeed, there is a fair amount of evidence suggesting that the containment of sex matters in private facilitated psychiatric treatment. But it is also true that the containment contributed to the system that deprived a number of healthy homosexual men of the right to serve the nation. Thus, when the egalitarian view of homosexuality came into conflict with the official view of it as an illness, as it did in wartime, liberal psychiatrists were rather ineffective. Sullivan was aware of this, but he attributed it to the limits of democracy in wartime, as he said in 1941:

[First,] the army of a democracy cannot be democratic . . . There is no conceivable place for an equal voice in the government; and often no freedom of decision but rigid discipline and unquestioning execution of orders. Second, the civilian population of a democracy . . . cannot remain free to question the necessity for maximum . . . effort for the national defense. . . . Painfully banal as these two thoughts may be, I fear they need very much wider acceptance. (1941d, 292-3)

This can be seen as his self-critique. In the years after the war, however, the “painfully banal” thought of sacrificing democratic procedure for national interest became his main tactic. His postwar work for international organizations, such as the aforementioned international commission, was not specifically about homosexuality. But I see a link--a conceptual, even metaphorical link--between his approach to homosexuality and his work in the postwar years for two reasons. First, he divided nations and peoples into “mature” and “immature” groups,

building on his distinction between heterosexuality and homosexuality. Second, he tried, privately and even secretively, to absorb disagreements that emerged in international programs, refusing to bring them into open discussion.

An Inner Circle Tactic on the International Stage

Sullivan worked for postwar international organizations UNESCO and the International Congress on Mental Health. He explained what motivated him to do this in 1946, pointing to the human crisis after the war and a psychiatrist's increasing responsibility to help the world to recover. One of the psychiatrists' responsibilities, he said, was to identify well-informed "leaders" who would trace and correct dangerous "elements" in society--for example, aggressive political parties--that helped cause the war. Then, psychiatrists should pursue "remedial modification of these elements." Once these dangerous "elements" were corrected, wars would become "unnecessary for *mature* people." The war had happened because "there have never been enough mature people in the right places," and thus, it was most important to prevent "immature" people from taking charge. His message was clear: psychiatrists should regulate "immature" people, while making sure that "mature" people take leadership (Sullivan 1946, 83).⁵

In international politics, he further argued, a "mighty garrison state," clearly the U.S. , would play the "mature" role. He seemed to have few doubts that such a state would be well accepted by all who were intelligent:

I think that the peoples of the world would be less hesitant to become subjects of a world government . . . *if it were evident to the thoughtful among them that . . . this mighty garrison state . . . [ensures that] men of good will would be working out a fully civilized way of life for the people of the earth.* (Sullivan 1946, 86)

What is apparent in this statement is his belief that there was a "fully civilized way of life" that should be applied all over the world. What is also apparent is his belief that these "men of good will" must be equipped with scientific knowledge and skill to understand and facilitate human relations. He stressed this connection between goodwill and liberal science elsewhere: "[We have to] mobilize . . . psychiatrists, social psychologists, psychologists, sociologists, cultural anthropologists, political scientists . . . in a world-wide effort to . . . promote enduring peace and social progress around the world" (Sullivan 1947, 239). Thus, it was these scientists who would assist the world to be "mature" or, even become the "mature" leaders themselves. The resemblance this argument carried with his published view of homosexuality is striking. Just as psychiatrists would help patients with "immature" sexuality to grow, "mature" scientists in a garrison state would assist "immature" nations to develop.

The resemblance was not limited to theory and language. Just as wartime psychiatrists coped with the prejudice against homosexuality within a small circle of sympathizers, Sullivan tried to brush off disagreements in international conferences using what might be called an inner circle tactic. The International Preparatory Commission in 1948 brought together twenty-five conferees from ten countries. Sullivan participated as one of seven representatives from the U.S. The conference began in a friendly atmosphere, but the majority of the conferees concluded at the end of two weeks that the conference was a failure and the statement they prepared for the International Congress on Mental Health was useless. This was clearly expressed in a highly critical retrospect they wrote a week after the conference. For example, one of these reports reads:

[The conference was] a leaderless group . . . Gang formation took place. Figures strong enough to gather some members around themselves . . . formed points of crystallization. This was particularly evident around one figure whose chief significance for the group was negative . . . [His group] assumed characteristics of the true gang: it isolated itself in an aura of secrecy, it even separated from the rest of the members by disappearing a whole day, and came back after a prolonged absence surrounded by tales of great deeds done.
(Querido 1948, 351-2)

Another conferee said, “no arrangement was made to record the process of group formation and tensions at work. Such a document might have been more valuable than the [commission’s] statement itself” (William Alanson White Psychiatric Foundation 341). Others pointed out that at the end of the conference, an editor was selected from the “gang” group, and exercised gross influence on the final version of the statement. As Sullivan admitted, “the target-person” in these critiques was Sullivan himself (ibid. 342).⁶ His actions had a considerable impact, in particular on non-Westerners. Some of them thought that he was imposing Western values, perhaps in part because his small group did not include those from non-English speaking countries (Querido 350). Not surprisingly, as one of these participants commented, the final statement did “not include, even under a separate heading, any minority opinions, or opinions of circles far removed from Western conceptions. . . [The conference was] the least ‘world-wide’” (ibid.). Despite the lack of diversity, the commission’s statement served as a blueprint for the mission statement of the World Federation for Mental Health and the mental health program of the World Health Organization, building the foundation of the postwar international mental health policy. Sullivan’s tactic of working with a small group of sympathizers had not changed the homophobic policy of screening in the U.S. But when the same tactic was brought to the international stage and was presented as American way to others, it certainly made a public impact.

Sullivan and his professional associates used the model of “mature vs. immature” nations and the inner circle tactic to form American identity as a world leader. This approach made it difficult for others in the postwar international community to converse with the U.S. on open, equal ground. Psychiatrists’ dualistic approach to the issue of homosexuality after the 1930s--in particular, their failure to bring the ethics of inclusion to public policy making--might not have been the sole cause of the difficulty, but it influenced how America was perceived by the rest of the world after the war. The politics of sexuality in the interwar years need further examination in this light.

Notes

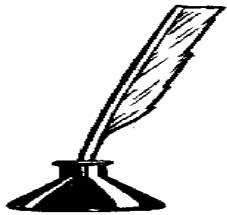
1. See Mullahy, Chapman & Chapman, Youniss, Wiggins, Alexander, Chatelaine, Evans, Kiesler, and Strack.
2. See Harned, Allen (1995 and 2000), Hansen, Blechner, and Hegarty.
3. The original criteria did not make it clear that homosexuals needed to be rejected. As seen in the proceedings of a seminar for psychiatric examiners in Chicago in May 1941 (right around the time when the criterion was revised), examiners were not really sure if they should reject homosexuals at this point. In this seminar, Colonel William C. Porter from the U.S. Army commented, “this morning during my talk there was a slip of paper handed to me with the word “homosexuality” on it. . . . We feel that the homosexuals, if they are overt in their manifestations, can do inestimable harm in the Army of the United States by seduction of youths who are not homosexually inclined. That has been our experience. . . . Therefore, we feel that if a man is a known homosexual . . . he should be excluded from the military service, not only for his sake, but for the sake of the others with whom he has to associate.” This comment makes it clear that the regulation of homosexual candidates was in flux in the early phase of screening. See Sullivan 1941c, 47-48 and 1941b, 440-464, in particular 451. “After mid-1941, however, homosexuality came to be recognized a definite cause of rejection and the criteria was revised accordingly. See Sullivan 1941a, 265-283 in particular 265. On the change of terms used by the Army criteria, see Hampf 13-20.

4. See Sullivan 1941c 48-49, where Sullivan said “there may be a hesitancy on the part of . . . [psychiatric] examiners to label a selectee as having . . . homosexuality, on the basis of what at best is an inadequate examination . . . we have been urging that causes for rejection shall be answered . . . in term of group so and so” instead of a specific diagnosis.
5. See Sullivan 1948. Also, see Sullivan 1950, in which he repeated his belief that fascist leaders were “immature” people who lacked “the preadolescent and adolescent” maturity and thus could not create “intimate give-and-take relations of equality” with others.
6. Lawrence K. Frank, in his interview with Helen Swick Perry, “expressed a great deal of exhaustion about Roffey Park [where the IPC took place]. Sullivan apparently acted somewhat like a spoiled child.” See Frank interview (1962). Margaret Mead, one of the participants at the IPC, also remembered “he [Sullivan] started out attacking me and baiting me in every conceivable way . . . he behaved as if he was being nasty to a previous sweetheart. . . . So the whole group was pretty disoriented by his behavior because he could be incredibly nasty” (Mead interview 1970).

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Self-Awareness through Study Abroad in Costa Rica.

by **Scot D. Yoder, Ph.D.**

Residential College in the Arts and Humanities

Recently a student who participated in my study abroad program, *Ethics and History of Development and Health Care in Costa Rica*, stopped by to talk about his medical school applications. He is now working in the emergency room at a local hospital and was reflecting on it in light of his experience in Costa Rica. At one point in the conversation he lamented, "I wish I knew what I know now about our health care system before I went to Costa Rica. It would have helped me understand their system better." He then paused thoughtfully and added, "On the other hand, I would never look at our system the way I do now if I hadn't gone to Costa Rica."

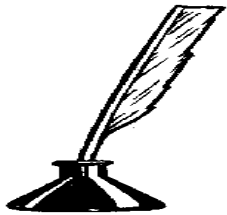
In their recent article, Currier, Canady, and Saint Arnault propose a model of cultural competence that includes three components--self awareness, cultural knowledge, and cultural skills--and describe the ways in which a study abroad program to Ghana increased the cultural competence of their students (2007). I have had very similar experiences with students in the Costa Rica program. However, recently, I find myself thinking most often about the first component--self awareness--and how I've seen it develop in students through the study abroad experience. The student who stopped in the other day is a great example of this. Through the study of another health care system and the values on which it is based students see, often for the first time, the values guiding their own health care system.

Costa Rica's health care system is part of the country's larger social security program, which is founded explicitly on the principles of solidarity, universality, and equity. These values have shaped how the system has developed over decades from a small program financing health care for poor workers in the 1940's into the nearly universal system of financing and comprehensive health services that it is today. Though I cannot adequately describe the Costa Rican health care system in such a short article, the imprint of these values is seen in many aspects of the system. For instance, the funding mechanism of constitutionally mandated employer and employee contributions expresses both solidarity and universality. All economically active citizens contribute financially and all persons residing in Costa Rica are eligible for services. Universality and equality are protected, in part, through a combination of centralized and regional planning that consciously seeks to distribute resources according to need rather than market forces. Though they are well aware of its shortcomings, most Costa Ricans are proud of their system. They have good reason to be. Though it spends significantly less per capita than the U.S. on

health care, the country enjoys health outcomes, measured by indicators such as expected life span and infant mortality, very similar to those in the U.S.

Despite its success, the Costa Rican health care system is under growing strain. Rising health care costs and an aging population have placed a financial burden on the system. Just as important, a growing private health care sector has emerged, fueled by pressure from international funding agencies to private government services. How Costa Rica ultimately responds to these challenges remains to be seen. However, what is apparent is that those involved in reform are quite conscious of the impact proposed reforms may or may not have on the values of solidarity, universality, and equality. Whether the values will continue to guide the system remains to be seen, but they are clearly taken into consideration.

Many of the students who participate in this study abroad program develop a new type of self-awareness, one which includes a heightened sense of what is contingent in their own culture. By studying a social institution that is guided by an explicit set of values, they become more aware of the values that underlie their own social institutions. This allows them to ask important questions about which values do and should guide our health care system.



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Health Disparities: The Study Abroad London Experience

by **Leonard M. Fleck, Ph.D.**

Center for Ethics & Humanities in the Life Sciences

For the past three years I have served as faculty leader for a Study Abroad course in London that involves comparing the British and American health care systems. I must begin this commentary by noting in London there is nothing as dramatic in terms of health disparities as what students would witness in Ghana. British patients have access to virtually the same standard of care as what most Americans would expect. Still, there are lessons to be learned there about health disparities, though the lessons are very different from what would be learned in Ghana.

The British spend less than half of what we spend per capita on health care in the U.S. They spend about 8% of their GDP on health care while we spent 16.3% of our GDP on health care in 2006. That was \$2.16 trillion, or just about \$7,000 per capita in the U.S. Our intuitive reaction to seeing these numbers is that British patients must experience substantial deprivation with regard to needed health care relative to their American counterparts. But the truth of the matter is the exact opposite.

Students are surprised to discover that the morally objectionable “health disparities” are on our side of the ocean, not the British side. In spite of spending more than two trillion dollars on health care, we are the country with 47 million uninsured individuals who have very spotty and very uncertain access to needed health care. By way of contrast, everyone in Britain is covered by the National Health Service (including uninsured Americans who might have a health emergency while visiting Britain!). To be sure, our students learn that there are “disparities” regarding access to specific health services among the health districts depending upon priorities established by local health authorities. But these are differences near the margins as opposed to being at the core of health needs.

Most British patients will not have access to these extraordinarily expensive cancer therapies (\$30-\$100K for a course of treatment that promises no more than additional months of life) that many well-insured Americans will have access to. But it is not obvious that this sort of disparity represents a serious injustice. By way of contrast, the poor in the U.S. are supposed to be covered by the Medicaid program (which provides a reasonably robust set of benefits). Individual states, however, are free to determine what fraction of the poor will be eligible for Medicaid in their state. Alabama and Mississippi, for example, will cover only 20% of those below the poverty

level, while Michigan will cover about 65% and Oregon will cover 100% of those below the poverty level. These sorts of disparities are morally troubling because they mean that many among the poor in the U.S. will not have access to the most basic and effective and costworthy medical therapies available (as opposed to very costly therapies that yield only very marginal health benefits), and such lack of access can often have disastrous consequences for individual patients (if, for example, an early treatable cancer goes undetected for lack of access to timely primary care).

The take home lesson for our students is that health disparities can be as much a problem for the First World as for the Third World.



News & Announcements

JUDY ANDRE

- Published “Learning to Listen” in *The Ethics of Bioethics*, edited by Lisa Eckenwiler and Felicia Cohn. Johns Hopkins University Press, 2007.

P. SEAN BROTHERTON

- Gave talk “Machinations of the State: Shifting Ideologies, Emergent Capital, and Expanding Therapeutic Itineraries in ‘Special Period’ Cuba,” Festschrift in honor of Margaret Lock at the Canadian Anthropology Society and American Ethnological Society Conference, Toronto (May).
- Presented “Emergent Capital, Shifting Ideologies, and Cuba’s Changing Health Sector,” XXVII Latin American Studies Association Meetings, Montreal (Sept).

LEONARD FLECK

- Gave a lecture and workshop “Taking Care: Ethical Challenges in an Aging Society” at Pine Rest Christian Mental Health Services (June).
- Presented “Is Rational Democratic Deliberation Robust Enough to Deliver Fair Health Care Rationing Protocols?” at International Bioethics Conference, Cambridge University (June).
- Published “Can We Trust ‘Democratic Deliberation?’” *Hastings Center Report* 37 (July/ August, 2007), 22-25. This was part of a five-essay collection on the theme of Regulating Reprogenetics.
- Wrote a section of a White Paper for the Director of NIH under the title “ELSI in Biomedical Nanotechnology.” The Hastings Center was commissioned to produce this paper. Fleck was asked by Tom Murray and Erik Parens to write a section that would address the role of rational democratic deliberation in addressing ethics and policy issues related to medicine and emerging nanotechnologies.
- Received grant for \$20,000 from Institute for Public Policy and Social Research to produce a policy paper regarding the stored blood spots program in Michigan and its potential research uses. Mongoven is also involved in this research effort. This project will involve the use of a “deliberative jury” as a mechanism for eliciting more informed public judgment regarding policy options for the use of these dried blood spots (collected at birth from all infants and stored for 21 years).

MARGARET HOLMES-ROVNER

Workshops and Presentations

- Was co-author on a presentation (along with C Bennett, A O’Connor, D Stacey, M Barry, N Col, K Eden, V Entwistle, V Fiset, M Holmes-Rovner, S Khangura, H Llewellyn-Thomas, D Rovner). “Does the Addition of 25 New Trials to the Cochrane Review of Patient Decision Aids Change Bottom Line Results?” Presented at the 4th Biennial International Shared Decision Making meeting, Freiburg, Germany (May).
- Was an invited speaker and wrote a background paper for the invited conference, DHHS Community Mental Health Services Branch in Washington, DC in July. The purpose of the workshop to introduce Shared Decision Making to mental health practitioners and researchers. I presented two lectures: a) Issues and opportunities for shared decision making in health care policy b) Personal, practice and system barriers. The title of the paper was, “Shared Decision-Making In Mental Health Care: Overcoming Barriers to Changing Embedded Norms.”

Publications

- Pylar J, Wills CE, Lillie J, Rovner DR, Kelly-Blake K, Holmes-Rovner, M. 2007. Men's interpretation of graphical information in a videotape decision aid. *Health Expect* June 10(2):184-93.
- Corser W, Lein C, Holmes-Rovner M, Gossain V. 2007. Primary Care Patients' Perceptions of Their Type 2 Diabetes Management Experiences. *Journal of Advanced Nursing*.
- Holmes-Rovner M. International Patient Decision Aid Standards (IPDAS): Beyond Decision Aids to usual design of patient education materials. *Health Expect*. 2007 Jun; 10(2):103-107.
- Corser W, Holmes-Rovner M, Gossain V, Lein C. Results from a "Shared Decision-Making" Primary Care Intervention for Type 2 Diabetes. Forthcoming, *Diab Educat*.
- O'Connor AM, Bennett C, Stacey D, Barry MJ, Col NF, Eden KB Entwistle V, Fiset V, Holmes-Rovner M, Khangura S, Llewellyn-Thomas H, Rovner D. Patient Decision Aids for People Facing Health Screening or Treatment Decisions: A Systematic Review and Meta-analysis. *Med Decis Making* 2007 Jul 20; 27(4).
- Holmes-Rovner M, Correa-de-Araujo R, Coulter A, Elwyn G, Nelson W, O'Connor A, Pignone M, Rovner D. Are Patient Decision Aids the Best Way to Improve the Quality of Clinical Decision-making? Forthcoming, *Med Decis Making* September/October 2007.
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LINDA HUNT

- Published (with KB de Voogd) "Are Good Intentions Good Enough? Informed consent without trained interpreters." *Journal of General Internal Medicine* 22:598-605. 2007.
- Published (with co-authors J. Hickner, S. Kent, and P. Naragon) "Physicians' and Patients' Views of Cancer Care by Family Physicians: A Report from the American Academy of Family Physicians National Research Network." *Family Medicine* 39(2) 549-553, 2007.
- Presented "Folk Categories and Origin Myths in Cutting-Edge Science: Race and Ethnicity in Human Genetics." Bioethics, Values & Society Faculty Seminar Series. University of Michigan (Feb).
- Gave talk "Culture, Competency and the Clinical Context: Reflections on an Amorphous Concept." Robert Wood Johnson Clinical Scholars Program Seminar Series. University of Michigan (Feb).
- Gave talk "Race, Ethnicity and Genetic Variation: Origin Myths in the New Genetics." The John P. McGovern, M.d., Award Lecture In the Medical Humanities. University of Texas Medical Branch, Galveston, TX (May).

ANN MONGOVEN

- Joined the Sparrow Hospital Ethics Committee (Feb).
- Participated in Michigan State University's 2007 "Meet Michigan" Health Policy Tour. This three-day intensive visited health policy-makers and sites in Detroit, Grand Rapids, and Ingham County, exploring state health policy and communication issues, and investigating the relationship between the health care sector and economic development in Michigan (May).

HARRY PERLSTADT

- Presented "What IRB Tutorials Don't Tell You: How to Negotiate with Your IRB" at the joint meeting of the North Central Sociological Association and the Midwest Sociological Association in Chicago (April).

GERALD S. SCHATZ

- Led a workshop, “Handoffs and Heartaches--Problems of Continuity of Care,” at the Annual Meeting of the Medical Ethics Resource Network of Michigan (May).
- Presented “Clinical Ethics Consultation,” at a Cancer Core Conference of the Michigan State University Breslin Cancer Center, College of Human Division of Hematology/Oncology and Great Lakes Cancer Institute (June).

TOM TOMLINSON

- Presented “The Ethics of Futile Resuscitation” at Lakeland Regional Medical Center, St. Joseph, MI (May).