Juvenile Homosexual Experience

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and its effect on adult sexuality

Robert H. V. Ollendorff

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Introduction by

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Introduction

by COLIN WILSON

This book first appeared in America in 1966, and quickly established itself as a major contribution in its field. Its author, Robert Ollendorff, was immediately recognised as a highly individual thinker in the European tradition of Freud, Adler, Jung and Wilhelm Reich. Since that time, Ollendorff has spent a great deal of time in America, lecturing at universities, and among the young and the "New Left", his name is often coupled with that of Herbert Marcuse as a post-Freudian revolutionary thinker. It is perhaps typical of England—Ollendorff's adopted country—that he should have had to wait a number of years for his book to be published here. The

English regard "ideas" with suspicion—rather like the priest in *John Bull's Other Island* who was outraged at the suggestion that he might hold a "theory".

For English readers, it may be of use if I say something about the tradition of ideas to which Ollendorff belongs. He was born in Breslau in 1912, of Jewish parents; his background was middle class and intellectual. This in itself is an anomaly in England; we do not associate the idea of intellectuality with the middle classes. Matthew Arnold accustomed us to the idea that the middle classes are Philistines. But in Germany and Austria this tradition of middle class intellectuality is a strong one. It has produced many major figures, including Mendelssohn, Mahler, Einstein and Ludwig Wittgenstein; our own Benjamin Disraeli sprang from the closely related Italian Jewish tradition; Spinoza's family were Portuguese Jews. In his important essay, "Freud and Reich, Non-Jewish Jews", Ollendorff has explained something of how this came about. During the Middle Ages, the Jews of Europe didn't do too badly; the Church was even inclined to protect them. The real trouble started with the Crusades, for as Christians worked themselves into a frenzy of piety and indignation, they suddenly remembered that Jews were also infidels, and slaughtered them. (The English, more civilised, simply ordered the Jews to leave in 1290; sixteen thousand did so.) When the plagues came, the Jews were accused of poisoning the wells, and again slaughtered and driven from their homes. Sheltered in Poland "beyond the pale", German Jews eventually drifted back to their own country, strengthened and individualised by centuries of "outsiderism", during which their religious and intellectual traditions had been their chief source of comfort. Many prospered, and then their cultural breadth, their interest in ideas, in music, in literature, made them acceptable to wealthy German families. "The newly infiltrated Jews offered fresh energy to the aristocrats in comparison to the usual boring, stodgy, Germanic types of citizens", says

Ollendorff. Moses Mendelssohn, for example, learned German (his ancestors had spoken Yiddish), ceased to attend the Synagogue, and wrote philosophical works that delighted such eminent contemporaries as Lessing, Kant and Goethe. And so the European Jews divided into two groups: those who stayed in their ghettos, spoke Yiddish and strictly observed their religious traditions, and those who became more-or-less assimilated into the native population and took an active interest in contemporary culture; like Spinoza and Moses Mendelssohn (grandfather of the musician), these often became freethinkers, and were noted as fighters for freedom, both political and intellectual. Ollendorff's own great-grandfather, Abraham Muhr, was a famous teacher and thinker in this tradition.

After 1848, the year of the European revolution, these Jews began to suffer from the forces of reaction. Patriotic racialists saw Jewish liberalism as a cunning plot to overthrow traditional values and introduce intellectual chaos. The world of Freud's childhood (he was born in 1856) was already beginning to feel the pinch of this new form of conservatism, an intellectual antisemitism quite different from the social and religious intolerance of earlier centuries. No doubt Karl Marx did a great deal to confirm the notion that to be Jewish and to be a dangerous revolutionary were much the same thing. It is interesting to note—as Ollendorff has—that many of these Jewish humanists were inclined to deny their Jewishness. When asked if he had ceased to be a Jew, Moses Mendelssohn replied "I am a man", and Marx, Freud and Wilhelm Reich later took the same attitude to their Jewishness—even to the point, occasionally, of becoming downright antisemitic. (Ollendorff regards this attitude as a dangerous mistake.)

And it was into this world—of intellectual antisemitism—that Robert Ollendorff was born in 1912. In his mid-teens, he was surrounded by the ferment of the pre-Hitler Germany, the world of Kurt Weill and Bertold Brecht, of Berg's *Wozzeck*,

of German expressionism, of clashes between Nazis and Communists, Like his sister Ilse (two years his senior), Robert was on the Communist side. So was a remarkable young disciple of Freud, Wilhelm Reich, whose first book, *The Function of the Orgasm*, was published in 1927 (when Reich was thirty). Ollendorff was fascinated by Freud—inevitably (what German intellectual was not in 1927?). He was fascinated by the social revolution that was taking place around him. He was not only the great-grandson of Abraham Muhr; he was also the nephew of Paula Ollendorff, the well-known suffragette and fighter for women's rights. It was natural that he should come to know and admire the work of Reich; for Reich not only united the two currents of Freudianism and Communism; he declared they were inseparable. When Ollendorff was twenty-one, Reich published his *Mass Psychology of Fascism* (1933), asserting that the repression of sexual freedom is one of the basic methods of fascist regimes, because sexually repressed individuals are easier to regiment, and hypnotise with words and slogans, while the sexually free individual ignores them. But in that same year, 1933, Hitler came to power, and Ollendorff, as a known Communist sympathiser, spent nine months in a concentration camp. Ilse left Germany (in March, 1933), to go to England (where she had trained as an actress) and then America. Ollendorff himself went to Tanganyika, where he first came into close contact with Reichian ideas—through his books.

By this time, Reich himself had started the unhappy period of wandering that took him halfway across the globe, and ended in an American prison. He had quarrelled with Freud, perhaps about politics (although a close friend of Reich's told me he quarrelled with Freud about his theory of breathing); he had had a brief honeymoon with the German Communist Party, when his views on fascism aroused their enthusiasm, then been rejected by them because his sexual views upset them; he had been thrown out of Denmark (probably as a

Leftist, although he believed it was due to the plotting of the Psychoanalytic Association), and in 1934 he would be thrown out of Sweden too. He moved to Oslo, and there, for a while, conditions were better. But even psychoanalysts who felt personally friendly towards Reich—like Ernest Jones—felt nervous about his political views, as well as about his criticisms of Freud. He had been expelled from the German Psychoanalytic Society—because of the political situation—and now he felt there was an increasing amount of plotting against him. There undoubtedly was, and it served to reinforce the suspicious, potentially paranoid side of Reich's character. A newspaper smear campaign did nothing to improve the situation; the Norwegians found Reich's sexual revolutionism as upsetting as they had found Ibsen's social criticism fifty years earlier. All might have been well if Reich had stuck to his psychoanalytic theories of "character analysis"; but by this time he had already made what he considered his most important discovery—of orgone energy, the vital energy of life itself, and of the microscopic vesicles that contain this energy, bions. When Reich started to publish his researches into "bions" in 1937, the newspaper campaign was intensified; finally, in 1939, Reich left for America. In October, 1939, Reich met Ilse Ollendorff in New York; and not long after, Christmas Day, 1939, Robert Ollendorff heard, to his astonishment, that he had become the brother-in-law of Wilhelm Reich, the psychologist he admired above all others.

Oddly enough, Reich and Ollendorff never met; for Ollendorff was pursuing medical studies in England, and Reich was on the other side of the Atlantic. It may have been as well that they never met—or at least, never became closely associated. Reich needed followers rather than equals, and his paranoid tendencies increased as his conflicts with authority snowballed. Ollendorff studied with Reich's Norwegian follower, Ola Raknes, and he must have learned from Raknes, as well as from Ilse's letters, that Reich could be very difficult

to live with. And since Ollendorff has no liking for patriarchal figures—regarding them as one of the root causes of the "sick society"—the instinct that made him stay away from Reich was probably a sound one. As it was, he was able to absorb the best of Reich—the ideas—without the irrelevant distraction of his fits of rage and suspicion.

I should add, at this point, that everyone to whom I have spoken about Reich's personality—even the gentle and kindly A. S. Neill, whom Reich admired and trusted to the end—seems to be agreed that he was an astonishing example of a dual-personality. He produced an impression of strength and brilliance, and also of compassion and wisdom. But almost any triviality might touch some raw spot of insecurity, and trigger suspicion or violent anger. Reich was very much a flawed man of genius, happy when totally absorbed in his work, tormented and self-divided in personal relations. He had reason for the deep-rooted sense of guilt; he had been one of the contributory causes to his mother's suicide, when (at the age of 13) he betrayed to his father that she was having a love affair with a schoolteacher.

But at this point it is necessary to say something of Ollendorff's own psychological theories, and to explain how they differ from Reich's. In order to do this, I must speak briefly of Freud and Reich. Until 1915, Freud's view of neurosis was wholly sexual; it was due to various forms of sexual repression, usually far back in infancy. It was in 1915, according to Ernest Jones, that he noticed his grandson playing a game that must have aroused wholly unpleasant feelings—to do with his mother's absence. Freud concluded that man's instinct of hate, of aggression, plays a part as important as the libido in man's instinctive impulses. The view was fully developed in *Beyond the Pleasure Principle* (1919) in which the self-destructive impulse, thanatos, makes its appearance. But Freud was also influenced, to some extent, by his disciple Adler, even after their break in 1911. Although Adler saw the frustration of the

"will to power" as a basic cause of neurosis, he also laid great emphasis on society and on the family unit, both of which, he felt, exercised an influence towards stability and unselfishness. Adler's view is reflected in Freud's late work *Civilisation and Its Discontents* (1930). This takes the view (derived from Adler) that man became a social animal because he was too weak to compete with other animals, and that the civilisation he has created is fundamentally at odds with his natural instincts. He is not entirely pessimistic; he believes that "in the course of time changes will be carried out in our civilisation so that it becomes more satisfying to our needs", but he believes the basic conflict will remain.

Reich discovered Freud in 1919, when he was 22, and became totally convinced by the sexual theory of neurosis. But Reich was equally influenced by Marx and Engels; that is, by the view that the world's problems are basically social and economic in origin. He simply amalgamated the two theories, denying that there was any fundamental contradiction. Sexual repression creates neurosis by preventing man's natural development; so does poverty and the enslavement of the majority by a capitalist minority. Caught between these two forces—of moral and economic repression—man has little chance of emerging unwarped. It followed that a true socialist revolution would also involve a true sexual revolution. Reich's social-sexual doctrine is closer to anarchism than communism; his view involves an assumption about the basic goodness of human nature, and man's capacity to become happy and creative in a free and open society. The present conditions produce sex-hatred and aggression, and man is forced to develop a kind of psychological armour-plating, like a tortoise, to prevent him from being torn apart by these forces of hate. (This "character armour" can express itself physically in the form of muscular tensions, twitches, "tics", etc.). So Reich tended to move towards the opposite extreme from Adler—to see society (or faulty social patterns) as the distorting force,

and to regard the family as a kind of miniature version of society. Freud came increasingly to dislike the twist Reich was giving to his theories; he was basically unidealistic about society. He was undoubtedly getting at Reich when he wrote in *Civilisation and Its Discontents*: "The Communists believe . . . man is wholeheartedly good and friendly . . . I am able to recognise that this theory is founded on an untenable illusion. By abolishing private property one deprives the human love of aggression of one of its instruments . . . this instinct did not arise as the result of property; it reigned almost supreme in primitive times when possessions were still extremely scanty . . ." He felt the communists were underestimating the complexity of human nature.

Reich ignored these criticisms. He broke with Freud, and continued to develop his own optimistic view that man would be altogether more happy and free if he could learn to express his sexual vitality without guilt. The orgasm was the natural release of this vital energy, which he called orgone energy. After 1933, when the Communist Party disowned Reich, he ceased to lay so much emphasis on the Proletarian Revolution, but the "discovery of the orgone" made the sexual revolution more important than ever. Yet there was no return to orthodox Freudianism. Like another Jewish colleague, Abraham Maslow, Reich was developing his own curiously optimistic version of psychoanalysis. There was an underlying feeling that human beings are capable of a great deal more than we give them credit for, and that if the social and sexual bonds could be removed, man might develop into an altogether more admirable creature. There was also, of course, a strong negative element in Reich; he felt that many people are so warped and distorted that their instinctive response to this doctrine of freedom is violent hostility; he invented the term "emotional plague", which eventually became a blanket term to describe anybody who disagreed with him. For the remainder of his life, the paranoia and the genius fought for control;

but by 1957, the year of his death, the paranoia had won.

There are many "Reichians" who feel that Reich's years in America were, to a large extent, wasted—at least, as far as the development of his psychology was concerned. Unsympathetic critics say that he became a crank, obsessed with his blue "orgone energy", and with such projects as rain-making and the spontaneous creation of life. Ollendorff declines to comment, saying simply that he is not a physicist—and that Reich wasn't either. He is by no means hostile to the concept of orgone energy, as he makes clear in his lectures on "The Sick Society" (delivered at the University of Florida): "I define sex as a primary amorphous life-force. It is possibly identical with the life-force as seen by Bergson and Reich. Sex is a bio-energetic reality. . . . " I have sat in Ollendorff's "orgone accumulator" (a cabinet made of alternate layers of organic and non-organic material—for example, wood and metal) and seen my temperature rise by several degrees in ten minutes; the inside of the box felt like a radiator, although its walls were perfectly cold. Ollendorff accepts many of Reich's findings on orgone energy; but he is more concerned with the development of his psychological theories.

Perhaps the key to Ollendorff's approach is to be found in his essay on Freud and Reich as "Non-Jewish Jews". "In renouncing their Jewishness, Freud and Reich renounced themselves". He believes that Reich's denial of his Jewishness "is best understood as a personality disorder of some depth". Why should this be so? Is not an insistence upon one's nationality perhaps as "inauthentic" (in Heidegger's sense) as an insistence upon one's wickedness or sexual deviance? Ollendorff would answer No, because the kind of denial of Jewishness practised by Marx, Freud and Reich was an attempt at repression, at self-deception. Human beings are already subject to enough distorting pressures from the society around them, without adding to them by a refusal to face facts.

And this brings us to the heart of Ollendorff's own theory

of the sick society. He accepts fairly unreservedly Reich's notion that neurosis is not generally due to some particular event or trauma, but to the long-term warping effect of the sick society. All living beings possess this primary life-force, which is naturally out-going. "It gives a lustful happiness and rhythm to all living functions"—breast feeding, eating, defecating, making love, discovering one's potentialities. And in a fascinating passage in his second Florida lecture, Ollendorff goes on to enumerate the conditions under which he feels that a human being would develop naturally and freely. Happiness and lack of tension in the mother is an important factor; her sex life should be satisfying, and she should also accept the sexual element involved in breast feeding her baby and enjoy it without guilt. (In this, Ollendorff is wholly Reichian; he accepts that the expression of sexuality should be wholly free of guilt; the poet William Blake had anticipated Reich in his early Prophetic Books.) But since Ollendorff feels strongly that the society itself is the main formative influence on the child, he also holds that "a broad family of loving women and men would be mama and papa to the infant, making the basic mother and child relation a non-fixated one". For, as becomes clear in this present book, Ollendorff feels strongly about the effects of the "patriarchal society", and about fathers who are patriarchal authority figures rather than loving protectors.

The present book does not fully develop this concept of the sick society, but it is clearly implicit. Reich, oddly enough, was nervous about homosexuality; there was an odd puritanical strain in him. (Neill told me he hated the word fuck.) He was not comfortable with homosexual patients, and there is very little about homosexuality in his writings. But Ollendorff's approach to the problem of the homosexual is confidently and sanely Reichian. He argues against the Freudian view of homosexuality as an outcome of the Oedipus complex combined with castration-fear (so that the adolescent rejects woman out of fear of his father.) He is only in agreement with

Freud insofar as he accepts that "the quintessence of a sick society is literally anchored into a cruel, vicious, destructive father figure". Apart from this, Ollendorff's view of homosexuality is altogether less complicated than Freud's. To begin with, he recognises that this is a mass problem, as common as the common cold, and perhaps not a great deal more harmful, provided it remains uncomplicated by other problems. The forces of society inhibit the expression of natural sexuality at the very time when it is most powerful; it is natural that these repressed forces should find outlet in homosexual leanings. And since, at this stage, the sexual character is still fluid, it may set in a homosexual mould. Homosexuality is produced by "conditioning", which, together with "induction", is one of the chief means by which neurosis is transmitted in the sick society. It sounds as if Ollendorff is judging homosexuality as a perversion brought about by the sick society; but I do not believe this is so. He says at the end of chapter one that all other developments (after this homosexual adjustment) are of secondary nature, "with a profound influence on the further maturation of the personality, mentally, physically and biologically". What concerns Ollendorff most deeply is this further maturation of the personality, and he seems to regard homosexuality as a perverse pattern only insofar as it impedes this further development.*

And it is this concern with mental, physical and biological development that gives Ollendorff's work its flavour of excitement. One's first reaction to his concept of a sick society, in which neurosis is transmitted by a form of magnetic induction, is depression. But it soon becomes clear that his whole approach, like that of Reich, springs from an optimistic sense of what human beings *could* be. It is for this reason, no doubt,

*"The male harbours a latent homosexuality which he dares not express. Where it becomes socially organised and partially used in the living-out of the complex social patterns of power and patriarchal legitimacy, it means armies, wars, the attempt to run away from the unbearable boredom and the hated woman". *The Sick Society*, lecture 3.

that his work reminds many of Marcuse, with its inspiring notion of a non-repressive society. But Marcuse's analysis gives strong grounds for pessimism. He sees America as a kind of fascist state, dominated by materialism, in which it is almost impossible for man to escape the fate of becoming "one dimensional". Many of Marcuse's concepts are profoundly Reichian (although he never seems to acknowledge Reich's influence). But this pessimism about our "sick society" seems to have led him, in recent years, to accept that only a violent revolution by the young, in whom idealism is still fresh, can create the non-repressive society. Ollendorff is at once less theoretical and less pessimistic. Like his friend, A. S. Neill, he seems to feel that a great deal can be done with a little decency and common sense. Man is not basically violent or criminal; let us begin by recognising this, and we have already taken the first step towards changing the sick society.

What *is* so refreshing, about Marcuse as well as Ollendorff, is that they are typically Continental thinkers; they belong to that great European tradition that accepts ideas as an explosive force. They feel there is some real point in thinking out their ideas on man and society, and setting them down on paper. Somehow, you would not expect this kind of confidence from an American professor—or an English one, for that matter. An American might well produce an analysis of the various causes of the sickness in modern society—religion, nationalism, patriarchalism, bureaucracy, sexual repression, mechanistic science (as epitomised, for example, in Eysenck), racialism—but he would feel that he was describing objective, historical factors—factors of which he might disapprove, but over which he has no more control than he has over the planets. When Ollendorff analyses these factors, he induces an odd feeling of optimism, for you sense that he feels they are absurdities, that would vanish like mists if the ideas of Reich —and Ollendorff—were generally understood. And, in fact, you may feel that some of his ideas are too simplistic to provide

a solution to the problem—for example, "children's rights"; but somehow, that is not of ultimate importance. What is important about Ollendorff is his sense of reality, the intensity with which he raises questions and demands an answer, the feeling of being engaged in the constructive discussion of major problems, the sense of intellectual boldness. And, on closer analysis, even this controversial idea of "children's lib" is less unrealistic than it sounds. Our first response to the idea is that it is based on some logical oversight, like the idea of a Trade Union for prisoners. (The logical conclusion of autonomy for convicted criminals would be, presumably, the demand that there should be no prisons and no penalty for crime.) But seen in the total context of Ollendorff's ideas, this is not so. It is not a question of giving children the rights they would like for themselves (i.e. no school, and Christmas four times a year), but of recognising the extent to which our children may be forced out of shape by the sick society. "In our sex-negating society, the un-encounter (with sex) is prepared in infancy by inducing the sick pattern: restriction, taming, disciplining, training and enforcing asexuality until a basic anxiety is produced in every member of the society". (*The Sick Society*, lecture III.) (It is significant that the English have a Royal Society for the prevention of cruelty to animals, but only a National Society for the prevention of cruelty to children.) Once again, it is important to understand Ollendorff's basic concern, the point he is starting from, and to understand that, to some extent, he is urgently raising a question rather than suggesting answers. He ends his lectures on the sick society by admitting that although some form of political action may be necessary if these goals are ever to be realised, he himself is too "deeply distrustful about political manoeuvres" to enter this field.

I find that the most interesting thing about Ollendorff as a person, is this curious mixture of modesty—almost of self-depreciation—with his humour and optimism. He observes the

sick society with a clinical detachment tinged with compassion, and he seems to experience a certain pride in noting that what he observes confirms what he has learned from Reich and thought out for himself. For example, in the sixth lecture, he tells the interesting story of a young American whom he interviewed by mistake. The young man came to be interviewed as a volunteer to work in the clinic; Ollendorff mistook him for a man who was coming to be analysed. The young man submitted to be questioned about his life and background, and although he was not, in the normal sense, in need of psychiatric help, his "case" was a textbook illustration of Reich's notion that our society makes everybody more or less sick. His father, an alcoholic, had left his mother when he was three; she married twice more, and one of these stepfathers made him leave school at 18—although he had scholarships and grants—and work on a farm. He had become a drug user in school—amphetamines and barbiturates—and eventually a "pusher". Then he became a criminal—in a small way—by joining a group who practised minor fraud (selling stationery that did not exist). The criminal period led to a reaction; after a period as a bum, hitch-hiking around the States, he joined a Christian group and became a social worker. In most ways, the young man had "adjusted" to society, by swinging from one extreme to another (Ollendorff points out that the same motivation lies behind the "Jesus freak" phenomenon). He admitted to an inferiority complex, but seemed otherwise psychologically healthy. Ollendorf analyses the case in some detail, and points out that here is an example of an "average" person, picked up in the street, as it were, who demonstrates the Reich-Ollendorff theory of the conditioning of the personality by the "normal" pressures of the sick society; Ollendorff goes on to speculate that you could pick up a few hundred passers-by, and detect similar "relevant psychopathologies".

(My own first book, *The Outsider* (1956) was subtitled "A Study of the Sickness of Mankind in the mid-20th Century",

and suggested that industrial society either crushes human beings into its own mould, or turns them into "outsiders". This probably explains my own immediate response to Ollendorff's ideas.)

Robert Ollendorff is now in his early sixties. For some years now, he has spent part of every year lecturing in America. Yet in spite of increasing celebrity, he prefers to continue to work in general practice in London. Reich had become a celebrity at half his age; but his celebrity carried him into a world of theorising, of conflict, of intrigue, and ultimately of paranoia. It is central to Ollendorff's idea of the role of the psychiatrist that he should be the working physician rather than the prophet and cult-leader. He writes in the second lecture on the sick society: "The status of the doctor, the psychiatrist, must be rapidly brought into a rational working role. The doctor, the psychiatrist, must be simply a servant to the members of a sick society, and his role must be reduced economically and mythologically to that of a directly involved helpmate. . . . This isolation is deadly in the long run. He must remain realistic in the training of new members of the profession. And the amalgamation of medical and psychiatric concepts must be forthcoming by finding a formula for working with all concerned. This means that he is not so expensive that the multitude of the sufferers could not afford him, and he should not interpolate techniques of avoidance and shortcuts which factually separate him from society". The attitude differs basically from that of Reich, who saw himself as a spiritual leader or nothing—and who was ultimately destroyed by rejection. Ollendorff, equally idealistic, has taken a saner and more balanced attitude to his task. He seems to me to demonstrate how far it is possible for an intelligent idealist to achieve health in a sick society.

Author's Preface

to this edition — Dr R. H. V. Ollendorff

In 1966, when this book appeared in an American edition, the legal pressures on the homosexuals in western countries had not been relaxed. Legislation to alter prosecution, new age clauses, were made later. In eastern countries, there is no alteration of their rather rigid laws. In fact, the death sentence is still possible in the Soviet Union, or, with some luck, the homosexual is sent to Siberia.

Time has come, then, to review the book from several aspects: firstly we must ask: Has the reduction of legal and police procedure produced a shift of homosexual life-structure? Secondly, have organisations like the Gay Liberation Front

taken off the prevalent anxieties, changed aggressive—even violent—anti-homosexual feelings, and most of all, reduced the appalling loneliness and the cast-iron mood of being an outcast, a monster in our society? Thirdly, have the theoretical presuppositions, made in this book, stood up against the test of time, and have the criticisms, levelled against the book, been justified.

Let us look at the life of the great number of young homosexuals, which I meet daily and who represent a fair sample of all groups of society.

No doubt, the removal of legal and police pressure, has lightened the burden of the young to an extent, which is easily discernible. Blackmail, the major source of anxiety in the well-to-do and elderly, has practically disappeared. That, too, forced the psychopathic homosexual or, more often, the youngster without any fixed sexual goal, to make his bread in some less destructive way.

Like everything in the last few years, he raised his price—inflation, as we observe, spares no field.

A further region, where the absence, or rather the amelioration of legal aspects, has produced greater ease, is the now more established tolerance of economic integration of homosexuals in most fields of employment. In most branches of the Civil Service, in factories, shops, offices, overt homosexuals have been accepted. Naturally, some self-conscious barter continues, often vitiated by covert, repressed, homosexuals in their grotesque compensatory aggression and hatred. Also, the sex-negating drive, incarnate in our society, still finds its primary target in the homosexual. In the "permissive society", he is, by his needs, the most promiscuous, and thus his sexuality becomes most obvious as the major preoccupation, the incessant outlet, a hunter's style of life. The attack there will not stop. Here, too, however, the homosexual has been helped by the new way of life of hundreds of thousands of young people. Call it Hippie, call it Hairy, the "unisex"

appearance makes it certainly impossible to shout "You hairy, effeminate Queen"—because there will be a greater proportion of these groups consisting of well-married, "square" workers, with little or no involvement in the homosexual scene.

A further factor, on the law-and-order issue, is the breakthrough of what is commonly known as pornography. From a cast-iron taboo on four-letter-words, from a heavy-handed censorship, which never could really differentiate between "hard-core" obscenity and witty, tasteful, often even beautiful description in picture or word of sexual acts we have now matured to a much more liberal attitude. Their importance, their intrinsic and positive life function, as we experienced in the last few years, led to a progressive loosening, a new approach—like the acceptance of all this in Denmark, the failure of the Oz trial. In the sense of Wilhelm Reich, a new epoch in the Sexual Revolution has started.

A drawback for the integration of the homosexual, on the other hand was the growth of, and the legal clamp-down, on the "drug-scene". Particularly in the Pot-smokers group, and, to a more limited extent, amongst the lysergic acid users, one found a goodish number of homosexuals. Thus persecution and prosecution continued, allowing the old anxieties to survive and flourish, leading to a perpetuation of the prototypical behaviour patterns of the homosexual, which, in olden days, were born out of anxiety, tension, total insecurity and the threat of the great sex taboo. The "pep-pill" scene had an even greater proportion of homosexuals, and a lot of confusion amongst them was promoted, when legal restrictions on the prescribing of these drugs left them high and dry. A rising number of young alcoholics illustrates the inevitable shift from one poison to another when unenlightened prohibition is enforced.

We can now discuss our second question—Have organizations like the Gay Liberation Front taken off the

prevalent anxieties of the Homosexual Youth? Did they manage to change aggressive—even violent—anti-homosexual feelings, and most of all, reduce the basic loneliness and the often, self-inflicted isolation of the homosexual? In an overall, perhaps rather superficial assessment, the answer is undoubtedly —yes! Young men and women, who a few years ago would have undergone agonies over their "otherness", who would have landed themselves in severe depressive illnesses, often suicides, are generally more contained and accept their sex-direction with greater ease—often even with a positive, creative aspect added.

The immediate sense of group-cohesion, to have a niche, is of great meaning to the isolate, the outcast, the person tortured by a non-acceptable pattern of life and love. Thus, the Gay Liberation Movement has helped many thousands who now live more peacefully, often in experimental communes, much better integrated and less harassed.

Another, rather subtle, change has been noticed over the last year or two. The more aggressive, drag-queen, homosexual, whom I described (on page 223: 10/128: Case histories), and who described himself as a "screaming lulu" is now, more legally, inserted and produced in pub-concert parties. In consequence their need to caricature the female, the ambivalently love-hated woman, has much declined. However the passive submission symbolising mother identification to a brutal father, of course, remains still to be the subconscious core of much passive homosexuality and, in a more complex way, of transvestitism.

A proclamation which I often handed to shy, depressed, anxious homosexuals persuading them to be self-accepting in their homosexuality and which I called:— The motto over the mantelpiece—is still valid.

"What was good enough for
Michelangelo
Socrates

Lawrence of Arabia
Shakespeare
Tchaikovsky
Might be good enough for you."

In conclusion of answering the conundrum, whether the Gay Liberation Movement has changed public attitudes towards the homosexual, one can say that tolerance is a slow-motion process; life-long prejudice and self-protecting mechanisms are not easily resolved. But all-in-all one can say that the heat is off and the movements have spread and performed some good work and usually have been well received by the media. Teaching recently in Florida, I moderated a confrontation of about 200 male and female medical students with about six representatives—also male and female—of the Gay Liberation Movement. The grace, dignity, warmth and wisdom exuded by the Movement supporters, the tolerance, interest and understanding shown by the students were surprising and truly a new level of co-existence.

We are now able to find out how much of the book, after six years is still valid. There is no easy answer to that—ideas rarely remain static.

In 1966, I tried to formulate the hypothesis that homosexuality is the product of our typical, Western, judaeo-christian patriarchal society, based on sex negation, on repression of sexuality. This, I deduced, happened in two waves, by two distinct processes, and, most of all, happens to every member-child in our society. The first is induction in infancy, the second I called conditioning. I put our pattern of society in juxtaposition to the two classical descriptions of non-patriarchal societies. These are "The sexual life of savages" (a study of Trobriand Islanders) by Bronislaw Malinowski, and "The Ghotul of the Muria" the Central-Indian Tribe, the Muria so deeply loved and understood, by Verrier Elwin. The patterns of child rearing in the Bachelor's dormitories, the Bukumatula respectively the Ghotul, found to be the hallmark

of the findings of the two anthropologists, make it inevitable to recognise that these patterns are going back to old matriarchal forms of living. The result is a spectacular absence of homosexuality, and a happy-making, profound integration of sexuality from infancy onward.

In some further writings, I have enlarged on the fundamental importance of the two processes, induction and conditioning,* and tried to establish an overall concept, that of a sick society. I hope to unify the ideas incorporated in the two processes, induction and conditioning, and the Concept of a Sick Society in further studies.

The red thread, going through all these ideas, follows to a great extent, the philosophy evolved and illuminated by Wilhelm Reich. He established that sexuality is a bio-energetic natural process of primary strength, which is continuously disturbed, deflected and ultimately substituted by secondary phenomena. The faulty, destructive response-mechanisms, evolved by a hostile, sick society lead to a total and lasting anchoring and perpetuation of just these response-patterns in the whole psycho-physical entity of the human being—as character structure when seen and eliminated psychologically, as a myriad of rigidities: in gait, posture, attitude, inhibited abdominal breathing, "psycho-somatic" dysfunction in well-nigh every physiological system. Reich's formulation of the identity of these processes with cancer—biopathy are bound to be re-examined in the very near future.

In the Concept of the Sick Society, and based on the theorems of Reich, as stated above, it is understood that all sexuality is bound to be trans-substantiated into secondary patterns. It is obvious that homosexuality undergoes the same fate, but over and above this, it is producing some "sick" features of its own. In response to the illogical hostility of

*See chapter 3 in "Children's Rights", p.97-134, The Rights of Adolescents, Panther 1972. (Leila Berg, Paul Adams, A. S. Neill, Robert Ollendorff, Nan Berger, Michael Duane).

society, although homosexuality is born and fixated originally in consequence of the incarnate anti-sex constellation of our society, on the one hand, by putting the whole weight of their legal, social, medical, theological ideologies of the establishment in condemnation, on the other, promotes a host of features, which are all part of our sick society.

The anxiety, basic to any group, who undergoes directly or indirectly persecution, contempt, hatred, disenfranchisement, discrimination or non-participation in civil rights, is still reproduced to a greater or lesser extent in every homosexual.

A system of signals, necessary to live out and indicate the homosexuals' special position, often leads to tragic and dramatic results—either leaving the homosexual deeply hurt and rejected—or more tragically, even nowadays—in social alienation and self-destruction. The message of this book remains unaltered—to make the homosexual proud in his or her self-acceptance, and to make the doctor, the psychiatrist, the social worker fully aware and helpful in the support of those homosexuals, who need their help.

Juvenile Homosexual Experience

Introduction

Historical development of homosexuality in the patriarchal society up to the present

The problem of homosexual feeling and behavior is as old as written history. That the earliest recording of history coincides with that of homosexuality is no mere coincidence. Both are the products of a patriarchal society. At the dawn of history, the increasing role of the individual as property owner, as one who possessed holdings of value, led to an ever narrowing concept of the family, to an ever

increasing aggressivity in the defense of property, to a growing belief in immortality and a final deification of the one God in contrast to the earlier deification of all ancestors en masse, as in totem worship.

The legitimacy of a man's sons, for purposes of inheritance, became increasingly important, a development which expanded in direct proportion to the quantity of property and/or possessions held. Record keeping became essential to this idea as a clear testimony and proof of past events. The role of sex changed from an integrated biological and physiological regulator of life rhythms, the quintessence of matriarchal community life, into a political weapon, that of patriarchalism, reinforced by inheritance, by primogeniture.

Sex was only permissible in the production of the unquestioned legitimate male heir, and also, of the mass production of a useful labor force without rights: women, slaves, serfs. When sex thus became the forbidden fruit, with narrowly defined exceptions, two basic moral attitudes sprang up—good and evil, God and the devil, heaven and hell. The preoccupation with these moral concepts grew proportionately with 1) the enforcement of their observation and 2) by the fact that wider and wider segments of society accepted this preoccupation due to the increasing recognition of the fundamental biological identity of both sexes of the human species. Sex became equated with evil, the devil, hell; sex repression was practiced, inculcated, taught, forced, and preached from infancy to death. Chastity, sex negation, and abstinence became virtues. Sex, again with narrowly defined exceptions, became sin, crime, horror.

Thus conditioned, sex, in the human mind, soon became the focus of abnormal activity. Life became full of unabated anxiety, while death and the fear of punishment in hell became a constant and overwhelming rumination.

Eras of slow or cataclysmic breakthroughs of human enlightenment varied with eras in which men wallowed in the perverted images of death, sin, punishment, and a whole flood of symbols, sick and sickening, which focused the tortured mind of man on the medieval hell on earth—as clearly depicted in Hieronymus Bosch. But the major tragedy of patriarchalism is its relentless corruption of every new and initially benevolent insight and attempt to reach new horizons by the all-pervading strength of the continually on-going sex-repressive mechanisms, which have been impressed deeply upon the minds of everyone in our own civilization.

The vision of the love of Christ sank into the horrors that pour out of Bosch's paintings and ended in repressive institutions like the Inquisition; the message of equality of the French Revolution was buried into the moralistic morass of the cold-blooded monster, Robespierre; the classless freedom and liberty of communism was degraded into the ruthless totalitarianism of Stalin; the achievements of the Reformation ended in the joyless straitjacket and intolerances of the Puritan sectarians. Finally, the conceit of man in his inability to face himself resulted in delusions, in projecting the Evil Incarnate onto hated rivals, onto neighbors, onto anybody not easily conforming, by superstition-fed witchcraft.

In the same way that we look back on witchcraft today,

so will future generations, should the species survive a further destructive wave, look back on our inability to live with sex as a rationally integrated part of our lives.

The descriptions of ancient Chinese, Japanese, Assyrian, and Hebrew societies demonstrate, directly or indirectly, that they judged or condemned homosexual activities. The role of homosexuality in Greek history has been very thoroughly described by Licht[31], and Petronius's satires of Roman society show that homosexuality was a very widespread behavior pattern at that time.[19]

In the last 2,000 years of Western civilization, periods of open homosexuality existed, as with the Teutonic Knights in their rule of the Baltic Provinces, the Italian Renaissance, Shakespearean England, the court of Louis XIV of France. These vary with periods of harshest suppression of homosexual activities, such as the death penalty for homosexuality in England, France, and Prussia up to the 19th century. The execution of Katte, the friend of the adolescent Frederick II of Prussia, was based on this law. To name but some of the ways society treated this problem: the Wilde trial in England at the beginning of this century; the Montague-Wildeblood [49] trial in the mid-1950s, Hitler's violent liquidation of the Röehm clique.

There are three fundamental positions expressed in regard to homosexuality in patriarchal society:

1. *Sin.* This may be more or less venial and runs parallel to the tolerance shown toward all sexual activities.
2. *Crime.*
3. *Degeneracy-deviation-abnormality-perversion.*

The meaning of sin is deeply rooted in the Judaeo-Christian faith and, as such, obviously cannot be treated further in this context. The meaning of crime is deeply rooted in the legal structure of Western civilization, and is not the subject of further investigation in this study.

For our purposes, we shall concentrate on the position of degeneracy-abnormality-deviation-perversion. This was a favorite topic of study of early psychologists and psychiatrists, and it has been the subject of discussion and prejudice most particularly during the last hundred years. Goëthe's dictum: "Everything that is in nature is natural" was one of the early and most mature commitments on this subject. Later, Krafft-Ebbing,[28] Moll, Forel, Havelock Ellis,[8] and Hirschfeld [23] all treated the subject and condemned or accepted homosexuality as a deviation from the normal. A more thorough summary of their views will be given later.

During the last century, partly based on the enormous influence of Freudian theory and practice,[13] homosexuality became the subject of very broad descriptions in modern literature; it is the theme of numerous novels. Thus, in modern times, a rather complex conflict is created between the acceptance of homosexual activities as being understood and tolerated on the surface, whereas, beneath the surface lies the whole severity of the law and the deep-rooted morals of religious teaching, which are in gross juxtaposition to acceptance.

Fundamental studies of the role of sexuality in matriarchal and transitional societies

The matriarchal societies have been studied thoroughly and significantly, with convincing authority, by two leading anthropologists: Malinowski[33] and Elwin.[9] The hallmark of matriarchal society is a total sex-permissive attitude which begins at birth. The tribal order, or tribal law and life, is grouped around the sexual organization, which usually finds its clearest social expression in the public dormitory of boys and girls, usually from the age of four or five years onwards, as was the case with the Bukamatula of the Trobriand Islanders, the Ghotul of the Muria in central India, and the Manyatta of the Masai.

A major problem arises from our concepts of matriarchalism and patriarchalism. These two basic patterns of human organization are incarnate in all human societies, and the historical events which favor one or the other pattern are, in some way, deeply interwoven with both sexual and economic causations. This may best be illustrated by the following scheme:

1. *Firm settlement.* Sex-permissive order leading to a broad basis of communal work and life; limited property owning.

2. *Nomadic economy leading to sex-negating order.* Owning of property, especially of domestic animals, predominates. A warrior class develops, and the progressive stratification of society leads to an ever narrowing basis of

the family concept and the importance of direct blood inheritance.

But also, in the matriarchal firm-settlement society, a gathering of property begins sooner or later in one form or another, and then, of course, the importance of the family law grows, and the narrowing basis of communal activities and contracting sib or community activities leads to a less permissive order.

There seems to be little doubt that, although homosexuality is as old as written and traditional history, one must recall that we look back to nearly 100,000 years of organized society, however primitive, and that those ancient communities obviously survived and their sexual organization must have been of great importance by reason of sheer survival. It seems, however, that there has been a great amount of retrojection in most hypotheses and speculation in this field. The tendency to glorify the past, every past, seems to affect all speculation on prehistory; for instance, the Marxist theory of the Ur communism expressed by Engels in "The Holy Family" is part of such glorification.

Profound studies of modern anthropologists like Malinowski, Elwin, and Mead [35] make it quite clear that both matriarchal and patriarchal elements are in the *Anlage* of every organized society. However, the idealistic philosophy with the glorification of the strong man leads to maxims of the absolute and maintains that all catastrophies and deviations, historical or sexual, have always been present; it rigidly rules that the necessity of order, law, and sex prohibition as mainstays of the patriarchal system must be upheld.

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Sexuality and its social integration being of primary and immediate urgency for survival, prehistoric primitive civilization has certainly been, and had to be, a sex-permissive one; there seems little doubt that once the acquisition of property became the mainspring of civilization, and of law and order, the tendency to patriarchalism and sex negation became stronger. This is of great importance, as the societies described by Malinowski and Elwin show a complete absence of homosexuality, which certainly forces one a priori to revise all theories of genetic influence, hormonal deviational perturbance, bisexuality, and Freudian hypotheses. These could only be upheld if a thorough and critical review of the total structure of societies which show homosexuality as a mass phenomenon had been tried; and this, so far, has not been done.

Critical review of modern theories of the causes of homosexuality

It is only in very recent years that sexual behavior has been studied without the influence of moralistic and prejudiced thinking. How strong these prejudices still are can be shown daily. A recent controversy following the discussions of the findings of the Royal Commission on Homosexuality has taken place in the *British Medical Journal;* about 60% of all letters sent to this journal expressed aggressive and moralistic views strongly advocating that no relaxation of English law on homosexuality should take

place. While this law reform was discussed in Parliament in 1960, a psychiatrist, Dr. Broughton, made himself the mouthpiece of all these tendencies and fought against any alterations or reforms. The same attitude is found in Germany where we find, for instance, in a review of "*Die Kriminalität des Homophilen Mannes*," Dr. Sperling-Oppenau talks of "psychosomatic disgusting features" and maintains that the homophilic man is "unappetizing." We find in these and many other examples, that clear thinking and clear study of this subject is grossly handicapped. Thus, the majority of modern views of psychiatrists and other research workers on this subject is frankly useless, and it must be stated that *the way homosexuality is treated by scientists is already perturbed at the source.*

It seems statistical nonsense, for instance, to try to apply genetic laws to a condition for which no factual figures of statistical significance and proven validity are available. The vast majority of studies on homosexuality are made on the homosexual; very little material in respect of the bulk of the male population, however, has been found in the literature, with the limited exception of the Kinsey Report[26] on the sexual behavior of the human male.

Over one-third of the male population is said to have, at one time or another, practiced homosexuality in some form; this figure has been ridiculed, doubted and, what seems to be worst of all, proclaimed as simply nonsensical. However, nobody has so far undertaken factual surveys of broad numbers of the normal population; thus, one is forced either to accept the estimate of the number of homosexuals as the usual 2% to 10% of the male population,

or one has to accept Kinsey's figure, which involves over one-third of the male population.

If one takes the first figure of 2%, this means that approximately 360,000 males in England and Germany respectively are involved out of a total of about 18 million males of the age of sixteen and over. If one takes 10% of this figure, 1,800,000 males in each of these two countries are involved, and if one credits the Kinsey Report, then about 5,400,000 males of each population in England and Germany are involved.

Now, however little knowledge of genetics the author possesses, it seems to be quite legitimate to conclude that we would deal here with a gene of overwhelming dominance which, in not less than three generations, should show itself in one form or another in every male of a given population, and it seems absurd to offer proof genetically or statistically of any inherited characteristics. It still remains impossible to sort out a massive general impact of a homogeneous, culturally conditioned onslaught on any and every child from genuine genetic factors.

Thus, even a painstaking and interesting study, as that of Kallmann,[2] becomes pointless, however convincing it seems to us. His study tries to prove that by separating uniovular twins in diverse social and environmental circumstances, they nevertheless develop homosexual tendencies in 100% of these cases. Although Kallmann is very cautious in the interpretation of his findings, once it can be shown that a homosexual complement is part of the make-up of most males by sex-negating induction and conditioning in Western civilization, any genetic explanation

of this phenomenon remains unacceptable, as will be argued later at greater length. Equally unacceptable are endocrinological hypotheses, as, there again, wherever and whenever we deal with a mass factor of such numbers as given above, physiological and glandular elements cannot seriously be involved.

On the basis of an abnormality, the views of the German sexologist Magnus Hirschfeld are of great interest. His basic theory was that of a third sex; he allows genetic and endocrinological factors as well as personality disorders and social conditioning to make up the homosexual. Great play is made by him of the fact that, in the embryo, sexual differentiation is a late process, and that both male and female show rudiments of the sex organs of the opposite sex (Steinach). This imbalance, he feels, produces a third sex, but, according to Hirschfeld, this is not an invariable and unalterable occurrence in the established homosexual.

This, of course, sounds quite plausible, but it suffers basically from the same quantitative impossibility which breaks the arguments of the geneticists and endocrinologists. Even Hirschfeld's own finding that 2.3% to 3.4% of the male population are homosexuals would result in a figure of about 1 million males of post-puberty age in each of the two countries. It is unreasonable to suggest that any abnormality of such magnitude to provoke species-destructive developmental errors would remain undetected and, most of all, would not have already affected our survival.

Of some influence on modern thought were the theories of André Gide,[15] expressed in his book "Corydon." From a great wealth of animal studies and the occurrence of ho-

mosexuality in animals of many species, he deduces that homosexuality is a basically normal and natural phenomenon and that any social and biological stricture against it would not only be useless but also dangerous. His studies, however penetrating and of great spiritual verve, suffer from the impossibility of comparing and contrasting any behavior pattern of one species with that of another.

Perhaps the most important insight and elaboration of this has come from Konrad Lorenz,[32] who shows with great clarity that instinctual behavior varies from species to species, that, for instance, in birds, the acoustic and visual organs are predominant, whereas in mammals the rhinencephalon takes over, while social conditioning in the form of an imprint of early sensory events is of primary importance in the later appearing sexual-behavior patterns. Also against Gide's theory is the fact that there are many societies in which homosexuality plays little or no role at all.

A major impact on the problem of homosexuality is the Freudian theory, which could be shortly summarized here for the purpose as follows: In infantile sexuality, there appears the "polymorph-perverse" pansexuality, which finds the child's first love object in its mother, leading to rivalry with father. The discovery of the absence of the penis in the female leads to castration fear, and the hated father figure is perceived as a constant threat leading to the castration complex. At the age of about four, libido and position of the male child in the family produces some overt but totally unconscious seeking of the mother as a love object, and thus the Oedipus complex is produced. After the prepuberty

years of sexual quiescence, the choice of a heterosexual love object in puberty is blocked by castration fear and very strong incest taboos. Further elements of homosexual development are given a firm basis by the masturbatory sex play and its fantasies, by manifold variable factors due to the character of the person concerned, where elements of identification with father or mother play a preponderant part and in which, also, earlier infantile fixations on the oral, anal, or genital zone are further determinants.

The first choice flows therefore easily to the same sex, and a foundation for homosexual behavior patterns is laid.

This is a very tempting theory which can account for homosexuality as a mass factor in adolescence and can also account for the latent homosexuality in vast numbers of males; in fact, it is almost acceptable as an explanation of homosexuality as a phenomenon in Western civilization. However, there seem to be some fundamental errors which make an acceptance of this theory very difficult.

The foremost objection lies in the theory of the unconscious. Freud and, in a much more determined way, Jung accept the unconscious as an absolute faculty of the mind. The evidence of anthropology, however, and the extent to which the human personality can develop with complete insight into his basic drives make it clear that the unconscious, as defined by Freud, is only that part of a mental dynamic mechanism in which mainly the unpleasant, the unwanted, and the feared are made unconscious. This means that, fundamentally, the unconscious constitutes a variable part of the mental fabric, being that part of the individual

which develops in direct conflict between his primary drives and the pattern of sanctions set up to prevent their materialization by a hostile social environment.

Thus, in a society where sex taboos, all-pervading sexual fears, and frustrations are everyday influences on the growing infant, the unconscious will obviously constitute a great quantitative factor. Wherever these repressive influences are lacking, a quantitative factor of that description will be missing, and other factors dealing with hunger, disease, natural catastrophies, and complete lack of knowledge of the causalities of natural phenomena will lead to an unconscious of a totally different quality and quantity. The unconscious is a socially conditioned dynamic part of our mental structure which can never be given the role of an absolute. Hence, the Freudian theory of the unconscious can only be understood as a historically determined phenomenon, best shown in its limitation in the hysterias of the Victorians so well beloved by Freud. Most of the syndromes described by him have practically vanished from the modern psychiatric scene.

The hysterias of Charcot, Bernheim, Freud, Morton Prince, and other psychiatrists of the 19th century have virtually ceased to exist. Such spectacular attitudes of catalepsy, magnificent amnesias, trances, and the famous Sally Beauchamp and her dual personality, alas, have disappeared from the field of everyday psychiatry, and nowadays we have to go deeper and deeper into the field of physical medicine to find the traces of hysteria. Now we must be content with patients showing conversion syndromes and, with incomplete understanding, demonstrating their image of an

illness and dissociating themselves from a devouring anxiety in an unbearable situation by reproducing this image of illness. The subconscious mind of the Freudians is not an absolute, but in those days was constituted to a great extent by the hypermorality and unnatural ways of life of our ancestors at the middle and end of the last century.

If, then, the unconscious (and the subconscious processes deriving from it) is not given an absolute validity and if one feels that the factors of sexual development can be quite easily, regularly, and completely brought into the realm of understanding and acceptability, then whatever quantitative factors of the unconscious are left are the expression of the given functions and feelings of a given society at a given time; and with that, of course, the problem of homosexuality is not so much the expression of an unconscious mother fixation, father hatred, the rejection of everything female from incest fear, etc., but it must be bound up with the social setting of a given period and pattern of society.

A further criticism refers to the illogicality of the theory of the Oedipus complex. That it is an illogicality is best expressed by the Freudian acceptance of the hypothesis that the Oedipus complex is found in every culture and civilization, that it is a basic developmental step in every male child, and that it is the *fons et origo* of all neuroses, most psychotic processes, and also of homosexuality. Clearly this implies that neurosis, psychosis, and homosexuality should be found in everyone. The analytical schools should set forth how these illnesses are produced in a given individual, how the Oedipus complex leads to one form of illness in one type of personality and to other forms in others, and

how and why the bulk of the people cope with the initial onslaught. However, we are told that comparatively few people suffer from psychotic and neurotic illness, and only a minute percentage of the population is admitted to be homosexual even by the psychoanalysts. *The typical therapeutic failure of psychoanalysts to understand the homosexual is thus buried in this illogicality, that we deal, in fact, with the same cause of psychotic, neurotic, and sexual abnormality in a minor part of the male population based on a developmental process which is supposed to be true for all.*

The major criticism, however, of the Freudian theory lies on a more philosophical level. Freud accepted the mental mechanism and the energetic processes underlying all living activity on a dichotomous basis. His basic sexual energy, libido, and the mental faculties, their growth and development, remain totally unconnected with all other living functions. Philosophers and most schools of psychology will give lip service to the human being as an entity, but so far very few have made this unitarian principle the basis of their researches and speculations. The separation of the mechanisms and functions of the mind from those of the body has brought an increasing rift into medical thought as a whole.

The influence of the mechanistic and materialistic workers of the 19th century has left its mark on medical thought and practice against the ever increasing evidence that all response-and-reaction-patterns of biological phenomena are based on the whole living unit. Their thoughts were, in some aspects, retrogressive ones. At that point, the Freudian school perpetuated its basic fallacy, which brought it

into an esoteric absolutism, intolerant and lacking in understanding of the dynamics of the human unit and its complete energetic exchange with its environment. Moralistic concepts of the Freudian teaching which are most clearly shown in the theory of sublimation and in speculative delusions like the death instinct, *Thanatos*, show this incompetence.

The most advanced and perhaps most significant development of Freudian thought was that of Wilhelm Reich.[40] He stipulated that libido, the energy underlying sexual processes, is part of a total bio-energetic exchange, and, although the proof of this energy is very difficult to produce, he tried to show that it is inherent to all living functions and, in fact, that this energy must have properties and qualities of its own. Reich is leaning here probably on Bergson's[3] *élan vital.*

This flies, to a certain extent, in the face of established science, but there seems little doubt that such biochemical cycles like the famous Krebs cycle are, in fact, leaving over a greater amount of energy in the form of ATP (Adenosine Triphosphate) than can be calculated from the input of carbohydrates, fats, proteins, and the resulting products of amino acids, respectively, of the utilized pyruvic acid.

The second argument in favor of such energy is a mere observation of the growing fetus, the growing infant, the growing child. The rate of growth, the energy output of a child, can scarcely be calculated against the metabolic rates, nor can the food and fluid intake be correlated to this enormous and well-nigh miraculous burning up of energy of the infant. Thus, Reich gives a basis for a unitarian princi-

ple on a bio-energetic scale which also allowed him to bring environmental aspects into a concrete concept. His researches into the function of the orgasm and the bio-energetics of sexuality are well worth further study and elaboration.

Reich also enlarged the psychoanalytical concepts by formulating the hypotheses of character neuroses. In his book "Character Analysis," he elaborates the mass of earlier experiences and environmentally conditioned traumata during the oral, anal, and pregenital phases, and shows how the total personality is formed by these fixations and how this is expressed especially in the pathological field. However, Reich had very little understanding of the formation and importance of homosexuality. In his book "The Sexual Revolution," there is practically no mention of this condition, and especially not as the inevitable outcome of patriarchal upbringing as found in Western civilization.

A last criticism of the Freudian view: It has led, in respect to homosexuality, into a therapeutic nihilism for the reasons given above and below. The moralistic Freudian outlook is most clearly marked in the concept of the infant's "polymorph-perverted" sexuality. Although one cannot quarrel with polymorphism, the very injunction and indictment of perversion clearly shows a moralistic attitude which is not permissible in scientific research and shows, also, retrojection of mature sexuality into the nonsuspecting infant. That, in the growing world of discovery of the infant, the products of his own body, the body itself, are natural objects of interest is unavoidable and clearly understandable. That the sources of pleasure and displeasure

are clearly sought or rejected is equally natural, and only the introjection of the abstrusities of an absolute unconscious and the introduction of grown-up values and prejudices based on the guilt born out of sex prohibition can make any of this into a perversion.

Finally, in the understanding of the development of the personality, the Freudian school left out the thousandfold mechanisms of maturation of the personality as a whole. Their vision of sex is, and remains, generally, a pattern of adult sexuality; it shows and accepts all the guilt feelings, all the horrors of a bent and nonintegrated sexuality. This is probably one of the reasons for the elaborate ritual of analytical techniques, which takes the place of factual research and the lack of a complete understanding of the human being in his total setting.

The psychiatry textbooks treat the problem of homosexuality unable to decide whether to deal with a "normal phase," an "inborn developmental error," a "genetically determined intersex," a "perversion," "normal bisexuality," "endocrinological dysfunction," or a "psychopathic personality disorder." The textbooks give a mixture of all these hypotheses, with a good deal of Freudian theory in the background.

The inability to see the problem in its entirety, to accept the mass character of this phenomenon, to understand its origin from the social quality of our patriarchal society, is demonstrable equally in all textbooks—English, American, German, and (to judge from Wortis's "Soviet Psychiatry") Russian.

In Henderson and Gillespie's "Textbook of Psychia-

try,"[20] three developmental stages are invented based on Freudian theory: the autoerotic, the homosexual, and the heterosexual:

> In this auto-erotic stage, satisfaction giving a pleasurable feeling akin to sexual pleasure is attainable by stimulation of almost any part of the body surface, but especially of certain erotogenic zones (mouth, anus, etc.). Thus, for example, stimulation of the mouth area is associated with pleasurable sensuous feeling—an association which persists in adult life. Similarly stimulation of the zone of the anus is, at least in some individuals, associated with pleasurable feeling, and this persists in adult life in a few of them as "anal erotism." In the later stages of development of the sexual instinct, these regions usually lose most or all of their pleasure-giving possibilities, which are now largely confined to the zone of the genitals. In the second or homosexual stage, the object of the sexual instinct becomes another individual but of the same sex, and the third or heterosexual stage, of the opposite sex. This is probably the normal development in which the stages overlap. But it may be arrested ("fixated" is the technical term) at any stage—one of the erotogenic zones may continue to afford sensual pleasure to as great an extent, or greater, than the genital zone; or the development with reference to the object may not go beyond the autoerotic or homosexual stage. Further, "bisexuality" has to be taken into account. The individual's sexual instinct is capable of expression and satisfaction in two opposite ways—with the individual as active or the individual as passive.

In spite of the magnanimous invention of a normal homosexual developmental phase in infancy, which has never

been observed and factually does not exist, the authors swing over to a complete psychoanalytical theory but become totally incomprehensible in the chapter: *Psychoneurotic Reaction Types*, subsection Sexual Abberrations:

> Homosexuality: a constitutional factor suggests itself in a number of homosexuals (fixation and repression), on two accounts:
>
> a) That an apparently significant number of them show not only strong artistic interests, but also special artistic ability (*author's query*). They are fond of the arts, music, drama, ballet, painting, etc., and often show more than the average skill in one or the other; they have excellent aesthetic taste, tending to the exotic (cf. "The Picture of Dorian Grey"); and many of them follow appropriate careers, e.g. the stage and interior decoration.
>
> b) On the physical side, it has been shown that they tend to show in a higher percentage than heterosexual controls, physical characteristics belonging to the opposite sex (e.g. horizontal pubic hair).
>
> Some homosexuals appear to be the victims of early conditioning (in a number of cases, the first sexual experience appears to have been a homosexual assault at the hands of an older man), but it is doubtful whether this is ever permanently effective without some sort of predisposition, constitutional or psychogenic. Other cases are clearly the result of faulty upbringing, especially explicit parental prohibition in early adolescence, so that all heterosexual interest becomes repressed. (*Author's query—How many parents expressly permit heterosexual practice in early adolescence?*) Such late repression is readily accessible to psychotherapy.
>
> A third group, much commoner, appears to be determined largely by unconscious factors, consisting of:

a) an Oedipus situation;

b) an unconscious picture of the mother (she is consciously idealized) as a fearsome, dangerous object.

The unconscious fear of her is evidently a fear of castration, since the female genitals are pictured as capable of inflicting damage, i.e., of castrating.

According to Freudian theory, this is explained by—

a) the perception that the female lacks a penis, this perception implying a threat of castration; and

b) a regressive identification of the vagina with the mouth (vagina *dentata*, and therefore dangerous).

The result of the conscious mother identification coupled with the unconscious fear of the woman (*? author*) is that the patient becomes capable of falling in love only with people who would have resembled himself in her eyes in his earlier life, i.e., with younger men or boys. (*Author's query—Here the authors misunderstood in the first instance the Freudian theory but, moreover, to blame identification with the mother—consciously or unconsciously—in infancy with the choice of young men or boys as "resembling himself in her eyes in his early life" must certainly be described as a ne-plus ultra of faulty thinking.*) Another "solution" consists in identification both with the mother and with her sexual position, so that the homosexual puts himself in the same position as the mother with regard to the father, i.e., passive and feminine. The first solution is said to be determined by a pre-existing narcissistic type of libido-organization, and the second by a pre-existing anal fixation.

There are many homosexuals in whom the sexual attitude is much less clearly defined.

Mayer-Gross, Slater, and Roth's "Clinical Psychiatry" [34] treats the problem of homosexuality in Chapter 4—*Psy-*

chopathic Personality and Neurotic Reactions; the quotations here only refer to opinions which are considered unsound by us. The authors treat sexual perversions as not necessarily neurotic or psychopathic; however, they do not deny the causal interrelation between sexual perversion and a neurosis, or psychopathy, respectively. In many respects, they lean on Freud with a reservation in regard to the etiology of sexual perversion from developmental disturbances and traumata of infantile sexuality.

They recognize the difficulties created by our society that hinder sexual maturation; they mention the impact of biological and physiological maturation processes in puberty, but misunderstand the decisive reinforcement process, the conditioning, the formation of the superimposed neurosis ("pfropf" neurosis) as mass occurrences forced by the patterns of Western civilization. The authors are satisfied with their statement, in rigid rejection of anthropological findings:

> Even then, however, in our Western culture, although physiologically and anatomically, normal sexual function is possible, it is further delayed by psychological barriers and social sanctions.

The authors treat masturbation as a perversion but limit this statement at once; they see in it "the preparatory practice." They consider masturbatory guilt rightly as a component of neurotic reactions which can be successfully cleared up by explanatory therapy.

In their discussions in respect to the role of erotic fantasies in masturbation, the authors, however, are quickly

lost in obscurities which are of great importance for the misunderstanding of the total problem, because they only allow the mechanics of conditioning for the "rarer sex perversion," but deny their place in conditioned homosexuality.

> As the main incidence of masturbation is at an age when young males are thrown much in their own company and have a very limited access to the female, it has been thought that the practice can lead to a conditioned homosexuality. This has never been proved. It is likely, however, that a similar mechanism (*? Author*) of conditioning plays a part in the rarer sex perversions, such as fetishism, exhibitionism, sadism, and masochism.

Homosexuality is discussed by the authors in five subtitles. In the treatment of the genetic basis, Lang's 1940 study, "Genetic Determination of Homosexuality" is quoted at length from the *Journal of Nervous Mental Diseases* and the paragraph closes as follows:

> The appearance of hermaphrodites and homosexuals could be plausibly (*! Author*) explained in this way.

This, in our opinion, shows great lack of understanding in regard to genetics as well as the mass character of homosexuality. "Hermaphrodites are," according to Price's "Textbook of the Practice of Medicine" 1944, "of extreme rarity and it is probable that up to now not more than 20 cases have been described.

Even the most orthodox estimates of the number of "constitutional" homosexuals lie between 1% to 10% of the

male population. For this reason it seems impossible and unscientific to explain genetically a condition which happens once in perhaps many hundred millions of births as developmental error and to correlate this to a sexual activity which, without doubt, has been and still is practiced by millions of males of all ages in patriarchal civilizations with more or less intensity.

If the author would here try to correlate a genetic identity between cases of Huntington's chorea (an illness with a genetic basis of much greater importance than hermaphroditism and with a strong suicial tendency as one of its major symptoms) with the tendency to suicide (30,000 attempted suicides in England in 1960), one would rightly declare such an attempt as unscientific.

Later on, the authors quote, "as further observations which support a genetic hypothesis," Sanders, Lange, Hirschfeld, and especially Kallmann's studies with uniovular twins. Henry[21] is drawn into the support of a genetic hypothesis as follows:

> Although Henry has not analysed his data, the families show a tendency among the women to be more than usually aggressive, among the men to be more than usually submissive; a sprinkling of overt homosexuals was also found to be among their relatives.

Freud's theory of "an exaggerated emotional attachment to the mother" is accepted by the authors, but finally they come out in favor of a genetic basis and state:

> In conclusion, there is some genetical basis for the development of homosexuality and some influence is prob-

> ably exerted also by the attitude prevalent in society and the circumstances of the patient's upbringing. The proportional contribution of heredity and environment probably varies not only in different ages and countries but also from one individual to the other.

The idea that a gene changes its role so accommodatingly in time and space and from one person to another is the more astonishing as one of the authors, Eliot Slater, is a geneticist and a director of the Psychiatric Genetics Research Unit of the Medical Research Council. (Even more astonishing, as we will discuss below, is the fact that Professor Kallmann, in the "American Handbook of Psychiatry," verbally quotes the above sentence and uses it without criticism in support of his own genetic hypothesis of homosexuality.) The next paragraph treats the occurrence of homosexuality in the "normal." Kinsey's figure of 37% is quoted but

> Only a very small fraction can consist of constitutional homosexuals. Another small fraction only continues to refrain from contact with the opposite sex, probably because conditioning in the formative age has taken root and has, for some reason, not been overcome later; the great majority take up heterosexual relations and never or only occasionally return to homosexual practice. It is not surprising that, where members of one sex are absent, inaccessible or in short supply, the sexual activities of those of the other sex turn in on themselves, e.g. gaols, convents, monasteries, ships at sea, residential schools, universities, etc. It must not be thought that such an early training in perverted sexual behaviour must always lead

> to a permanent fixation of the libido. Just as the sailor when his ship reaches port at once departs for the inn and the brothel, forgetful of his sexual partners on the high sea, so also the ex-schoolboy or college graduate turns his interests on the opposite sex when it becomes accessible. This type of homosexual behaviour might for convenience be called facultative and is not of very great psychiatric importance.

The author disputes the theory of a normal homosexual in detail in the following section, and treats the role of facultative homosexuality in Part IV.

The "American Handbook of Psychiatry" treats the problem of homosexuality in two chapters, which are both important for our study. Professor Kallmann describes, in a chapter titled *The Genetics of Mental Illness* and under the subtitle Male Homosexuality, the findings of Sanders and himself in the uniovular twins; he compares them with the binovular twins. He states:

> The more plausible genetic explanation for these findings would seem to be a gene-controlled disarrangement in the balance between male and female maturation patterns resulting in a shift toward an alternative minus variant in the integrative process of psychosexual maturation.

He closes this paragraph with the above-quoted sentence from the chapter of Mayer-Gross' textbook.

This again opens the whole question of hereditary factors and genetic predisposition to such conditions as homosexuality. Although we enter here, in full consciousness of

our limitations, into a very hotly debated region, we feel it necessary to discuss and dispute some of the basic principles in this field, even against the best of authorities.

1. It is quite evident, in the human species, that instinctive actions and behavior patterns are partially lost during a very prolonged time of gestation and maturation. If we understand instinct and its development as genotypical, it becomes acceptable to see these patterns as dormant, in other words, instincts remain genetically a potential.

2. Such genetical potentials can be, and are, developed by environmental conditions either phenotypically or they are, under special circumstances, recalled genotypically. One can demonstrate, in analogy, that the genetical potential of growth and longevity exists to such an extent that the heights of the human being or his longevity increase under favorable modern conditions. A further example comes from child psychology: If an infant is given its own choice at feeding, as in the studies of cafeteria feeding by C. M. Davis (quoted by Leo Kanner[25]), the infant spontaneously chooses an optimum in regard to ideal proportions of protein, fats, carbohydrates, and vitamins.

3. The dangers implicit in genetical theory and doctrine grow, if and when the research workers in this field try *to force a theory* in a rather scholastic manner. This is true especially in regard to theories which become a straightjacket, woven out of hypotheses which cover, to a great extent, our ignorance of the way we are conditioned. The Neo-Lamarckism of Lysenko is a classic example of these dangers. A further example seemed to us to lie in ad-

vocating a genetical origin of homosexuality. The genetical theories expand further and further.

What does Kallmann's statément of a genetically controlled disarrangement of the balance between male and female maturation patterns mean?

We agree that such patterns are genetically controlled, that there exists a balance between such patterns, which means that biological maturation processes are preformed and an endocrine control is genetically given. No investigations, however, have so far brought any convincing proof that there is an endocrine dysfunction in the genesis of homosexuality.

A genetically controlled disarrangement presents a *deus ex machina* which cannot be shown biologically and which —and this is the main argument—occurs only in patriarchal societies in many people (ancient Greece), in some people at times (England and Germany at the present time), sometimes in many people (U.S.A., according to the Kinsey report), *in matriarchal societies, however, never* (Verrier Elwin's Muria and Malinowski's Trobriand Islanders).

4. Such genes and the interpretations of their functions demonstrate a *reductio ad absurdum* of investigations and findings, which in themselves are quite valuable and valid, as in this case the studies on uniovular twins.

5. The identical twin shows only one thing, that is identity, phenotypically and genotypically. A total concordance is to be expected in all fields. In the realm of the phenotypically conditioned phenomena—as in schizophrenia, for instance—such a concordance in the absence of

identical environmental factors is rightly quoted as a factor of a genetical causality. In the genotypical, it proves nothing of relevance, as such a potential can only be provoked by environmental influences.

6. In the sexual field, this potential is only given genotypically: it is the basic elasticity to express oneself sexually in all possible variants. It is the social impact in its broadest sense, which forms the sexual patterns and their outlets.

In Chapter 29, Paul Friedmann[2] writes on the sexual deviation. His historical survey is very thorough; he gives all the existing theories and accepts the Freudian teaching *in toto*.

Lange's "*Kurzgefasstes Lehrbuch der Psychiatrie*" (1943) discusses homosexuality in a subtitle Abnormal Mental Reactions–Sexual Aberrations. He states that:

> . . . the development of sexuality hails from a bisexual basic disposition: that there exist, without any doubt, predisposed homosexual men, that in many families homosexuality appears very frequently and, without any doubt, on a hereditary basis, that we find very often already in the physique marks and stigmata which belong to the other sex (in the man, for instance, gynecomastia, broad hips, high-pitched voice, anomalies of hair distribution), combined with that a soft, often artistic, manner with manifold feminine inclinations.

He strongly advocates that:

> . . . juveniles under 21 need exceptional protection, and especially hard punishment is justified for their se-

> ducers, as in this period of their life they are not usually regulated with full clearness of their sexual goal. They therefore easily become victims of these seducers and, under those circumstances, remain in their homosexuality as it is mainly the earliest sexual experiences which fix in many human beings and especially in the psychopath the later development of their sexuality.

Lange thus describes two forms of homosexuality: a genetically determined form and an environmentally conditioned, newly developed, form, which is especially noticeable in the psychopath. It seems thus, that, against all observations, the nonpsychopaths have no early sexual experience.

What we think of these opinions has already been elaborated above. But the way in which the whole theme of homosexuality is treated shows the deep prejudice, the complete lack of understanding, and the inability of so many psychiatrists to remain in the framework of the rational whenever they enter this field. If homosexuality is genetically predisposed, one could rightly claim that total freedom of action should be given to such born homosexuals inside their own group. Red-haired people, for argument's sake, do not make us demand their incarceration and castration. If homosexuality, however, is the product of early sexual experience, especially in the psychopath, which would then mean, in fact, a primary neurosis with a later reinforcement in predisposed perturbed personalities, can jail and castration really be the best therapy? What does the German textbook offer as a solution?

Table 1: COMPARATIVE STATISTICS OF THE OCCURRENCE OF HOMOSEXUALITY IN THE MALE POPULATION

Author	*Study*	*Technique*				*Population*	*Number of males studied*	*Number of homosexuals*	*Expressed in percentages*
		Estimate	*Controlled study*	*Questionnaire*	*Interview*				
Krafft-Ebbing[28]	*Psychopathia Sexualis*	+	−	−	−	30,000	−	120	−
Hirschfeld[23]	*Sexual Anomalies and Perversions*	−	+	+	−	−	8,721	−	3.4%
Ellis quotes:[8]	*Psychology of Sex*								
Peck	"The Sex Life of College Men"	−	+	−	+	−	60 students	9	15.0%
West quotes:[47]	*Homosexuality*	+		−	−	−	−	−	10.0%
Hamilton	*A Research in Marriage*	−	+	+	−	−	100 students	17	17.0%
Finger	*Sex Beliefs and Practices among Male College Students*	−	+	+	−	−	111 students	30	27.0%
Kinsey quotes:[26] *American Service Bulletin*	*Sexual Behaviour in the Human Male*	+	−	−	−	−	−	−	0.4–1.0%
Kinsey's own findings	———	−	+	−	+	−	4,000 white Americans	−	37.0%
Spencer[43]	"Homosexuality among Oxford Undergraduates"								
	I Patients	−	+	−	+	−	100 psych. ill students	51	51.0%
	II Control	−	+	−	+	−	100 students (controls)	35	35.0%
Ollendorff[37]	"The Problem of Juvenile Homosexuality in Psychiatric Illness"								
	I Total number of patients		+	−	+	−	292 psychiatric outpatients	111	38.0%
	II Patients with relevant histories		+	−	+	−	197 psychiatric outpatients with relevant histories	111	56.0%

> The fight (*? Author*) against homosexuality is, in the first instance, a prophylactic one; especially must one combat the seduction of juveniles with all means. The next step is to counteract the masturbatory inclinations of sexually disorientated psychopaths because, especially in the masturbatory fantasies, all kinds of abnormal drives can implant themselves.

If this is to be taken seriously, society would need a vice squad of unimaginable strength and power, which would not only have to control the seduction of juveniles by older men, but also the immensely more important mutual seduction of juveniles by juveniles, and that, on a permanent basis. Not enough at that, all juveniles would have to undergo psychiatric investigation to separate the psychopaths from the nonpsychopaths. As the nonpsychopaths probably do not masturbate, according to Lange, there remain the 99% of all juveniles who do masturbate. These are the psychopaths, supposedly, in whom the masturbatory tendencies would have to be counteracted. This obviously would be a task so impossible, one does not need to elaborate further.

Problems

Is juvenile homosexuality a mass problem?

From the acceptance of adolescent homosexuality as a passing phase by vast groups of scientists, psychologists, psychiatrists, educators, and criminologists, one may draw the conclusion that it is not only a mass problem but also acceptable as such. However, on this major point, a divergence between the Freudian school and others comes into the open.

Although one agrees with the great importance of the

first years in life as the formative ones, and also with the acceptance that severe and prolonged traumata in this period lead to manifold psychiatric morbidity, it must be noted that *the first overt steps in sexual exploration, experimentation, and direct sexual activity are not considered of equal importance by the Freudians, although they may lead to the formation of sexual habits and behavior patterns.*

This is considered here as unsound and contradicts the observations which can be made in this field. It seems naive to presume that the events and experiences in early infancy are of decisive importance, whereas the first extra-personal, or masturbatory, sex activities in early and late adolescence and puberty disappear without a trace, and that another pattern, strongly propagandized by society, will take its place without a hitch. *Where and whenever a full sexual orgasm is experienced—especially for the first time—the fundamental figure in fantasy or reality with whom such an action is performed seems to be of primary importance and will continue to influence and condition the further pattern.*

The question of whether homosexuality can become a mass phenomenon has been answered, without any doubt, historically. Licht has clearly shown in his work on the sexual life in ancient Greece that the free male Greek had a fully established and essential homosexual life foremost in the emotional and secondarily in the physical sense.

In regard to our age, mainly two studies have impressed us, and although we have given the figures of authors in Table 1, we limit ourselves here mainly to the findings of Kinsey[26] and Spencer.[43] According to Kinsey:

> On the whole, the homosexual child play is found in most histories, occurs more frequently and becomes more specific than the pre-adolescent heterosexual play. This depends, as so much of the adolescent homosexual activity depends, on the greater accessibility of the boy's own sex. In the younger boy, it is also fostered by his socially encouraged disdain for girls' ways, by his admiration for masculine prowess and by his desire to emulate older boys.
>
> The anatomy and functional capacity of male genitalia interest the younger boy to a degree that is not appreciated by older males who have become heterosexually conditioned and who are continually on the defensive against a reaction which might be interpreted as homosexual. About half of the older males (48%) and nearer two-thirds (60%) of the boys who were pre-adolescent at the time they contributed their histories recall homosexual activity in their pre-adolescent years.

Kinsey goes on to say that preadolescent homosexual play is carried over into adolescence or adult activity in something less than half of all the cases. He comes to the following conclusion:

> In these terms (of physical contact to the point of orgasm), the data of the present study indicates that at least 37% of the male population has some homosexual experience between the beginning of adolescence and old age. This is more than one male in three of the persons that one may meet as he passes along a city street. Among the males who remain unmarried until the age of 35, almost exactly 50% have homosexual experience between the beginning of adolescence and that age. Some of these persons have but a single experience and some of them have much

more or even a life-time of experience, but all of them have some experience to the point of orgasm.

The study by S. J. Spencer[43] of homosexuality among Oxford undergraduates is of great importance to our investigation. Spencer saw all psychiatric cases at Oxford University and took the number of homosexuals from the first unselected patients. He contrasted these figures with the findings of a random sample of 100 male students who were in no way recognizably psychiatrically ill. His figures are reproduced here, in part:

SUBJECTS DISPLAYING HOMOSEXUAL PRACTICES, FANTASIES, OR DESIRES

	Patients	*Controls*
Total homosexual	51	35
Grown out of	10	27
Persistent	41	8
Prognosis guarded	24 (58.5%)	*
Prognosis poor	10	*
Prognosis dubious	14	*
Prognosis good	17 (41.5%)	*
Practices	27	13

* *Prognosis not estimated.*

After thorough statistical treatment, Spencer works out the correlation of the homosexuals of both groups in regard to physique, personality, and environmental factors, especially of the family and the dynamics of mother and sibling fixation; here, he most interestingly produces figures which are almost the exact opposite of Lang's (1940), whose finding he rightly describes as "naive." He discusses it as follows:

> One may question, due to this evidence, whether Lang (1940) was not naive in his deduction of genetic intersexuality from his figures of an increased proportion of brothers among his homosexuals. Is it not much more probable that the presence of those brothers provided an easier way for the potential homosexual into homosexual activities? One may also ask whether this is not the group which consists of all the 'facultative homosexuals' of wartime in ships and all similar early male situations.

Spencer tries furthermore to find a correlation between homosexuality and school and social class. On the basis of his findings, he brings them into the Kinsey classification as follows:

0	1-2	2-3	3-4	4-5	5	6	
49	10	9	8	7	7	10	100

We believe the Kinsey classification is not sufficient here for our purpose, and we reformulate in Table 2 and its concomitant explanatory text our own classification. Nevertheless, Spencer's figures are of great importance, as they allow, for the first time, a comparison with our own figures. His 51 patients are comparable to our 111, so that his figures, Kinsey's figures, and the findings of this study can rightly be taken to show the same order of magnitude.

For the purpose of this study, a normal control group was sought. We approached professional and semiprofessional men, and a questionnaire was handed out to 100 men. This questionnaire was anonymous, and the men selected were asked to give some details of their sexual development and activities, especially those in prepuberty and pu-

berty. The answers were to be given by simply ticking off *yes* or *no*. Moreover, we tried, in six different sessions with these 100 men, to impress upon them the necessity for research on the subject and showed them that there was absolute anonymity in this question-and-answer ticking system; there was no possibility of even guessing or tracing the person who had completed a given paper should it occur, by any mischance, that such an attempt should be made.

The questionnaire was folded in an envelope, which was put in a ballot box placed in a given spot. The trial was a complete failure. Out of 100 questionnaires, a total of 45 were returned. One of these was totally blank, 25 seriously answered, and 19 poorly answered. Significant answers came from only 28, while 17 questionnaires were considered useless, especially for the homosexual part of the control.

It is obvious that, in spite of every humanly possible safeguard, in spite of great pressure on an intelligent body of men who, by their professional status, should have been beyond ordinary prudery, it was impossible to obtain more than 28% of significant answers. Only on account of general interest, the author gives the following figures:

16 admitted mutual masturbation in puberty
9 admitted homosexual activities
6 admitted homosexual activities before puberty and 4 continued them after puberty
6 admitted homosexual fantasies at times
4 admitted homosexual activities after marriage

(*all in 28 significant answers*)

These figures are clearly understood as being of no great significance and are quoted here to show the enormous difficulties one meets when factual evidence is gathered on this subject. The questionnaire technique leaves people torn between their true selves and their inaccuracies, fears, and false memories, quite often with genuine anxieties; thus, in any case, it remains a basically inaccurate and uncontrollable method.

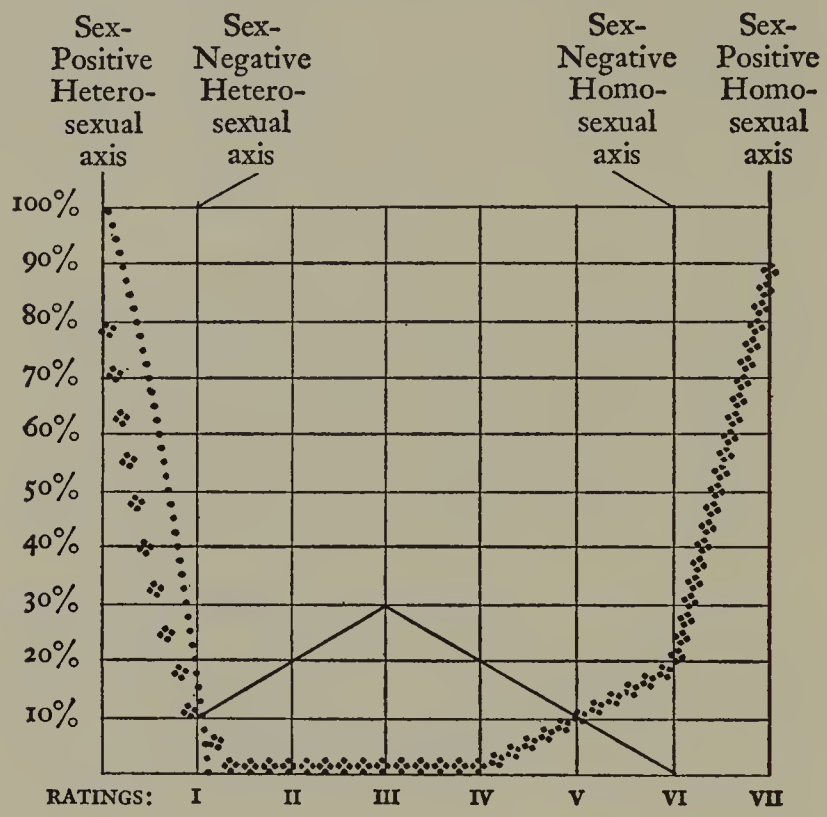
It is understandable, for this reason, that every attempt to work out the number of men involved in homosexual activities occurring in the nonpsychiatric population does not result in correct figures. Thus, as stated above, *our figures gained from the psychiatric outpatients are probably just as relevant and revealing for the normal population.*

We are convinced that juvenile homosexuality is a mass phenomenon, and we tried here in the form of a graph to show how homosexuality can be demonstrated as a mass factor in a sex-positive patriarchal society (curve II, Table 2), as nonexistent in a sex-positive matriarchal society (curve I, Table 2), and finally as a less obvious mass factor in the framework of our own rating in a sex-negating patriarchal society like our own (curve III, Table 2).

Is juvenile homosexuality a normal phenomenon?

It is frequently mentioned that adolescent homosexuality is a passing phase of sexual development; many authors main-

Table 2: GRAPHIC REPRESENTATION OF MALE POPULATION DISTRIBUTION IN REGARD TO THEIR HETERO- OR HOMOSEXUAL DIRECTION IN SEX-POSITIVE OR SEX-NEGATIVE SOCIETIES



CURVE I ••••••• matriarchal sex-positive society
CURVE II ❖ ❖ ❖ patriarchal sex-positive society with ❖❖❖❖❖ facultative heterosexual direction
CURVE III ——— patriarchal sex-negative society

RATINGS

0: Natural love potential—libido heterosexually induced and conditioned from infancy—orgastic potency kept free from anxiety in heterosexual intercourse—no substitute fantasies—natural socially necessary warmth and understanding for the same sex—masturbation and homosexuality unknown to the

adolescent or mature adult (Elwin's Muria, Malinowski's Trobriand Islanders).

I: Social and natural inclination toward the same sex—early preadolescent sex play, possibly with the same sex in anxiety- and fixation-free relations—short masturbation period with heterosexual fantasies—first prepuberty and puberty sexual activities on a heterosexual basis—little or no anti-sexual induction or homosexual adolescent conditioning—psychosexual reactions: heterosexual—neuroses formation: minimal.

II: Little induction in early infancy by relatively easy and incomplete enforcement of sex taboos—psychosexual reactions: heterosexual, some minor homosexual attachments—anxiety and fixations in existence, but able to be resolved either spontaneously or with reassuring and explanatory psychotherapy —masturbation throughout puberty with heterosexual fantasies—where homosexual activities occur in puberty: conditioning to the first degree of a facultative homosexual—usually, however, full heterosexual adjustment in marriage—orgastic potency: only mildly secondarily inhibited—formation of neuroses: mild, but under special circumstances leading to acute anxiety state.

III: Full induction in infancy—enforced sex taboos—psychosexual reactions: primarily homosexual, secondarily heterosexual, in need of constant heterosexual stimulation—anxiety and fixation in existence and difficult to resolve—masturbation with homosexual fantasies which, under social pressure, change to mixed homo-heterosexual fantasies or are expressed in aggressive (rape) fantasies, often, too, with masochistic or sadistic situations involved—homosexual conditioning massive and frequently of long duration—second degree of the facultative homosexual. Heterosexual adjustment usually, but mostly perturbed—orgastic potency: secondary, fantasy cheating on heterosexual or homosexual basis usual—formation of neuroses of medium strength, acute and chronic anxiety states occur.

IV: Full induction and conditioning in infancy and prepuberty, reinforced in puberty and adolescence—psychosexual reactions: homosexual, rarely repressed—masturbation fantasies usually homosexual with cultural change to double fantasies—heterosexual adjustment possible, but rarely permanently successful—orgastic potency: secondary, fantasy

cheating on a homosexual basis, especially with heterosexual intercourse—the last degree of the facultative homosexual—in predisposed personalities: strong formation of homosexuality, chronic anxieties, hysterias, obsessional states—in non-predisposed: acute and chronic anxieties, therapeutically reversible.

V: Complete induction and conditioning, usually traumatically enhanced by family-dynamic features (mother fixation or hatred, father fixation or hatred, early incest with siblings or parents, abnormal frigidity, especially in regard to sexual matters of the persons involved in the child's upbringing, etc.)—inversion pattern 2 according to Spencer—prepuberty and puberty homosexuality—masturbation uninterruptedly practiced, often as compulsive anxiety—discharge mechanism—first degree of the constitutional homosexual—potentially, however, a facultative heterosexual, usually the type of overt homosexual—orgastic potency: secondarily determined, multiple infantilisms, perversions—in each case, predisposed neurotic—the more open and accepted his homosexuality, the less neurotic illnesses per se—chronic anxiety usually present.

VI: Similar to V but total reinforcement in exclusive homosexual pattern of conditioning in prepuberty and puberty—the completely and easily feminized constitutional homosexual—no heterosexual psychosexual reactions, reversal impossible—neuroses: maximal and most clearly expressed in sexual behavior.

VII: A hypothetical deduction from Licht's works: a sex-positive homosexual patriarchal society—facultative heterosexuality in primarily induced and conditioned homosexuality which is designated as socially desirable in prepuberty and puberty.

NOTE: Ratings 0 and VII are natural juxtapositions in sex-positive matriarchal and patriarchal societies. Ratings I to VI relate to sex-negating patriarchal societies.

tain that this is a normal phase and an inevitable event prior to maturation. The medical geneticists here, too, are in the forefront. E. B. Ford[12] states:

> It is by no means clear to what the human physical aberrations of sex are due. . . . Some of the combinations so

> produced may cause a weak or abnormal response either to the male or to the female hormones, giving rise to instincts inappropriate to the physical sex, perhaps combined with some slight tendency to approach the opposite sex in the proportions of the body or in the quality of the voice. Such are some at least of the homosexuals: though the psychological attributes of that condition are very liable also to be environmentally produced, but doubtless more easily in some constitutions than in others. It is important also to notice that the development of the full sexual activities is reached gradually, while genes exist which control the rate of processes in the body and the time of their onset; indeed the facts of inter-sexuality demonstrate that the action of the sex-genes is sometimes (and perhaps always) of this type. It is not surprising therefore to find that a phase of homosexual instinct is common in the adolesence even of sexually normal males and females. The length of time that such instincts persist varies, no doubt both genetically and environmentally. They may be prolonged into adult life, sometimes permanently, but at others they are replaced ultimately by normal sexual reactions.

We have at length discussed the genetic approach to homosexuality previously. It remains here to show that intersex in the human is, up to this date, practically a terra incognita in regard to homosexuality. Any correlation to hormonal changes, physical characteristics, gene structure has not been proved, nor has "a phase of homosexual instinct common in the adolescence even of sexually normal males and females."

In regard to homosexuality's "common phase" or "normality," both are questionable terms in psychiatric lan-

guage, and it seems necessary, therefore, to consider the argument of Professor Schneider[42] on normality. Schneider maintains that normality is either an ideal, and usually based on speculative, moral, and social values, or a study of the factual and the average which is applied to behavior patterns in his case. Schneider dismisses the ideal as not in the realm of science and advocates the pursuit of the factual as statistical and biometrical evidence which can be produced to prove or disprove such averages. One must agree with Schneider that, in scientific work, subjective formulations, which are semantically ambiguous—prejudices and terms in common use, moralistic connotations—are not permissible and highly confusing.

Factual and average findings in themselves are not necessarily scientific in the sense that these prove or disprove the validity of any thesis. If and when one uses quantitative studies on the basis of a population-distribution curve, averages are utterly meaningless unless a comparative counter-norm has been given, and in behavior patterns the average quantity and quality may have no significance to the subject studied. On the other hand, confusion grows if one takes statistical findings as the core of scientific study without a fundamental criticism of the patterns which evolve from the total framework of a given society.

If one wants to study aggressivity in the young male, one would not choose, say, 1,000 young soldiers who had just undergone a strenuous commando training and compare them with 1,000 young men who had just declared themselves to be ardent pacifists. Both figures would probably show a totally opposite trend. Neither of them would

prove or disprove anything in regard to aggressivity in young human males, and any set of figures so gained would have no bearing on the problem. The best example for the necessity of a counternorm is given in the study of frigidity in women. Quoted here from the "Merck Manual of Diagnosis and Therapy," 1955: "More than 50% of all married women are so affected, either partially or completely. Many never achieve orgasm at any time in their lives."

Thus, if over 50% of all married women are frigid, one should describe this phenomenon as normal. However, any physician working in this field would declare a complete orgasm as the ideal goal of sexual intercourse. That forces us to study how this dysfunction, or any given quality or quantity in human behavior, has arisen, and one must, in fact, stipulate an ideal norm against which to compare one's factual evidence.

To revert to our problem of adolescent homosexuality as a normal phenomenon, we can now state that *the figures quoted before and found in our study show that adolescent homosexuality is a mass problem.* From Schneider's point of view, one will have to accept it as being normal, since the figures show a high peak of homosexual behavior in the average adolescent. However, not everyone can willingly agree to any form of homosexuality at any age as being normal, even if an average number participates in it.

We are in total disagreement with any and all schools of psychiatry, psychology, and pedagogics which entertain the idea of normality. Firstly, as argued before, it seems illogical and, moreover, patently wrong from all available evidence, to think that sexual experience in adolescence has

not the same impact, strength, and validity as compared with experiences in early childhood. Secondly, any experience which is in contrast to social convention and prevailing behavior patterns must produce a conflict which, in itself, hinders maturation and adjustment to normal life and primary instinctive behavior. Thirdly, the idea that anything that happens to anyone at any time in full consciousness, and especially experiences of great emotional depth, can evaporate without trace from its bearer, is patently nonsensical. We maintain, therefore, that any youngster who underwent emotional experiences coupled with sexual activity in a homosexual sense, be it homosexual fantasies, masturbation, mutual masturbation, or a complete homosexual act, is very unlikely to forget it. Moreover, as is well known to every practicing psychiatrist, events are not forgotten but, in the worst of cases, repressed, and the vast majority of efforts in psychotherapy are usually directed not to forgetting a given event or set of events, but enabling the patient to remember and cope with the experiences of the past.

Thus, in this study, an attempt is made in the following part to clarify a pattern of normality for a sex-permissive society as opposed to a pattern of development of sexuality in a sex-prohibitive society. However, one can say in anticipation that *homosexualty*, whether it is considered to be sin, crime, or abnormality, *remains biologically an unwarranted deviation which hinders normal sexual maturation.*

After having established that adolescent homosexuality is a mass occurrence, we can now add that, as such, it produces in the mass of young people thus affected an ab-

normal situation which is apt to produce major adjustment problems for practically everybody. In fact, we deal here with a socially and culturally conditioned flight from sexual maturation processes of such strength that it is felt it must reflect on society as a whole, and no doubt a profound study of the elements of undissolved latent homosexuality in the make-up and conduct of our Western civilized life would produce endless sources of the intrinsic truth of this presupposition. The attempt of Blüher[5] (1919) must be mentioned in this context.

In regard to our study, we will attempt to show that these occurrences are one of the most formidable sources in the "pfropf" neurosis and in most neurotic illnesses, a partial cause in psychopathic personality disorder, and that it repeats itself endlessly in the form and content of psychotic illness.

We feel, therefore, that *the occurrence of adolescent homosexuality is a product of a wrong social setting.* It cannot be considered normal in the ideal sense of a smooth sexual-maturation process and its mass occurrence, however high an average is shown statistically, remains an abnormal and undesirable state with enormous consequences for society as a whole. Homosexuality produces great unhappiness in multitudes of individuals beyond the reach of psychiatry, and is a presenting factor of major importance in most psychiatric illnesses.

The role of sexuality in the development of the personality

If it is accepted that an ideal norm is to be set, this norm has to be worked out for different patterns of society, that is, in a sex-permissive one and a sex-prohibitive one, and it has to be shown how these patterns of society affect the development and maturation of sexuality in a given personality.

Based on the studies of Malinowski, Elwin, and Mead, a sex-permissive society would evolve the following features:

1. Parents. Any connection and correlation of sexual activity, whether fully understood as essential for reproductive purposes or not, would be free from fear, anxiety, and secondary fantasy activity. Both parents would have a positive training of sexual activity which excludes any form of guilt and, moreover, would have trained their bodies in the art of love making to an extent that the point of orgasm would be reached together.

2. Motherhood and pregnancy are always socially fully accepted. It is considered a desirable state, and most tribes name the state of pregnancy as the "happy" one; a baby is a "prize possession," "a cherished treasure." Legal aspects never, moral aspects scarcely, play any role in pregnancy, and only very rarely could elements of jealousy and adultery produce any kind of nonacceptance of the coming offspring.

3. The pregnant woman is considered a normal member of the community, and pregnancy and the birth process are not considered to be quasí-pathological—extra measures with special protection or special care are only seldom sought for the pregnant woman; in fact, it is quite usual for most tribal women to participate up to the very last minute in all work and leisure activities of the community.

4. The birth process is considered to be a normal physiological event which proceeds with the minimum of fuss, and usually some elderly female members of the same family group help the young mother with the delivery and see that, for a short time, she is made comfortable and cared for. In fact, the woman is usually encouraged to put the baby to the breast at birth, as this is considered a good stimulation reflex for the expulsion of the placenta. The mother is made to move about with the baby and not to lie in bed for any length of time.

5. Under these circumstances, the vast majority of birth processes reported by Grantley Dick-Read [39] and witnessed by the author on many occasions during eleven years in East Africa show no difficulties, especially as the elements of anxiety, fear, and fuss are excluded, and thus the autonomic supply to the birth canal functions in an easy and smooth way instead of hindering the birth process by reversal of the reflexes essential to its normal functioning.

6. These circumstances given, the infant is exclusively living with its mother in intimate physical contact, is kept on self-regulated demand feeding, the breast being more or less within reach of the infant at all times.

7. Weaning is not a sudden process. Quite often, breast

feeding is continued right up to the second year of life; in fact, if a baby appears in the first two or three years of the first child, both children are often put together to the breast.

8. Any training or control of micturition and defecation is of very little or no importance. Both are in no way considered "dirty" or objectionable; usually, as a child lives in close contact with the mother's body, both have a wash and a clean up together after an evacuation of one form or another.

9. The child receives a maximal amount of love and attention. Affection is not only given by the mother, but practically every female of the sib participates in the rearing and, quite often, of the feeding of the infant. Grandmothers, aunts, sisters, even older sisters of the child will all carry it, fondle it, and allow the baby to play at least with the breasts or suck, even if it is not a productive breast. Thus, the exclusive role of "the mother" is reduced to very acceptable proportions, in that every female of the sib is a mother figure; the female becomes much less excluded from lustful activity, and the familial sharing of the mother's role leads very rarely, if ever, to the production of anxiety in her absence. Where there is no anxiety, there will be little or no fixation. Fixation in our sense here is a product of repressed lustful activities focused on one or two exclusive love objects. Anxiety on a generalized level is thus generated by fixation.

10. The infant's body as a whole is fully accepted; infantile play and masturbation is fully expected, and no

taboos, prohibitions, or disapprovals are ever uttered, expressed, or even felt.

11. Breast feeding in the tribal woman is accepted as a pleasurable and lustful activity for both mother and child. The Swahili have many a proverb in which they compare the three erectile organs of the human body—penis, clitoris, and nipple of breast—all considered to be lust-giving organs of the human being. This dynamic, mutual, pleasure-giving relationship between mother and child during breast feeding is an essential in our norm, as it prolongs breast feeding and usually excludes the pathological development of oral fixation, in the sense of Freud and Reich, just as in the same way an overelaboration of cleanliness taboos will lead to anal and urethral fixation.

12. From the age of two to four, the infant is part of a broad community rather than the family. In fact, every adult female belonging to the same sib is titled "mother," and every adult male is called "father." Uncles, aunts, grandparents, and friends are all completely acceptable to the child as substitute adults, and the narrow concept of our family image, father-mother-child, is not superimposed on the infant.

This makes for a very much broader social horizon, and the incest taboos can be, and are, somewhat stricter as the sexual outlet of the infant in its normal playful phase is not inhibited on the one side and, on the other, sex play of children among themselves always finds distant playmates without being driven in desperation to what, in fact, become incest relationships in other societies.

In the sex-permissive society, the child undergoes no sex-restrictive process; thus, no anxiety is produced, and no fixation on the erotogenous zone, nor on any specific member of its community, is developed, least of all on father and mother figures.

13. The "quiescent" period of the infant and child, where, in sex-prohibitive societies, sex is considered to be dormant and of little or no importance, does not exist in sex-permissive societies; quite often from the age of four, five, and six years onwards, the child is living in a community of his age-group comrades, e.g. the dormitories of the Murias, Trobriand Islanders, the Masais. Here, the child works, lives, sleeps, and is initiated in all forms of early play and sex play without harm or hindrance.

14. With puberty, a more selective process of love making takes place. Usually, after several trials and errors, a firm and very often lifelong and lasting relationship develops which takes the place of, or is, a marriage of great constancy and happiness, in contrast to the marriage of our society.

Masturbation under these circumstances is practically unknown, and masturbation which must be accepted in sex-prohibitive societies as an outlet in which a fantasy life is built up to substitute ordinary sexual relationships is unnecessary. Here again, although we accept masturbation as a normal substitute which is practiced by the vast majority of people, it is not considered to be normal, as the neuro-physiological co-ordination to produce complete orgasm is interfered with by the use of fantasies. Quite often this is demonstrably true in the acute repression of prohibited

love subjects when it interferes actively with this very fickle neurophysiological balance.

15. Thus, we have shown how normal maturation of sexual functions would lead to reach an orgasm, free of interference from repressed sex drives, not relying on fantasies, which, in turn, produce a secondary sexual stimulation, hindering an orgasm, which should have a complete biological co-ordination mechanism as its basis.

In a sex-prohibitive society like ours, the elements which interfere with the normal biological sex function have to be enumerated and disentangled, but firstly, the theory of anxiety and fixation must be elaborated a little.

If we accept the idea of a basic sexual energy which must be an integral part of a life energy, one must conclude that any interference in its proper function must produce factors of great influence in the development, not only of the specific sex function, but also, as this function is integrated into all life processes and behavior patterns, affect the living unit as a whole. A scheme, showing how this works, is given in Part IV in the discussion of neurotic illnesses.

To anticipate the scheme here in a basic formula, it can be said that *sex, where interfered with, becomes anxiety. Anxiety, thus, especially in the infant, creates overdependence and a mutual overbearing and exclusive preoccupation with the person or persons who are, from early on, the center of the child's world.*

In a further formulation, one may state that anxiety leads to fixation. Fixation means: Instead of expanding his normal circle of comprehension, understanding, and accept-

ance, the child remains unable to loosen his ties to the mother and father figures; he gets confused and bewildered by any new factor in his life, which ultimately leads to a child-mother or -father relationship, that is, he finally must seek fulfillment of his undeveloped and repressed sex desires in the only acceptable figures in his world.

This, of course, sounds similar to the Freudian Oedipus situation, although we do not accept its universality. Least of all do we accept its unavoidability, and most of all, one rejects its desirability. With this preamble in mind, we can now enumerate the factors which play a role in the sexual development of the personality in a sex-prohibitive society.

1. In parents with a great amount of anxiety, the pregnancy period is highly ambivalent, and complete acceptance of the coming baby is far from self-understood. The baby is, in fact, in many cases not at all wanted. Thus, physiologically, normal birth processes are already prejudiced by the mother's anxiety, which often is enhanced by the pseudo-pathological apparatus surrounding her in a hospital, but also sometimes in the home.

2. The birth process itself is still befuddled by a great amount of mystery and prudery, and, even under the most favorable condition, given the slight flavor of something pathological; the study of Dick-Read on the reversal of autonomic function during the birth process by anxiety has certainly now been accepted by the majority of gynecologists. Thus, a difficult birth which may be either prolonged in time or made difficult by the nonco-ordination of the process of physical expression of the baby, may leave some

mark on the baby. We consider it possible that a vague basic anxiety can be articulated in later years, so to say, in retrospect in the recurrent dreams and phobias of narrow passages. However, the Melanie Klein[27] theory of a birth trauma is unacceptable, as the unformed brain—empty of images, words, and associations, in our opinion—can never retain a traumatic mental process of great complexity. Under no circumstances can a normal physiological event be the basis of pathological mental development.

3. The breast and breast feeding are not considered of primary importance to both mother and child. In fact, the aspect of sexual pleasure in breast feeding is not at all discussed and understood. The mother's pleasure element is still grossly inhibited. As the breast and the mouth, and especially the baby's mouth, is considered to be the erotogenous zone of first strength, degree, and in time, the anxiety which grows out of any interference or abrupt stopping or muddly and unsatisfactory feeding leads to primary oral fixation which, of course, acts as a repetitive source of endless oral stimulation. Our culture has never-ending patterns of faulty feeding habits, overfeeding, underfeeding, regurgitation patterns in the baby, as well as chewing, smoking, alcohol drinking, prolonged thumb sucking in the adult. Finally, in the sexual field, the fixated oral deprivation will lead to an overelaboration of sexual mouth activities, of which fellatio and cunnilingus are but two.

4. The handling of the newborn by an anxious mother trying to conform to the given pattern of our culture in regard to toilet training does produce further elements of anxiety. Fixation to the anal and urethral zones are rightly

considered to be elements in the character formation of the child. The ways and means by which anxiety is created and transferred from mother to baby are quite markedly shown in the baby's response, with anxiety, in regard to feeding, which obviously is one of the major functions. Their habits very quickly can culminate in under- or overfeeding, of vomiting, of regurgitation, and a vicious cycle is set up in which the baby rules the mother, anxiety and tention growing in both. Similarly, sleep is easily perturbed, oversleeping and undersleeping are patterns which again lead to anxiety and tension in both mother and child with mounting fixation.

5. When the child, in its phase of discovery of its body, reaches its genitals, silent disapproval, which is now more fashionable than the overt interference with the child's play with its genitals, is still the rule, and in that interference further basic maladjustments are laid for the future. It is a most remarkable feature that most mothers seem to be, even nowadays, unable to accept the erection in their baby boys, and most mothers will deny strongly that this sort of thing has ever happened to their babies. It is not well understood or accepted that, by no means, the tensions, approvals, and disapprovals of a mother or father toward the child need find some form of physical expression. It is very clear that the tension the mother transmits to the child, without any speech or action, is a reality. This transmission grows proportionately to the amount of fixation between a mother and child. It becomes quite evident to the infant from a very early age onwards that the genitals are a tabooed part of his body, and with these first taboos, anxiety begins

to take the place of normal sexual impulsivity. There is thus created an arena of endless variability in which anxiety and sex can be, and are, played out. To give but a few examples, where infantile masturbation becomes a secret habit, it functions as neurotic anxiety-relief mechanism, sometimes right throughout the life of a patient. In the discussion of anxiety neurosis, this factor will be shown over and over again. Sex becomes so unacceptable that, as is shown in some case histories, it is replaced by anxiety completely and exclusively, or it remains always accompanied by feelings of guilt. Although in recent years, masturbation guilt and anxiety are much less in the foreground than, say, twenty-five years ago sex is still never free from anxiety in some shape or form. In this way, the sexual development and maturation of the personality is perturbed at its source.

6. It remains to elaborate a host of other factors which influence the infant. There seems little doubt from psychiatric histories that illegitimacy, perturbed marital relationships, prolonged separation, wrong handling of the sibling situation, physical or mental illness or death of one or both parents, the combination of sex-prohibitive upbringing on the one hand and physical closeness to other siblings (especially sleeping for many years in the same bed), lead to further bars to sexual maturity. Finally, the basic contradiction between the proclaimed social ideal against biological reality increases the factors leading to this failure of a smooth sexual development. By that we mean that a sex-prohibitive society proclaims as its ideal: chastity, virtue, absence of sexual feelings and desires up to

and until a legal marriage can be consummated. As that can never be possible, the conflict between the social ideal and the inner reality is, of course, an endless source of perturbance.

7. Adolescence and the fate of sex in the development of personality are perhaps one of the major points of discussion in this study. In adolescence the sexual force becomes a mature part of the person biologically and, in societies other than ours, the point of maturation of the person is reached mentally as well. The old rites of confirmation, initiation, and the countless ceremonies which introduce the young boy into manhood are the ancient expression of the acceptance of this point of maturation. In our society, however, adolescence, which we know to be the vital period of growing into manhood, is usually one in which sexual taboos are especially strongly enforced. There is little doubt, since Kinsey's study, that the sexual performance is highest in early puberty, and the desirability of the adolescent to exercise his sexual prowess in a heterosexual performance is, in the sense of this study, one of the major points in which the aforementioned fixations and repressions are strongly reinforced. At that period, in the sex-prohibitive society, masturbation is usually begun or strengthened by the sudden appearance of an orgasm with ejaculation, and it is on this point where we diverge from the Freudian theory of the basic infantile nature of the development of homosexuality. To judge from the case histories, it seems that the early induction by fixation and anxiety can be, and is, often somewhat overcome if and when the adolescent is enabled to have some kind of pro-

miscuous sex play with the other sex. If this is not loaded with too overwhelming an anxiety, and there are very few boys who do undergo regular sex play with girls of their own age group, these are the ones who are most free from homosexuality and, strangely enough, are usually the ones who have a certain amount of understanding and tolerance for the misfortune of the homosexual condition. However, the great bulk of the young male adolescents in a sex-prohibitive society has its only outlet in masturbatory activities and the beginning of a build-up of fantasies as the necessary preorgastic stimulus. At this period, right up to our time, sex play with girls is very strongly tabooed, and male and female children are, to a great extent, isolated from each other.

As any rational methods of sex education in our society are practically nonexistent, the mysteries of sexual urges in a world from which sex is banned are pondered over by the boy and his mates, and mutual masturbation of groups of boys is a basic common event which only the overprotected or overanxious child does not share. In the sense of Kinsey and our own study, it means that the first extra-personal sexual relationship of the average youngster in our society is basically a homosexual one. Unlike Freud, we think that this first extra-personal event is of foremost importance in the sexual conditioning of the adolescent, and it colors the further maturation to a much greater extent than has been understood so far. Once the growing force of tenderness, the full understanding and acceptance of one's sexual partner, has been thrown onto the same sex, the mechanism to extinguish these events has to be of ex-

Table 3: COMPARATIVE STATISTICS OF JUVENILE HOMOSEXUAL EXPERIENCE IN SAMPLING OF 292 PATIENTS

A. *Total Patients from Four Clinics (in numbers and percentages)*				B. *Mutual Masturbation in Adolescence (in numbers only)*	C. *Homosexual Activities in Adolescence (in numbers only)*
Age:	292	100%		111	57
Age group I (12-20)	39	13.3		28	15
Age group II (20-40)	122	41.8		65	33
Age group III (40-60)	92	31.5		14	6
Age group IV (over 60)	39	13.4		4	3
Marital Status:					
Married	168	57.6		43	22
Single	107	36.6		64	33
Widowed, divorced, separated	17	5.8		4	2
Type:					
A1 Acute anxiety state	36	12.3	All Neuroses 101:34.5%	16	6
A2 Chronic anxiety state	34	11.6		13	6
B1 Hysteria	21	7.2		6	2
B2 Obsessional neurosis	10	3.4		5	4
C Impotence, sexual disturbances, etc.	50	17.0		33	24
D1 Psychopathic personality disorders	21	7.2		10	8
D2 Subnormals	14	4.7		5	3
E1 Reactive depressions	13	4.4	All Depressions 64:21.8%	6	6
E2 Cyclothymia	23	8.0		1	1
E3 Involutional & senile depressions	28	9.4		1	1
F1 Organic psychosis, epilepsy, toxic, syphilitic, presenile, senile psychosis	16	5.4	All Psychoses 57:19.4%	2	2
F2 Schizophrenias of all groups	41	14.0		19	3
G Psychosomatic illnesses & borderline cases	15	5.0		8	2
Double diagnosis	30	9.8		14	11
Homosexual History:				*Complaint:*	
Tried	169	58.0		Impotence 10	7
Not tried	123	42.0		Homosexuality 10	10
Relevant	197	67.4		Perversions, court referrals 11	6
Not relevant	95	32.6		Marriage difficulties 2	1
No homosexual experiences	58	19.8		Proven incest with siblings 12	10
Mutual masturbation in adolescence	111	38.0	(or 56% of 197)		
Definite homosexual activities (taken from the above group of 111).	57	19.5	(or 29% of 197)	Small penis complex 5	3

traordinary persuasive force, and the whole weight of social disapproval, of legal restriction and religious taboo, has to be exerted to force the adolescent off this acquired habit of homosexual thinking, feeling, and the continuation of the homosexual outlet. The enormous propaganda apparatus which has to hammer in the rules and regulations of reward in a heterosexual sense clearly fill all theaters, cinemas, television screens, light literature, and advertisements.

To sum up, we feel that the reinforcement of heterosexual inhibition and generalized sex repression at a time when sexual prowess is maximal produces a normal homosexual outlet in the adolescent, and as the sexual character of the personality is at the point of maturation at that age, the conditioning and habit formation, in the sense of Konrad Lorenz, is effective. Homosexuality, instead of heterosexuality, thus becomes a pattern which is rarely, if ever, fully corrected.

Heterosexual direction has lost its primary position in the sexual development of the adolescent in our society. In the sense of Wilhelm Reich, all further adjustments are of secondary nature, with a profound influence on the further maturation of the personality, mentally, physically, and biologically.

Statistics

Psychiatric illness and juvenile homosexuality

Table 3 shows the figures collected from four outpatient clinics giving our findings according to age, civil state, psychiatric diagnosis, the number of case histories with exploration of their potential homosexual background, and the relevant case histories in regard to the study. Then follow those histories which show mutual masturbation in adolescence, next the case histories with homosexual activities in adolescence over and above mutual masturbation,

and finally the number of case histories with double diagnosis.

In England, since the introduction of the National Health Service in 1948, it is part of the basic organization that the general practitioner, who cares by now for over 90% of the population, refers all cases which, according to his findings, need special treatment, to the specialist who works in practically every full-size local hospital.

The integration of psychiatry into the National Health Service and the possibility of the general practitioner and his patients recalling a psychiatrist at once is of enormous importance, and enabled us to collect the figures for this study. As a result of this integration, consulting sessions are held once or twice weekly in most local general hospitals in England. This means that many more psychiatrically ill people, who in former days only came into the grasp of psychiatry as a result of a final breakdown, are now seen in the early stages of their illnesses.

The figures for this study have been taken from four such outpatient clinics and refer, naturally, only to male patients, as follows:

65 patients come from an industrial town of about 120,000 in eastern England

104 from a seaside resort with a small industrial and agricultural background from southern England

66 patients from a seaside resort of the southeast coast of England, again with a small industrial and agricultural background

57 patients from an industrial small town in southeastern England

292

Besides these case histories, there are an additional 11 of the author's own patients, which were of great interest and importance for the theme of this study, and 2 cases which colleagues, who knew about this study, have handed over to the author.

From these figures, it is evident that the material has in no way been specially selected, but that all male outpatients as they were referred from the general practitioner have been taken as the basis of this study. This means that *the 292 male patients are the total of six years' specialist outpatient work of the author from 1955 to 1961.*

The break up into age groups shows, as one would expect, that in the group aged twenty to sixty, one finds the greatest number of referred patients, whereas the group aged twelve to twenty and the over-sixty group show the same percentage of 13 1/3%. Children under twelve, but in certain circumstances up to the age of fifteen, are usually referred to the child psychiatrist.

The proportion of married to unmarried men corresponds more or less to the ordinary proportions in the population, and so does the number of divorced, separated, or widowed men.

The analysis of psychiatric diagnoses probably needs some further explanations. The total percentage should theoretically be adjusted, as one should make allowance for the number of cases with double diagnosis. This, however, was thought to be unnecessary, as the double diagnosis could possibly only influence five of the diagnostic groups, namely the group of neuroses, the sexual disturbances, the psychiatric personality disorders, depressions,

and the psychosomatic and borderline cases. These groups together present the majority of all cases and are those in which double diagnosis has occurred. As the total percentage of double diagnosis is 9.8%, it would have only been of academic and mathematical interest to undertake such corrections. Here again is the tabulation of ıe diagnoses with the author's criteria:

1. The total neuroses are separated into acute anxiety states, chronic anxiety states, hysterical illnesses, and obsessional (compulsive-repetitive) illnesses.

2. Acute and chronic anxiety states have been diagnosed, and differentiated from each other, by the intensity of the phenomena, first appearance or reappearance after complete disappearance of all symptoms, or, in the chronic state, by the partial adjustment of the patient to the phenomena of his illness.

3. In hysteria, the occurrence of symptoms of dissociation have been essential for its diagnosis; in the obsessional illnesses, the diagnostic criteria were elements of compulsive thinking, behavior, and the impossibility of escaping from the stress of the obsessional thoughts and actions.

4. The 50 patients who present sexual disorders were mostly cases of psychogenic impotence, of sexual deviation and perversion, and ten cases of homosexuality. The diagnosis of psychopathy was made by the author mainly when a number of defined characteristics were fulfilled, which unfortunately leaves some of the problems of psychopathy unanswered. But here, perhaps, is the place to repeat the

fundamental definition which the author took as a basis of his diagnosis:

Psychopathic personalities are usually those whose lust- and pleasure-seeking features are abnormally strongly developed, explosively fulfilled, and whose social co-ordination and integration is abnormally weak. Such persons are usually classifiable in two groups: the aggressive and the weak ones. Both groups show the same lack of self-control and the lack of correction by punishment and/or example. Both groups sooner or later fall foul of the law, and the symptoms with which they present, often combined with severe depressions, are: behavior disturbances, sexual deviations (very often as recidivists) in a broad, anti-social setting, alcoholism, drug addiction. All these combine with the above-mentioned features of a disturbed personality.

The diagnosis has only been made when and where the neurotic, depressive, and other features were clearly secondary to the basic personality-disorder.

5. The mental defectives who appeared at the outpatient clinic were mostly high-grade feeble-minded patients whose intelligence quotient roughly lay between 60 and 80.

6. The depressive patients have been subdivided into three groups:

1) The reactive depression forms the first group; in these patients, there was clearly an abnormal prolongation of a depressive phase after a mental trauma.

2) The second group presented manic-depressive illness with clearly marked cyclothymia in which re-

current depressive phases repeated themselves at regular intervals.

3) Involutional and some senile depressive illnesses.

7. Organic psychoses need no special explanation, and the group of schizophrenics have been classified in the classical order of Bleuler[4] in catatonic, hebephrenic, simple and paranoid schizophrenias.

8. Finally, there remains the group of borderline cases in which psychosomatic illnesses, traumatic or other brain illnesses, accident cases with compensation expectations, and similar problems have been seen in our clinics. The author is not very happy with the expression "psychosomatic illness," as he feels that this is a pleonasm, as all illnesses are bound to be psychosomatic, but, for reasons of conventional acceptance, illnesses like asthma, hay fever, allergies, duodenal ulcers have been graded as psychosomatic. The cases seen by the author were usually patients in whom there was little doubt of a huge psychogenic element in their illness.

All these groups are discussed later in greater detail.

Basic analysis of statistics

We now come to the analysis of the figures which show sexual occurrences in adolescence. The headings try to clarify that case histories relevant to homosexual occurrences have only been tried in 169 patients, that is, in 58% of the total number; 123 patients (42%) had to be left out from such attempts. The reasons for this, however, are

quite obvious, but we still must discuss them here in detail.

Roughly half of the 13 1/3% of young patients, especially those under fourteen years, could only in a few exceptional cases be investigated for their relevant sexual histories. The same was true, to a certain extent, for the greater number of men over sixty. In all these cases, it was not only a question of tact, but also the inability of the patients concerned to comprehend fully the extent of the search, and in certain cases it would have been regarded as highly shocking and incomprehensible.

In patients with a clear-cut psychotic background, one would have found either an intellectual incapability, a state of confusion, massive blocking of realistic associations, or a particular block against the object of these investigations.

Under the circumstances, a systematic discussion of homosexual occurrences would be senseless. A great number of patients had, unfortunately, to be left out from such attempts, as the human rapport between the patient and the therapist would have been hopelessly disturbed by such investigations. With aggressive psychopaths, in a few cases, it became impossible to study a relevant homosexual history. In any case, it is very difficult in these conditions to sustain reasonable contact. On the other hand, as can only too clearly be shown from the figures which we tried to elicit with nonpsychiatric persons, prudery, anxiety, and suspicion are always present, and necessarily more so in the neurotic; and a very prolonged and deep study of their prehistory may lead sometimes to the destruction of a very unstable secondary adjustment.

Over and above the 169 patients in whom a homosexual

history has been attempted, we considered the case histories as relevant in 197 cases, that is, in 67.4% of all patients seen in this survey. This means that 28 cases of the 123 in whom no histories for homosexual occurrences were attempted have been recognized as relevant to the material used in this study. These cases naturally need special discussion.

Here are, in the first instance, the cases of the very young patients who came under review with sexual disturbances as a presenting symptom. Four cases of boys between twelve and sixteen have been seen for these reasons: stealing of panties, rape of children, or exhibitionism. In this group also are the neurotics whose mother fixation was so overwhelming that they did not find any sexual outlet or even companionship with the other or their own sex. In these cases, we felt that a mother castration has become complete, although some of them do look entirely for male companionship without any sexual activity at all.

A further group of these 28 are the depressives, in whom it became clear that longstanding sexual disturbance existed throughout most of their life and that their depressions were triggered off, to a great extent, by the forceful repression of their sexual urges. Here, especially, are three cases of older men in whom gross masturbation guilt and anxiety, with the occurrence of nocturnal emissions, played a great role. Nevertheless, it was not possible to gain a valid and relevant history; still, one could come to firm conclusions from their whole personality and their life conduct that homosexual occurrences in adolescence must have played a part in their make-up.

Still another group in whom, quite obviously, homosexual experiences or fantasies have been of great relevance are the paranoid schizophrenics, in whom the character of their delusions and persecutions is clearly projected, directly or symbolically, on a homosexual basis.

For this reason, these 197 cases are in column B of Table 3 for a comparison, and, also, probably reflect greater accuracy. The sections which show the nonrelevant histories, and which relate to 95 patients (32.2%) of all persons in this study, naturally draw on all diagnostic headings. In these cases, we find the organic psychotics, a small number of manic depressives, schizophrenics, mental defectives, and a number of neurotics in whom nonhomosexual and, in some cases, nonsexual traumata were sufficient reasons for their illness.

It has to be stated, however, that the figures which are the basis of this study in no way represent a maximum. On the contrary, these are minimum figures, and we must understand them as such.

Before we discuss the final results of the number of male patients whose histories show either mutual masturbation or, over and above this, direct homosexual activity in adolescence, we have to state again that the number of those who probably rightly deny homosexuality in their early history comes to 58. This figure has been derived from the difference of those in whom an attempt for a homosexual prehistory was made, and those in whom a denial has been evaluated as trustworthy.

To clarify this statistical treatment, we have to repeat that the percentages are worked out in the first instance

against the total number of 292 cases. In 169 (58%), an attempt to gain a trustworthy history in adolescence was made. In 123 (42%), such a history has not been made. However, 28 further patients out of the 123 nonattempted cases gave such a history or demonstrated such a pathology that they have been regarded as significant for the theme of this study. So that 197 (67.4%) have been given as those with a relevant history; 95 (32.6%) have been declared as of no relevance, and 58 (20%) are credited as nonhomosexual cases.

We now come to the decisive figures. Of the total number of cases, 111 (38%), or 56% of the 197 relevant cases, gave a history of mutual masturbation with other boys or men in their adolescence. The number of these 111 patients who showed, over and above mutual masturbation, a prehistory of direct homosexual activities is 57 (20% of the total number), or 29% of the 197 relevant cases. These figures are of great importance, and two arguments spring at once to mind: 1) do we deal here with a special group of ill people with little or no significance for the mass occurrence of homosexuality? 2) are these figures only typical for some parts of England and of little significance for the rest of the Western countries?

To the first argument, one can state at once that *the figures mentioned are practically identical with those of Kinsey and Spencer,* as determined by Kinsey for the average population, and in those of Spencer with his controls. The studies of Westwood,[48] Henry,[21] Hemphill,[18] figures taken from the study of Giese[16] and those of Freund [14] in Prague usually refer only to active overt homosexuals.

These authorities all deduce that the number of men who occasionally or permanently enter into homosexual relationship must necessarily be much larger than the usually accepted 3% to 10% of the male population from the age of puberty onwards.

For instance, if the author accepts the number of 10 men presented as overt homosexuals—that is, roughly 3% of the total number of 292, or 5% of those with a relevant prehistory—without further investigation, this would then be his final figure, and obviously, in the sense of our study, *a totally misleading one.* The danger here is that one blinds oneself by accepting the primary presentation as identical with real occurrences. Moreover, one deludes oneself that these may not be of any importance and neglects the search into such a prehistory. This has been mentioned in several studies as a most unsatisfactory method, but it creeps into textbooks with the greatest of ease. Thus, in Mayer-Gross' "Clinical Practice of Psychiatry," the finding of 1% of patients during the war at an army neurosis unit presenting as homosexuals is more or less accepted by the authors as a true figure for England's constitutional homosexuals. *There is little doubt that the numbers which have been extracted from the prehistories in this study and the figures which Kinsey and Spencer find in the average population are too concordant to allow that we deal here with a special phenomenon of psychiatric cases.*

Unfortunately, the author's attempt to draw on normal controls for comparison failed, and any such small figures cannot be seriously used as a comparison; even these figures show, however, concordance with the values of the above

statistics. There is also nothing to show that the population distribution, the social status of the people concerned, or their occupations in any way represent an extraordinary aspect of Western civilized countries. In fact, if anything, the reverse is true, as all these studies were made in small urban, semi-rural, and rural districts, and it is, of course, well known that a massive concentration of homosexuality takes place in the great cities, as a certain amount of security is gained by anonymity, especially in those countries where homosexuality is illegal.

There is no doubt that the sexual activity of adolescents in prepuberty and puberty leads to a secondary escape mechanism in over half of them which brings them into sexual relation with their own sex. Over and above that, it cannot be doubted that at least a quarter of these youngsters are entering homosexual activities in which anal, intercrural, oral, or other methods of intimate sexual contact or penetration occur.

We now come to the analysis of the figures which are contrasted in columns B and C. Column B relates to the 111 cases, in whom at least mutual masturbation occurred. Here we can at once show a change in comparison to the total statistics in column A. The figures are too small to express in percentages and are therefore only given as numbers.

The age groups change thoroughly and we have:

28	patients in age group	I
65	patients in age group	II
14	patients in age group	III
4	patients in age group	IV
111		

The greatest difference shows up in the number of married as compared with single men: 43 married men as opposed to 64 single men (5 of them were either separated, divorced, or widowed). Thus, Kinsey's statement, that *in single men over the age of thirty-five the occurrence of homosexual experiences rises to 50%, is fully borne out.*

The presentation of psychiatric diagnostic columns seems to be roughly the same as in the total number, with the difference that 33 of the 50 cases with sexual disturbances naturally play a greater role. In column B, *Complaints*, however, the sexual disturbances are clarified in greater detail, and we find 10 cases of impotence, 10 cases of homosexuality, 13 cases of perversion and court referals (fetishism, attempted rape, exhibitionism, sadism, severe marriage difficulties, bestiality). A further 5 cases which produce a great amount of suffering on an obsessional and quite often delusional level is the complex of the small penis.

A very surprising figure seems to be the occurrence of incestuous traumata. The natural basis of its frequency seems to be the habit, especially in financially poor households, of letting children of the same or both sexes sleep in the same bed over a period of many years. If children of the same or both sexes lie for years night after night together, right into puberty and longer, sexual contacts must well-nigh occur automatically.

Column C analyses only the 57 cases in which there were homosexual occurrences in their early history. The statistical relationship between columns B and C remains more or less the same in regard to the proportion of married,

unmarried, and divorced people and in its presentation in diagnostic categories.

In the subcategory of sexual disturbance, the number of overt homosexuals remains the same, and the rate of incestuous play stays quite high. However, it is interesting that the small-penis complex shrinks from 5 to 3 where homosexual activities have occurred.

Finally, it has to be stated again that juvenile homosexuality is a mass phenomenon, that the author does not believe that this is peculiar to people with a history of psychiatric instability or that this is a local phenomenon of this country or the particular area where he has worked, that the figures found have in no way undergone any preselection and that it is highly probable that they present a minimum, not only in the patients here studied, but in regard to the mass of the population.

Psychoses—Neuroses—Psychopathy

Content and form of psychotic illness with homosexual events as a determining factor

26 CASES: I 1, 4, 6, 24, 25, 26; E 30, 32, 46, 49; R 61, 70, 71, 73, 79, 80; A 92, 97, 101, 112, Z 2, 3, 4, 5, 7.

As usual, the author accepts a division of psychotic illnesses into two: the organic and the functional. We begin with a short discussion of the organic psychosis. In these cases, we are able to show a pathological basis for the illness and the pathological changes, that is, the distortion of

normal anatomical tissue and normal physiological activity is evident.

Nevertheless, even in these organic illnesses, the specific mark of a given premorbid personality can be shown and, most markedly in the presenile and senile dementias, the sexual complexities play a great role, as the progressive failure of inhibitions quite often precipitates masturbatory and homosexual activities. This, in fact, frequently leads to legal persecution, and one finds that, in one or another case, an old man suddenly appears in court indicted for seduction of children, molestation of youngsters in public toilets, exhibitionism, or similar acts. In these cases, there is no doubt that the cause of the illness has nothing to do with this particular form of abnormal activity, but as already mentioned above, the sudden disinhibition only occasions the expression of conditioned and induced aberration and can be evaluated as a specific rebound from the general sexual repression.

The functional psychoses, especially the schizophrenias, produce a more difficult problem. It is indeed well known that the search for organic reasons in the causation of schizophrenia has produced an enormous mass of studies, but we have, up to now, *not found a solid basis to classify schizophrenia as an organic illness. Nevertheless, the author believes that the schizophrenias represent a biochemical and biophysical form of illness,* and this is based, to a great extent, on the author's practice with high-dosage phenothiazine therapies.[37] The opinion was formed mainly by the fact that such pharmacological treatments did not influence the illness in their causation but achieved a par-

tial remission, and a great number of such patients are often brought back to a normal conduct of life. Such an effect cannot be credited to the influence of even the best of hospitals, nor to the personality of the doctor, nor can it be ascribed to the ways and means of modern psychotherapeutic methods, but can only rationally be explained as *a specific effect* of these medications.

The schizophrenic illnesses are seen as a primary disturbance of thinking, affect, and volition, accompanied by a great number of secondary symptoms, all of which fundamentally interrupt the normal life processes. We also do not accept in these illnesses—in sharp differentiation from psychoanalytical theory and practice—the possibility of a causation by childhood traumata or any environmental disturbance. However, we think that quite often the form and, still more frequently, the content of the illness is most profoundly influenced by the premorbid personality.

It seems convenient here to oppose the three forms of schizophrenia: the catatonic, the hebephrenic, and the simple, against the fourth form, the paranoid schizophrenia. In the first three, the distortion of the personality is far more obvious, whereas in the paranoid illness the personality remains on the whole much more intact, and one can rightly state that paranoid schizophrenia is found more often in people with severe sexual traumata.

The theses of Freud and Ferenczi[10] that paranoid illness always has a homosexual basis has rightly been doubted, for in numerous female and male cases, heterosexual traumata play a preponderant role in the content of the delusional system. Nevertheless, it is the homosexual repression

which, especially in men, gives that form of schizophrenia its paranoid hallmark.

In numerous catatonic, hebephrenic, and simple cases, the author has found early homosexual occurrences and their repression. There seems little doubt that a mixture of homosexual and incestuous occurrences, in particular, give these illnesses their content. The "chaotic sexuality" of the catatonic and hebephrenic often shows a regression into infantile parasexual mechanisms, which are induced in infancy and reinforced in adolescence by further conditioning.

One of the most interesting cases, which is not in the collection of case histories used in this study, can be given as an example:

> A young man broke down in his twenty-fourth year while working as a chartered accountant in East Africa. He developed, with very short and very partial remissions, the classical catatonic syndromes. One of the most interesting symptoms was the imitation of attitudes and actions of other patients. This echopraxia showed up quite clearly while he was lying in bed, during a difficult therapeutic attempt, next to a catatonic adolescent, aged fifteen. This boy masturbated overtly continuously, and the above-mentioned patient suddenly broke out of his catatonic stupor and began to masturbate his neighbor. These scenes, which were repeated twice, led to a gross deterioration of his condition, but he could, during a short remission, be persuaded to discuss this action, and he declared that such a maneuver was one of his former preoccupations, as it had happened in his schooldays and later on had happened in Africa, and had deeply disquieted him at the time.

Here we can show that, in the content of such schizophrenic actions, the tendency of homosexual feelings and their repression is often expressed.

From the remaining material in our collection of case histories, it can be clearly deduced that paranoid schizophrenia is found in persons in whom homosexual occurrences or repressions are in the foreground and that the content of the other forms of schizophrenia are frequently influenced by these experiences.

In some cases, one can illuminate very interestingly that acute schizophrenic episodes can be triggered off by touching these complexes. These cases naturally provide ammunition for the psychoanalysts, but without doubt, this is not a causation of the schizophrenic illness but solely its precipitation by a sudden touching of these deep-seated complexes. It is also shown later on that such precipitation is quite frequent in all other mental illnesses, which again demonstrates that the causation of the illness is primarily of different origin and independent of form and content, whereas precipitation in any form or shape of personality make-up and the reactivation of their intrinsic complexes must always be considered as secondary.

We conclude then that *juvenile homosexuality plays a great role in the formation of paranoid schizophrenia* and that the contents of the remaining schizophrenic illnesses are frequently influenced by it.

Juvenile homosexuality in psychopathic personality disorders

10 CASES: I 14, 23; E 38, 41; R 57, 59, 75; A 106, 114, 115.

From the definition of psychopathy given in an earlier section, we can expect that homosexuality plays a predominant role in the history of the psychopath. From the 10 cases collected here, one sees that homosexuality did appear as an overt element except in one case, and even there it is open to doubt (case R 57) because, in this one case, there was a history of mutual masturbation in reform school. However, the violence of his father and the sadistic taint in his love relationships show that, in his case, sheer explosive aggressivity, mixed with severe depressions, gave the main picture of the personality disorder. In the 9 other cases, overt homosexuality plays a great role.

In nearly all their histories, one finds: early incest relationships, usually on a homosexual basis, with their siblings; continuous homosexuality in the critical years from nine to seventeen; broken marriages with women who, interestingly enough, are frequently either hysterics or psychopaths themselves; homosexual activities during their married life which change, without emotional commitment, to heterosexual adventures; endless permutations of prostitution, blackmail, alcoholism, petty or severe criminality, and depression, frequently with pseudo-suicides.

The unfortunate constellation of blackmail, the time spent in reform schools in their early puberty—where the

psychopath not only fails to reform but successfully undergoes a training in crime—their particular personality perturbance (of which callousness of affect is the most frightening), the abysmal discrepancy between conventional (especially legal) demands of society and the biological urges of the human being, all naturally prepare an unlimited ground for psychopathic activities in the legal prosecution of homosexuality. Most sex crimes are committed by such psychopaths.

Homosexuality in the psychopath does not lead to a form of sexual outlet accepted by the patient; it does not appear as a precipitating factor in mental illness; it does not produce a deepening and a reinforcement of a primary maladjustment, as in the neurotic. It becomes a weapon of the psychopathically disturbed personality; *here, homosexuality is a basic element of illness per se.*

In other words, psychopathy is a state of incomplete development in all infantile stages, oral, anal, and genital, probably caused by an over-all frustration in infancy. Sharp, uncontrolled aggression of the parents is often put against the infant's demands, whereby a vicious circle is clearly created. The stronger the aggression from one or both parents, the stronger the reactions of the infant to materialize the presence of the unfulfilled parent figure. We find thus, as the basic elements in every psychopathy, *a reproduction of the parents' aggression,* sometimes enhanced by lovelessness and by overt or covert rejection of the infant by the parents or the figures taking their place. The moralistic, sanctimonious attitudes of the hating adult

are clearly reproduced in every psychopath. The global frustration in infancy also explains why the psychopath is chronically, and often severely, depressed.

However destructive the psychopath's impulses may be, however ruthlessly he overrides every convention, law, and sanction, woe behold anyone trespassing on his rights, real or imaginary, and not fulfilling any contract with him to the very letter of the law. Being a law unto themselves, they claim the right of immediate wish fulfillment, irrespective of any damage to anyone else; their intolerance against infringement of their inflated social code makes therapeutic work with psychopaths so exhausting.

The psychopath is a hater and a destructive person. The acquisition of any pattern of social sickness, such as drug addiction, comes with much greater ease to the psychopath; the barriers of social conformity and self-preservation are broken through mainly by the destructive drive, which is clearly the strongest of all motivations in the psychopath. This, unfortunately, produces one of the most tragic errors in the law: the identification of all homosexuality with destructive perversions *á la* Gilles de Rais, the original Bluebeard of the Charles Perrault fairy tale who also perversely murdered young men, and the echo of this attitude in books of sexual criminality.[41]

A number of 100 cases, male and female, mostly weak psychopaths, were investigated recently by the author[37] and a partner in regard to drug addiction. In some of them, habituation to marijuana and amphetamine showed an interesting reflection on their sex habits. All addicts stated that their sexuality became vastly reduced—in fact, in the greater

number of heroin-and-cocaine addicts, it had virtually ceased. Of 63 men, only 2 had been overt, practicing homosexuals; 2 more professed strong homosexual feelings at times; a further 2 gave a history of prolonged homosexual relationship in late puberty; 4 more, of the seventeen-to-twenty-five age group, stated that they prostituted themselves to both males and females in want of money for drugs. While the majority of male cases had mutual-masturbation histories in boyhood from their ninth to their sixteenth years of age, most of the male addicts had heterosexual feelings. With the exception of 2, most have had heterosexual intercourse or were relatively successfully married until the onset of their addiction.

The overt homosexual heroin-and-cocaine addict maintains that he took to the drugs to kill his sexuality, and successfully so. The other overt homosexual felt that Methedrine enhanced his sexual potency and desire for two years, but after that, for the last five years, found his sexual drive rapidly decline.

The greater number of women taking heroin and cocaine, however, were strong and overt lesbians. Although most of them prostituted themselves in times of financial need to either sex, the strong lesbian undercurrent was quite marked and in contrast to the comparative rarity of overt homosexuality in the male addict.

The psychopathic drug addict is clearly divided into two categories: the strongly homosexual "pillhead," the man or woman habituated to the amphetamines (in a group studied later, fourteen young men and four young women were found to be homosexuals) and the genuine heroin-and-

cocaine addict. The second type direct their hatred and destructiveness against the self—the martyred venous system, the continuous septic reinfections, the gross malnutrition, the rapid physical and social deterioration are only part of the story; and in their case the sexual outlets become uninteresting and unimportant. The factor that the bulk of the female heroin-and-cocaine addicts were much more homosexually orientated really bears out part of our thesis—*that the counterpart of homosexuality in the female is frigidity, and that overt homosexuality is always a part of a neurotic illness.* The more neurotic the female addict, the more lesbian she is, whereas the explosive psychopathic female addict is the prostitute.

Neurosis and juvenile homosexuality

COMPULSION NEUROSIS AND OBSESSIONAL ILLNESS

7 CASES: I 1, 10; R 68, 70; A 96, 99; Z 6.

We purposely begin with the obsessional neurosis. The author thinks that in these cases there exists a prepsychotic predisposition with such frequency that one can regard them, so to say, as the borderline region between psychosis and neurosis. In one case (R 70), this illness ended after fourteen years in a schizophrenic psychosis. In another case (R 68), the compulsive swearing must be evaluated as a neurotic mechanism in which the ambivalence of an overstrong mother fixation finds its expression in this repetitive

obsessional symptom. A third case (I 1) has been admitted to several hospitals as an obsessional neurotic on three occasions and as a schizophrenic on two occasions. In a fourth case (I 10), a very severe psychomotor tic which, in the sense of Stekel,[44] symbolizes a terror reaction, presents a third form of the possible expression of an obsessional neurosis.

All obsessional neurotics had one factor in common: they were traumatized by rather severe or prolonged incest experiences. In the case of I 1, it was with mother and sister in the presence of foreign soldiers; in the case of I 10, it was a connection of many years with his brother; the same in case R 70. In the case of R 68, we did not get a clear-cut incestuous history, but here the patient presents as the classical mother castrate who has not been able to separate himself from his mother (age seventy-six) in spite of advice and treatment lasting nearly twenty years.

In the first three cases, acute juvenile homosexual occurrences played a major role in the production of the symptoms and symptomatic treatment with psychotherapy, and phenothiazines led to some tranquilization and improvement, with the exception of case R 70, in which no method of treatment led to any success and where a leucotomy only produced a very temporary arrest of the relentless schizophrenic fragmentation. We therefore declare that in the obsessional, a predisposition to a prepsychotic illness is frequent and that this particular illness is guided by severe incest and homosexual traumata into the classical compulsive-repetitive form.

This compulsive-repetitive appearance can be understood as symbolically determined by the psychiatrist, in the sense of Bleuler, and can be interpreted to the patient, which, under favorable circumstances, leads to a tranquilization as symptomatic treatment, whereas under unfavorable circumstances, a break through to an open psychosis cannot be avoided.

HYSTERIA

11 CASES: I 20, 23; E 28, 47; R 56, 57, 60, 78; A 90, 108, 111.

Hysteria is regarded by us as an illness with two foundations. On the one side we have the hysterical personality, in which the predisposition to dissociative actions is always ready in a latent form and in which it is easy to recognize the classical histrionic patterns of behavior, such as: always to be the center of each group, to overreact even to the smallest physical or mental injury and to show at once, with the appearance of anxiety, massive conversion syndromes. In these cases, Janet's[24] teaching of the dissociation is accepted as fundamental.

The second foundation is in the hysterical illness which appears as an expression of acute panic. Here, we more or less find an actual motivation underlying the illness and an incapability to deal with certain situations molded into a symbolic form. We more or less follow in these cases Freud's theory of the conversion, but, as was shown particularly in war hysterias, it need not always be the continuity of infantile anxieties and repressions, but can simply be the expression of the overwhelming fears which are solved dissociatively in an hysterical fashion.

In our cases of hysterics, both groups are represented and both groups confirm the idea that hysteria is usually a weapon of the less intelligent. Cases E 28, R 57, and R 60 belong to the acute-panic category, whereas cases R 78, I 20, and, in some respects, I 23 belong to the hysterical-personality category.

In all these cases, juvenile homosexuality played a great role, mainly as an element which led at once to dissociation. Whenever homosexual desires come near to consciousness or where homosexual activities produce such anxiety by guilt feelings, this anxiety is at once converted. The histrionic behavior, especially of the young male prostitute, is only partially determined by hysteria. On the one hand, we must regard this ostentation as a dissociative mechanism; on the other, it is a natural propagandistic medium. But thirdly, it is a product of many years of existence in the subversive, insecure, and emotionally overtensed milieu of the homosexuals.

Dr. R. Wyss[50] shows in his study the family structure of ten, young, nonhomosexual male prostitutes and compares it with that of ten young homosexuals. He declares all homosexuals to be neurotic; regarding homosexual prostitutes, however, he sees them as a product of a family disorganization, disintegration, or overorganization. This author agrees fully with Dr. Wyss that every homosexual is neurotic, but he thinks that the second explanation in regard to the origin of the homosexual prostitute is an underestimate of the strength of even superficial and gainful exploitation of homosexual experiences, as in cases E 47 and R 75.

ANXIETY STATES

24 ACUTE CASES: I 2, 11, 13, 18, 19, 22; E 29, 33, 36, 42, 43, 50; R 58, 66, 67, 69, 84, 88; A 95, 109, 110; Z 1, 2, 3.

20 CHRONIC CASES: I 3, 12, 15, 16, 19, 27; E 31, 33, 44, 47, 48, 51; R 76, 82, 86; A 94, 104, 113, 116; Z 8.

Anxiety states, in all forms, produce most of the material in this study, and we here confirm Freud's dictum that every psychoanalysis, or psychotherapy of some depth, shows some trace of homosexuality. However, we believe that the predisposition of the personality plays a great role. As we deal in juvenile homosexuality with mass factors, one may come to the conclusion that anxiety states, acute or chronic, will happen in every person sooner or later, and, of course, they do. Thus, we must differentiate between the personality which can bear a certain amount of anxiety, who is able to cope with it, and those in whom it leads to conditions in which psychiatric help is required. Thus, we are led to the temptation to give the search for psychiatric help or, perhaps, in a wider sense, for the help of a doctor, diagnostic importance.

We find, therefore, that a neurotic personality disturbance is based on an inborn overpreparedness to generate tension states, to give in to these states, to lose himself without resistance and without even the wish to fight these free anxiety states, and to fly into panics with the greatest of ease as a result of these tension states. This is probably expressed strongest in the chronic anxiety state, where such a secondary identity of sexual tension and anxiety state is made well-nigh the basis of the presenting patient's exist-

ence. We can demonstrate this identity best in the young masturbator who realizes that his chronic anxiety state can only be relieved temporarily by excessive masturbation. This then leads, in the sense of Giese, to masturbation addiction—case R 64 shows this especially well. This is a vicious cycle in which the sexual need remains orgastically frustrated, thus leading to guilt and anxieties, which, in turn, require the discharging mechanism of masturbation.

In the infant these anxiety states often lead to early psychosomatic illnesses, such as asthma, eczema, etc., which constitute, under these circumstances, a classic example of Kretschmer's[29] autonomic-reflex hysteria.

Here it would be suitable to differentiate the manifold forms of anxiety, so often misunderstood by laymen, from the hysterical-conversion syndromes and finally from those symptoms more deeply anchored in the so-called psychosomatic illnesses. The acute anxiety state produces, in the first instance, acute symptoms which correspond to autonomic vegetative overactivity. In the chronic state, this could lead to two conditions.

On the one hand, the repetition of such symptoms by themselves lead to an organ fixation: thus, tachycardia; the cold, clammy, sweaty skin; the contracted stomach; the wrong superficial breathing rhythm, with overbreathing and sighing; the diarrhea which alternates with constipation; the headache, after exclusion of all organic illness per se—all these symptoms, and many more, become the focus of anxiety. On the other hand, the psychological picture with free anxiety-and-tension state plays a major role and often masks, usually in the more intelligent, the concomi-

tance of physical symptoms which, under well-defined circumstances, may lead to duodenal ulcers, muscular and circulatory disturbances, and other forms of illness.

From these we must differentiate the hysterical phenomena in which, usually, a wrong organic image of an illness symbolizes a motive which is not being consciously grasped by the patient; still, of course, we find the hysteric who dramatizes, with great coolness, such minor anxiety symptoms wherein the difference between the dramatic representation and *la belle* indifference easily demonstrates to the doctor the phenomenon of dissociation.

The psychosomatic symptoms are very frequently based on pathological reflex activity acquired in early childhood, and one does best in these cases to treat them symptomatically. Only where a clear psychogenetic causation is given should the psychiatrist involve himself in the case.

In explanation of anxiety states, we must here try to find a chain of basic occurrences that allows us to understand the anxiety states as a whole and especially their reinforcement by homosexual traumata in the puberty period. For this reason, the following scheme is given:

Disturbance of basic drives ⟶ Anxiety

Intensity of quality and quantity of the functional disturbance of the drives

1. Maximal in the predisposed neurotic. Illnesses of infancy (skin, asthma, severe disfunctions of the alimentary canal, sleep, crying fits, etc., severe behavior disturbances).
2. Behavior disturbances of less severity. Preparation of the acquired neurotic personality.
3. Minimal, the normal human being.

On these three groups falls the impact of the sudden reinforcement of the sexual drive in prepuberty and puberty, a fact which becomes quite evident anatomically and physiologically. The deepening of the social conditioning of reinforced sex negation thus falls on a personality that becomes increasingly prone to this impact according to his early induction and consequential placing, by definition, in group 1, 2, or 3.

In group 1, we see a strong reappearance of the primary illnesses, usually a severe failure to adjust to normal sexual and occupational standards. In the second group, it is a chain of neurotic reactions. In the normal young man, it leads to temporary faulty adjustments; but he, however, usually learns to integrate himself into the usual life processes.

For our study, it is naturally of special importance to show that the sex taboos of our society strike all three groups with the same strength and that the usual homosexual relations, however incomplete they may be, become the main irritant and, as such, a block against normal sexual maturation.

In the sense of Wilhelm Reich, we accept here that wherever such functional disturbances of the drives occur, the primary rhythm of life becomes deeply perturbed, and in all three groups further development and adjustment become secondary. Here we must again draw on the anthropological work of Verrier Elwin, who shows undisturbed primarity in the naturally grown up, primarily heterosexual-adjusted *shelik* who has lived in the Ghotul, and compares it with the fate of those boys who, instead of having

lived in the Ghotul, were sent to state or missionary schools and in whom the natural life and learning of all life functions, especially of sexuality, has become secondary.

In our case histories, we can demonstrate that the normal man of group 3 can suddenly get into acute anxiety states if and where the secondary adjustment suddenly breaks down.

In cases of group 2, sooner or later the picture of a chronic anxiety state appears, and in the case of group 1, we find the deeply disturbed neurotic who, under all circumstances, at one time or another will need lengthy psychotherapeutic treatment and even hospitalization.

We think that our study proves, firstly, *that social sex-negating conventions prepare a neurotic process;* secondly, *that the reinforcement of sex-negating conventions in pre-puberty and puberty makes a deep mark on the sexual behavior pattern,* especially at a time of emotional preparedness, which, as an "imprest" in the sense of Lorenz on the maturing drive in the adolescent, *leads to homosexual activities in one form or another,* probably in two-thirds of them; so that, *in these cases,* thirdly, *the adjustment to a normal heterosexual sex activity is hindered,* as it remains unavoidably on a secondary basis.

Here, however, a further fundamental fact comes into the foreground. In this period, the young man naturally understands that homosexual activities, and even homosexual feelings, are regarded as crime, sin, or contemptible abnormality by our society, and this in itself leads to a great number of heavy conflicts whose solution remains anchored in the individual predisposition of the individual,

but which can be prognostically predicted according to his category.

Thus, in cases belonging to group 1, it means that, in those in whom the intensity of quality and quantity of the functional disturbances of the drives were maximal, their disturbances will lead to a flight into an illness whereby the spectrum of illnesses is well-nigh infinite and in whom the adjustment to normal life processes will always remain very faulty, if possible at all.

In the second group, it most frequently leads to an overt homosexuality, and most of the 10 overt homosexuals in our study doubtlessly represented as neurotic personalities. They can be expected to suffer from recurrent anxiety states, the length and depth of these being determined either by their attempts to repress their homosexuality unsuccessfully or by the guilt which is generated by showing the necessary bravado to challenge a hostile society continuously.

In the third group, however, this secondary adjustment becomes suddenly disturbed by acute panic attacks. The constitutional homosexual belongs to the groups 1 and 2, the facultative to groups 2 and 3.

The role of anxiety in sex crime is quite obvious and not discussed here, but the very mature study of Dr. J. Hewetson[22] must be mentioned in this connection. This study, which mainly leans on the findings of Malinowski, Reich, and Neill,[36] comes to the same conclusions as the author, but without full understanding of the role of homosexuality.

There remains little doubt that the theory of secondary

adjustment produced a great number of pictures in which it is not the clear homosexual occurrence in prepuberty and puberty which is expressed but, instead, infantile immature sexual mechanisms, which lay a basis for habit formation and, by repetition, lead to conditioning. Such cases produce the exhibitionist, the fetishist, the sado-masochist, the Don Juan in his implied contempt for women, and similar phenomena.

To summarize this discussion of the acute and chronic anxiety state: the author feels that *neurotic illness is due to the enforcing of conventional, socially determined methods of upbringing; the intensity of these methods, mainly in regard to the ways and means in which love and affection are given or withdrawn from the child, especially the predisposed one, plays a great role in further preparing a child constitutionally for neurotic episodes.*

In prepuberty and puberty, a second wave of neurosis is superimposed on these conditions. For, in this period, the biologically matured sexual instinct finds the youngster untutored and confused; this state leads him to undesirable sexual outlets, toward his own person in probably over 90% of adolescents, and toward a homosexual outlet in nearly two-thirds. The opinion that these phenomena are normal and disappear without a trace in the man's further history is, in the author's view, very naive. He maintains, on the contrary, that these phenomena lead to a reinforced, socially conditioned neurotic illness whose effects are of great individual and social importance. Not only the 10 case histories of overt homosexuals but vast numbers of homosexuals seen outside the range of this study were,

without exception, neurotics belonging to the first or second group, but whose adjustment, however faulty, did not lead them into direct contact with psychiatrists.

Depressive illness and juvenile homosexuality

13 CASES: I 8, 17, 21; E 29, 34, 40, 54, 55; R 56, 62, 85; A 107; Z 9.

From the above, we can conclude that the relation of depression to juvenile homosexuality has two bases: the neurotic and the psychotic. We have categorized depression in three subdivisions. In one, it is the susceptibility to prolonged emotional perturbances in reaction to traumatic events, and here we follow Aubrey Lewis,[30] who treats depression generally as part of anxiety neuroses and vice versa. In the other, however, the picture of classical cyclothymia shows such clear-cut psychotic features that it must represent an illness per se. Finally, in the involutional depressions, we frequently find features of both neurotic and psychotic order. From our point of view, it is important to appreciate that *depression appears in practically every form of psychiatric illness and hence presents as a global symptom.*

The past history with homosexual connotations plays a very great role as presenting symptom—of special interest here are cases I 17, 21; E 29, 34, 40, 55; R 56, 62, 85. In the few cases where there occurred a psychotic periodicity, one could sometimes deduce, from the content of the ni-

hilistic and catastrophic delusions, that there existed gross masturbation guilt, and in 1 case we could retrace it to early homosexual activities. It is also demonstrable in the depressive illness, so nearly related to the neurotic illness, that such a basis of a double maladjustment exists. We must mention here that, especially in the involutional depression in man, an early homosexual history can often be shown. In these cases, it is considered very dangerous to overlook the juvenile-homosexual causalities as well as in those cases where the sudden search for homosexual adventures in the middle-aged man—as a new and uncontrollable urge—may have the most disastrous social consequences. We may mention here that every year a number of prominent men, politicians, men of academic status, officers in the army and navy, reveal this problem in sudden sharp illumination. Insight into this problem found its most artistic expression, perhaps, in Thomas Mann's "Death in Venice." The danger of suicide in these cases is very great. In our histories, case I 22 best illustrates this problem.

Subnormality and juvenile homosexuality

13 CASES: I 14; R 63, 72, 77; A 91, 93, 96, 98, 101, 103, 105, 117; Z 9.

Numerically, the "subnormal" person makes up a considerable part of our society. This is well borne out by psychometric statistics, which show that there exists a vast

number of borderline cases lying between subnormality and low average intelligence. Out of this group are recruited, on the one hand, the completely rigid, ultra-conservative men who routinely reproduce the moral and professional teachings which they have learned with great difficulties, and who are unable to deviate one inch from these cast-iron routes. All their complexes, all their intolerable desires are totally repressed. A triggering off or a loosening up of these repressed entities can sometimes lead to a catastrophic reaction, in the sense of Goldstein,[17] and, as "pfropf"-psychotic processes are easily produced in the subnormal, evoke in some cases a temporary pseudopsychosis. Case Z 9.127 illustrates this process.

In many belonging to this group, it was practically impossible to eliminate a homosexual prehistory and, in any case, such prehistory was thought improbable as homosexual adventures are unacceptable for such persons. In fact, this type of rigid monolithic subnormal is rather dangerous in this respect. From time to time, one reads of cases when young men who were solicited for homosexual purposes reacted with gross cruelty, often with murder, toward such invitations.

The other group of subnormals is probably better known, for their problems are very similar to those occurring in female prostitution; they represent a great proportion of the young male prostitutes. Their prostitution reflects on the high-grade feeble-minded person or the borderline case who has never been drilled into the acceptance of moralistic and social conventions, or one in whom the

strength of his drives and desires functionally overwhelmed all such moral teachings and thus opened the way to a clear-cut homosexual conditioning without any resistance.

Studies in which these subnormals are recognized as producing a great proportion of the recidivist criminal are manifold,[41] but by far the most progressive study is that of Albert Ellis and Ralph Brancale[7] in their book "The Psychology of Sex Offenders." These personalities often present psychiatric symptoms, and homosexuality is accepted by them immediately, quite often without any deep perturbance. To judge from the description of overt homosexuals, these men are usually very reliable in their homosexual relationships and are especially looked for as partners by the unfaithful homosexual. As they do not profess strong esthetic demands, they form the great reservoir of the public-lavatory homosexuals whose anxiety-stricken infantility and orgastic incompetence does not need to be elaborated.

In our case collection, we found both these groups and many transitional cases well represented. They seem to us a very penetrating proof for the hypothesis that juvenile homosexuality is induced in infancy and hence prepares the ground for the events in prepuberty and puberty which, in turn, become of decisive conditioning importance. This appears all the more clearly expressed in the subnormal, in whom all finer controls are lacking which, in the other psychiatric pictures, play a preponderant part in the defense against sexual impulses.

Juvenile homosexuality with sexual disturbances as presenting symptoms

31 CASES: I 7, 8, 9, 11, 12, 19, 24; E 35, 37, 39, 40, 42, 45, 53, 54; R 56, 62, 63, 64, 74, 77, 89; A 91, 93, 98, 102, 103, 105, 117; Z 7, 8.

For this group, too, the main argument has been previously given in the discussion of the neuroses. There we tried to explain the sexual disturbance as a secondary adjustment of a neurotically predisposed personality, so that it only remains here to interpret a number of cases in which this factor is not so easily demonstrated.

One of the most interesting cases was I 7, a highly intelligent teacher presenting with two symptoms: firstly, a history of impotence for about one year, after a marriage of ten years, and secondly, a great irritability rising to irrational attacks of fury against his son, aged nine. It was found in the anamnesis that he, at the age of nine, entered into intimate relationships with a group of boys, mostly older than himself, in which mutual masturbation and other homosexual activities played a major role. Explanatory psychotherapy, which showed the identification with his son, led to complete rehabilitation of his potency and made him accept his son without hindrance.

Most of the other cases are nearly self-explanatory, and we are trying here, with more depth, to discuss the role of overt homosexuality.

Every neurosis presents a safety valve in the sense that nonadjustment to reality chooses a particular form of ill-

ness, and it is this safety valve which the psychiatrist treats and, rightly so, with the greatest caution. One can well-nigh state as axiomatic that the physician has only the right to interfere in the life conduct of the patient when and where he expects to achieve an amelioration. In this sense, the author understands overt homosexuality as a safety valve and the so-called constitutional homosexual as a neurotic who has developed his homosexual activity as such a safety valve.

The rigorous persecution of homosexuality by a sex-negating society forces these neurotics to adopt a style of life which carries the character of a secret society and, as in all such groups, naturally a great amount of special neuroticisms are developed spontaneously. Emotional histrionics, the formation of pseudo-femininity, and an incessant and real anxiety of discovery or blackmail inevitably play an essential role. Besides these circles of homosexuals who are found mainly in the great cities, one finds quite astonishingly and very frequently in rural communities the naive homosexual, as we may call him here. We find thus the farm laborer, the peasant boy, the inhabitants of small towns with primary education who usually have grown up under the complete dominance of their mothers and who found, in prepuberty and puberty, mutual masturbation or homosexual friendships which sometimes last all through their lives. Case R 86 is a classic example, and Z 8 equally shows this clearly.

In psychiatric literature, the expression "facultative" homosexual is very often used to denominate usually those

who take up homosexual connections in enforced monosexual situations (school, army, ship, prison, etc.). This seems to us a euphemistic presentation of the facts, which show that the reverse is true: *the noninduced, nonconditioned person will not become a homosexual under any circumstances.* Reliable reports of prisoners of war and prisoners, etc., show that masturbation is probably unavoidable but that homosexuality is never practiced where induction and conditioning have not existed a priori.

Further, we feel that some features of compulsive repetition which are incarnate in every sexual activity are of great importance; it has already been demonstrated how this particular feature leads to the special phenomena in the pattern of the obsessional neurotic, in involutional depressions, in the manifold perversions, and also in overt homosexuality. According to our opinion, which directly opposes the opinions of the above-mentioned psychiatrists, the so-called facultative homosexual is, in fact, a homosexual who, for social reasons, represses his homosexuality more or less successfully, and who, under favorable conditions, which in so many cases—like choice of professional or leisure activities, he is naturally in a position to control himself—allows himself to fall back on these activities. Here again one can show the naiveté of those psychologists and psychiatrists who, in these cases, usually maintain that the facultative homosexual at once takes to a heterosexual sex life if a woman becomes available, and that all former homosexuality or homosexual feelings disappear without leaving a trace.

Hirschfeld's dictum, although he used it in part for his genetic hypothesis, is based, however, on a very true observation:

> It thus would be possible that not only a heterosexual becomes homosexual, but also that a homosexual becomes heterosexual. This however is in contrast to the results of widest observation and experience.

To summarize the chapter on sexual disturbances: based on the formula that every sexual disturbance must be understood as an anxiety neurosis which, as in all neurotic illnesses, shows in the first instance a predisposition of the personality and, further on, is exposed to induction by the intensity of the quality and quantity of the basic drives, and finally is formed decisively by the conditioning processes in prepuberty and puberty, we maintain: that the special phenomena and patterns of parasexual activities are not of causal importance and that they can usually be understood by a thorough anamnesis which, in many cases, can lead to either an acceptance of their condition or, in some few cases, even lead to a break up of these unwanted features.

Borderline cases

7 CASES: I 5; E 52; R 65, 81, 87; A 100; Z 10.

Only a few borderline cases came under our observation. The author is rather sceptical in the acceptance of the psychosomatic illnesses. He believes that the psychiatrist does well here to act with great caution and mainly follows the opinions of Weitbrecht.[46] Only where a clear history shows the influence of a psychopathological genesis in these illnesses can psychotherapeutic help be admitted. On the other hand, the teaching of Kretschmer of an autonomic-reflex hysteria is recognized here as of great importance, as these observations and studies often illuminate the extraordinary strength and depth of the presenting symptoms.

Hence, in most cases of this kind, symptomatic treatment in contrast to special psychiatric therapy seems of foremost importance. In cases, however, where the causation of the symptoms can be explained psychogenetically, we find in our collection of cases mainly the same features as shown in acute and chronic anxiety states.

In the cases I 5, E 32, R 65, and Z 10, the "father-hatred-through-beating trauma" is the trigger element of the illness and is clearly recognizable. It is of interest that we find in the first three cases massive repression of homosexuality but with quite clear latent homosexual features in their life conduct, whereas Z 10 demonstrates the overt constitutional homosexual who suddenly, in his fourteenth year of life, gives in to his "inborn" homosexual oral wishes.

In the remaining cases, mutual masturbation constitutes

only a reinforcement factor. Here, too, we see the importance of a partly overt, partly latent homosexuality in the development of the pattern of the illness, and the role conditioning as such plays during puberty.

The following case is given at length, because it demonstrates, not only the intimate correlation between a well-defined character neurosis and psychomatic illness and their definite expression in fixed postures, rigidities, muscular tensions, and faulty functions like breathing, but it also shows that a successful attack on the whole entity of an ill person, on a vegetotherapeutic level, can be made.

The case of S.

S. came to our outpatient clinic in an acute panic state. During a holiday, he lent his room to friends, who had a number of wild parties in his flat. Some of his friends were overt homosexuals, and some of the young male prostitutes they brought into the flat burgled the place and stole about £400 worth of cloth, tape recorders, furniture, antiques, and any other valuables they could lay their hands on. This was reported to the police, who understandably wished to interrogate S. on his return.

The very fact that the police must gain some insight into his private life, as well as that of his friends, produced a severe panic state in S.; he sweated profusely, there was marked peripheral circulatory disturbance, and his asthma, a childhood complaint, returned at times of great severity to the point where he needed medication by adrenaline injection, sprays, and other relevant medications.

S. is thirty-three years old, born in New Zealand, the

son of wealthy parents. His father was part owner of a department store and his mother came from a Scottish county family, and was, without doubt, very class conscious and snobbish. Father was described as a man of emotional instability and not really interested in the children. S. was the youngest of four, with two older sisters by twelve and ten years and a brother the older by five years. Mother is described as a very powerful personality who incessantly and insistently modeled all her children to the image of Scottish county ideals. The siblings were said to be very fond of S., but in no way involved in his life or emotionally fixated to him, nor he to them; they play no major role in his make-up.

S.'s asthma began at the age of two and one-half. At this time, or a little later, he was hospitalized for a considerable period. He was supposed to have stated very early on that he rejected everybody else and wanted his mother. The quotation "I want my mummy" was said to be the beginning of his overfixation to mother, but he clearly states that he resented the visit of his sister who did not bring him an expected toy, and equally clearly remembered that, on that specific occasion, he shouted and screamed that he wanted his mummy because she was actually the bearer of the expected toy. He was rather stunted through his asthma, and he produced already in childhood a triad of neuroticisms respective of psychomatic manifestations. Firstly, the asthma itself; secondly, a rather empty toothy smile which never left him; thirdly, infantile premasturbatory penis play, which always filled him with an enormous amount of guilt and fear of retribution in some form or another.

Overt masturbation began at the age of twelve and one-half, and he clearly states that he remembers a wave of asthma attacks at the very beginning of his overt mastur-

bation which fell off when he began to accept this pattern of sexual outlet.

At the age of nine, he remembers a friendship with a twelve-year-old boy. Although there was no sex play of any kind or description, they usually built tree houses and cuddled up together under a blanket after undressing. His second overt homosexual adventure began at school. He was sent to a major public school in Australia, and there had his first love play with a boy slightly older than himself which led to practically all methods of homosexual love making. This remained his only sexual activity, and when this relationship broke up, he masturbated daily—a habit which he had not broken until seen in therapy. He went to a university, and, as his I.Q. is a peculiarly brilliant one of 148, he had, of course, no difficulty in achieving his academic degrees. However, he refused to take them, as he felt that, at that period, his love life, which consisted of an infatuation for a very rich woman over twenty-five years his elder, was more important than his studies. He actually had, concurrently, a more harmless infatuation for this woman's son, who was practically his age. Identical with his overt homosexual adventures and his sexual outlet with women usually much older than himself, were more quiet nonasthmatic times.

By the time he was seen, he presented an acute anxiety state in regard to his homosexual adventures quite out of proportion to the dangers which he imagined. He was inclined to leave the country with some histrionic conspiracy, and it was very difficult to get him to see the burglary of his flat and his homosexual guilt as separate entities.

The therapeutic attempt was directed at his asthma. His breathing was very faulty, he had a high, fixed, cage-like

chest, and all the breathing he did was a very rapid chest respiration. The therapeutic main attempt was to break up the chest rigidity by retraining him slowly to use deep abdominal breathing; this succeeded to a certain extent.

The therapeutic attack was then directed against his fatuous empty smile, which was, as so often, a complete armor hiding his real feelings toward himself and others. Characterologically, he could be typed as narcissistic; the smile was partly an arrogant contempt against everybody else and covered a great amount of aggression. There was, in fact, a connection between his fixed smile and his asthmatic attacks. The worse his asthma and the tension arising from his asthmatic attacks, the more prominent his smile became.

Another factor to be considered was the compulsive-repetitive anxiety-relief mechanism of his masturbation, with infantile masochistic and homosexual fantasies.

A summary of the therapeutic attempt can be given as follows:

1. Acceptance of the neurotic personality disorder showing as homosexuality.
2. Intensive work on breathing, to replace the faulty, shallow, chest-breathing mechanism by deep abdominal breathing.
3. Continuous work on the muscles of the face, neck, and back with a resulting breakup of the smile, neck stiffness, shoulder aggression, and pelvic attitudinalistic posture.
4. Finally, the attempt was made to reduce the infantile daily masturbation pattern to a more satisfactory, twice-

weekly sexual outlet whereby the depths of orgastic feeling substituted for the quantity, which had been recognized by the patient as an anxiety-relief mechanism.

The methods of therapy will again be discussed in Part VI.

Summary

Survey and reformulation of the causes of homosexuality and especially juvenile homosexual occurrences in their role as element of later psychiatric illness

We try to establish the following points:

1. That homosexuality is a condition which appears only in sex-negating societies. We accept Elwin's and Malinowski's evidence that, in the sex-permissive societies,

homosexuality is either unknown or considered to be a childish deviation of no interest to the normal sexually matured personality. We have tried to show that early induction and conditioning by sexual taboos produce a neurotic reinforcement, and—although we deny the existence of hereditary, hormonal, or constitutional elements in the phenomenology of homosexuality as such—we do feel that a predisposing neurotic element is present, as it is present in every sufferer from any psychiatric illness.

A neurotic is partly made and partly born, but we advance the opinion that *early induction and conditioning in a sex-negating society are the causes of foremost importance in making men homosexuals.*

2. It is stated here that *the causes of homosexuality, as induced in childhood by the sex-negating patterns of upbringing, grow to promote a fixed neurotic illness in the predisopsed, especially by the mass occurrence of mutual masturbation and homosexual play in adolescence.*

This is the inevitable result of the strengthening and reinforcement of heterosexual taboos at a period of life when sexual potency and the search for sexual outlets are at their strongest. In the vast majority of our case histories, mutual masturbation at the age of from eight to fifteen appears practically as an invariable element. Although the difficulties of producing figures from the normal population seem to be insurmountable (unless one has the machinery which Kinsey found necessary for his survey), it could be shown that, in our opinion, exactly the same mass factor is involved in the bulk of the normal population.

3. The quintessence of this study can be expressed thus:

homosexuality is a neurotic illness of great strength caused by two factors: a predisposed neurotic personality and the impact of sex-negating and prohibitive elements of conventional upbringing, which produce the classic features of neurotic illness; that is, fixation on one or the other parent or their substitute with inversion of sexual desires, immaturity in their love relationship, compulsive repetitive mechanisms of such overwhelming strength that they break through the sanctions of a given society against such practices. This neurotic illness is suddenly grossly reinforced in prepuberty and puberty.

Here the author accepts the theories of Konrad Lorenz, which, for our purpose, can be summarized as follows: Where there are instinctual processes, a certain amount of induction and conditioning is necessary to make these instincts function. Once these conditioning processes have taken place, they more or less repeat themselves automatically if and when certain stimuli trigger them off. It is only natural and obvious that the sexual instinct is even more prone to conditioning at a period in which the biological and physiological propensities are reaching maturity. At that period—in our society—this instinct is driven, in the first instance, toward the self; and as the instinct usually and normally is directed toward another person, it is more or less forced, in the second instance, into a homosexual relationship which, from available studies, initially takes the form of mutual masturbation and quite often develops into a more or less direct, intimate, bodily contact, again with a person of the same sex, although the latter process is not such a mass factor.

In this sense, the predisposed neurotically ill person will easily accept and adapt to homosexual feelings, desires, and practices. *We thus consider the overt homosexual*, who is often called a constitutional homosexual and who numbers among the male population certainly not less than 3%, *as a doubly reinforced neurotic.*

We consider the psychopath as a person in whom homosexuality is one of the strongest elements of an illness, as we feel that any pleasurable conditioning will be greedily accepted by the psychopath and rarely, if ever, given up. In the vast numbers of acute and chronic neurotics, the conflict stems from his primarily neurotic induction in childhood and the "pfropf" neurosis of secondary conditioning in adolescence. The enormous numbers of conflicts which quite often remain unconscious make the homosexual history of such sufferers of great importance and can usually be eliminated. This, by itself, often produces partial remission in people thus afflicted.

The depressive illnesses, with few exceptions of clear-cut cyclothymic pattern, very often allow similar findings. In the psychotic, form and content of his illness is very often determined by these conditioning processes and, although there is little doubt that these illnesses are not caused by these occurrences, one certainly must understand their triple role of giving form, producing the content, and very often being a precipitating factor.

In the bulk of all cases where psychiatric disorders are either on an organic basis or combined with epileptic phenomena, in the great number of the so-called psychosomatic illnesses, one can often determine the psychogenic

elements of disturbance stemming from such experiences.

In the subnormal, whose hallmark is a rigid acceptance of conventions and sanctions, on the one hand, or equally rigid acceptance of his conditioned source of a sexual outlet, homosexuality plays, of course, an enormous role in the latter and must be understood as a great element of danger in the former.

4. In formulating this hypothesis, we obviously drew on many sources, and in trying to establish this hypothesis, we had to argue the case against all other theories of homosexuality. We feel that this argument was easy in the case of the theorists of inheritance, the endocrinologists, the theorists of a third sex and inborn bisexuality. The necessary criticism of the Freudian theory leaves us, however, partly with the acknowledgement of Freud's and the Freudian school's breakthrough into the recognition of the role of sexuality, especially in infancy.

We must acknowledge our debt to Reich in his pioneer work in the recognition of the role of environmental factors in childhood, on the character formation and the importance of social and anthropological factors in forming a cultural pattern which, in turn, produces the environment. Our further indebtedness to Reich lies in his revolutionary attempt to reunite the human being as an entity, based on bio-energetics.

We must also explain here at greater length the terms "induction" and "conditioning." By induction, we understand the relentless pressure under which a given social pattern is impressed upon the infant. This induction is transmitted, not only by the material aspects of infant up-

bringing, not only by the ways and means by which food, drink, and the earliest rituals in regard to cleanliness and all the other aspects of early upbringing are continuously played upon the child, but, most of all, in the latent make-up of those who care for the infant—their tensions, anxieties, tempers, the love proportion given to the child, the whole spectrum of reactions toward the demands of the infant, all are part of the induction of the social pattern upon the child.

The term "conditioning" is, of course, even more ambiguous. Here at once the image of Pavlov's[38] conditioned reflex appears, and with it the American mechanistic schools of behaviorists.[45] We do not understand by conditioning any of those terms used by either Pavlov or the behaviorists. Both are thought to be mechanistic philosophies in which there is gross overrating of the physiological reflex patterns. Their importance is not denied in the growth of numerous automatic functions, but they are thought to have very little, if any, bearing on the complex formation of the human mind. Moreover, the American school of behaviorists has reduced the human mind to a very naive mechanistic concept, contemptuous of the creative and self-appreciative qualities which are, in the author's opinion, the hallmark of the human mind.

In our sense, conditioning means that there exists an acquired pattern of behavior in the complex make-up of: intelligence, pleasure-displeasure response, their affective quality, their compulsive-repetitive urge to reproduce especially pleasurable events—all playing a part in recreating a dynamic background which, in more or less rhythmical

or cyclical periods, forces the person to fulfillment or inhibition. These urges, which have been expressed as "drives," "instincts," "forces," are modified in varying ways by the cultural pattern against which they try to discharge themselves. *The modifications are the factors which we believe to constitute the conditioning process*, and in this sense conditioning is defined.

Of interest here is the very valuable study of Clifford Allen,[1] who tries to combine the Freudian theories with those of Watson's behaviorism. Unfortunately, this marriage is quite impossible. The major error of Clifford Allen is the therapeutic optimism based on Watson's theory, which contradicts the basic pessimism of Freud's theory in regard to the alteration of the human make-up.

5. An obvious query in discussing the causes of homosexuality refers to female homosexuality. Here the author feels that both induction and conditioning produce in the female child a primary dysfunction which represents a mass phenomenon similar to that in male homosexuality, namely frigidity. From clinical experience, one may state that the inability to reach orgasm during intercourse is inhibited in women in a similar proportion to men of homosexual conditioning, which means approximately up to 60% of all women. Partial orgasm may be reached, massive clitoridal sensations can be evoked, but the major and profound anesthesia, which is intravaginal is, unfortunately, again in the author's opinion, a mass phenomenon.

Due to the fundamental difference in the role of sexuality in the female, the personality development allows homosexuality only as a very complicated process of neurosis

to come into the open and, as such, will certainly only be in the region of the same 3% which is shown to be roughly the figure for overt male homosexuals. The sexual spectrum in the female is much broader, and the sexualization of her whole person is a process which leads more easily to parasexual emotional outlets. On the other hand, it facilitates the dissociation of sex from her genitalia, especially the vagina. However, all this is speculative, except the fact that frigidity is a mass phenomenon.

Conclusion

Therapeutic approaches

If the psychiatrist accepts the above formulations: 1) that we have to regard homosexuality as a complete neurotic illness which is the product of early conditioning and induction in the infant in a sex-negating society; 2) that these behavior patterns are reinforced further in puberty by socially induced taboos in which sexuality is forced to be directed toward the self and, on a mass basis, to the same sex; 3) that these twofold impacts lead in the nonpsychi-

atric personality to a rather brittle secondary adjustment with manifold and often dangerous social outlets for the thinly veiled remaining homosexual component in the adult male; 4) that, as such, they appear more or less in all psychiatric illnesses and personality disorders—then the limits of therapeutic attempts are very clearly set.

The author presupposes here, as outlined in the discussion of upbringing patterns in sex-permissive as against sex-negating societies, a profound change in the social pattern, especially of our Western society. To integrate sex as a normal life function into our society is clearly a task which is quite outside the terms of reference of the medical profession as a whole and the psychiatrist in particular. What remains then for the psychiatrist can be stated quite simply.

The understanding of the deep-seated attitudes of our society should produce a tolerant and human response, and as the "blame" for a given condition must be firmly put on to the basic weakness, if not sickness, of our society, this response must be in favor of the patient. This, in the psychiatrist's attitude, should be similar to the response of the teacher to the child in the sense of A. S. Neill,[36] that we must always be on the side of the child. Quite often the possibility exists that people are being helped by the psychitarist with the understanding and reassurance he can give, people who are tortured by their homosexual illness, by the manifold neurotic illnesses which we have shown to be so intimately related to badly repressed homosexual tendencies. One of the primary maxims which can be quoted here is that *it is often more useful to help the pa-*

tient to live with his illness, which cannot be cured in a final sense, than for the psychiatrist to become the mouthpiece of moralistic and legalistic attitudes.

In a multitude of other cases, the insight into the brittleness of a readjustment to a heterosexual sex life can also help the patient to put this readjustment on a firmer basis. Where the symptoms of a homosexual illness are, however, of decisive influence on the social status of the sufferer, symptomatic treatment with sex-depressive medications of the Oestrogen group and the use of tranquilizers with sex-depressive action are felt to be permissible. The ethics of more drastic surgical interference like castration seem to be, to the author, only a sign of the total lack of understanding; and treatment with these means, not only for the psychopathic sex-crime recidivist but also for any other form of sex deviation, is very much questioned.

The attempts of psychotherapeutic maneuvers of greater depth have, according to the literature, been somewhat of a failure, and a great amount of self-deception on the part of the psychiatrist or psychoanalyst and the patient seems to be practiced.

The ups and downs of the neuroticisms, as expressed in any given patient, vary to an incalculable degree, and many a temporary adjustment to please the therapist has been recorded in the same way as a strong suggestion of the doctor in regard to drugs in any condition is known to play a considerable part in the efficacy of the drug.

If the hypotheses outlined above do come nearest an explanation of the phenomena of homosexuality, it would be necessary to undo the induction and conditioning in in-

fancy, prepuberty, and puberty and to create an opportunity for experimental readjustment to heterosexual love play. But these conditions, given the same set of social and cultural pattern in which the sufferer lives, seem to be asking the impossible.

The physical methods used in the direct treatment of homosexuality are primarily the removal of the male sex glands—castration. Although of great emotive provocation, it usually denotes a minor operation, the removal of both testicles. The results of this operation in post-puberty males are not very spectacular. Usually, there is a minor decrease of sexual desire, by no means complete; erectile potency is only influenced by long-term decline, for it takes years sometimes to achieve its eradication; obesity, gynecomastia, and a more female pattern of hair distribution may occur. The psychogenic factors of homosexual basic causes are in no way treated by this maneuver. In fact, the incomplete feminization, due to the impossibility of affecting primary sexual growth factors in post-puberty illogically makes the homosexual pattern more certain.

The method of chemical castration, with drugs of the Stilboestral group, produces results identical with those of castration. However, they are, to a certain extent, reversible. We quote the case of A. A., because it is highly relevant to the discussion here:

> A. A., aged 26, ex-naval cadet, was referred to our outpatients' clinic on probation. He had had two-and-a-half years in an approved school, and had spent, off and on, many months in prison for theft, homosexual activities,

blackmail, and working as a male prostitute; the final referral was due to introducing boys under fifteen into homosexual prostitution. His history compares very closely to case R 59. The difference between A. A. and R 59, an aggressive psychopath, was that A. A. was a very plausible, nonaggressive psychopath with very much better intellectual equipment and very accomplished manners. While serving his last prison sentence, he was given six implants of 125 mgs. of Oestradiol, with the result that he became obese and gynecomastic. In compensation for his overt feminization, his homosexuality became more of the active kind; he tried to have coitus per ano with his partners on each occasion. The first attempts to reverse the feminization by male hormones were, so far, not very successful. The influence on his homosexuality and the parahomosexual criminality was nil.

Tranquilizers are used to a great extent in the treatment of sexual deviation; it is only when high dosages are given that the side effects play a great role and their sex-repressive activity becomes prominent. Thioridazine, a minor tranquilizer, curiously enough interferes regularly with ejaculation. In our observation of this drug with chronic schizophrenics, however,[37] Thioridazine did not affect the libido at all, and thus comes more into the category of a male oral contraceptive than a sex-repressive medication.

Interestingly enough, the observations with heroin addicts made it quite clear that heroin is a very potent sex-repressive drug, but we doubt whether anybody will have the courage seriously to propose giving massive doses of heroin and cocaine to homosexuals to repress their sexual urges.

Aversion treatment, which played, and still plays a great role in the treatment of alcoholism, has also been introduced in the treatment of sexual deviations; recently, an attempt was made to introduce it into the treatment of homosexuality. One or two cases were quoted as great successes, but the inexperience of the observers and the inconsequential number of one or two patients among those treated, immediately puts this aspect into the right perspective—namely, a mechanistic, behavioristic attempt of wishful thinking and massive suggestion which flows from the therapist to the gullible victim. The rather primitive idea that a deep-seated, massive, social-response pattern to a sex-negating upbringing in our Western society can be deconditioned with a mixture of Apomorphine, followed by the production of naked males with erect penises, must clearly fail with the onset of even the smallest degree of sophistication.

The psychiatric approach to therapy for homosexuality

From our repeated generalization that homosexuality in the male is a neurotic illness, one can clearly deduct that the treatment of homosexuality should be that of neurosis, and as such, should be brought into the field of psychiatry. From everything said in this study, however, it is evident that psychiatry is not willing to accept that, nor has the treatment of homosexuality been a prominent or successful part of psychiatric therapeutics.

A great amount of blame must be laid on the early psy-

chiatrists who were thorough moralists and clearly frightened off by social stricture—those that fostered the genetic theory, on the one hand, and, on the other, considered it as a moral weakness. In the first case, they rather cowardly considered the homosexual man as outside their competence; in the other, they were willing to hand over the treatment to the policeman.

The analytical schools realized, like Freud, the omnipresence of homosexuality, especially in neurotic illness, but, as discussed at length before, the illogicalities and discrepancies in theory and practice made analytical treatment of homosexuality an unsatisfactory and inconclusive treatment. The number of homosexuals who came under treatment after prolonged psychoanalytical treatment was greater than one would expect even with the usual shop-and-change of the neurotic in regard to his therapists. All numbers here are too small to be of consequence, but the failure of all analytical schools to apperceive homosexuality in the framework of a sick society failing to cope with sexual maturation makes one expect these results.

The vegetotherapeutic approach is based on the work of Wilhelm Reich. The recognition of the anchoring of character structure, of character armor, of neurotic dysfunction in the whole person—especially in the muscular system, the facial expression, the breathing function, the digestive function, the sexual function—are the essentials of vegetotherapy.

The diagnosis of a neurotic illness is not made solely on the basis of self-expressed ideas, behavior patterns, or social dysfunction, but on the total appearance of the patient:

his attitudes, his postures, his gait, his facial expressions, his mannerisms, his gestures, his speech, not only by analysis and interpretation of content, but—of greater importance—of the way the patient talks, laughs, cries, and modulates his voice.

Muscle by muscle the body is tested for muscular tension, tested for pains of rigidity and frozen posture, and these aspects in combination with the usual techniques of psychiatric history taking and the analytical techniques of unstimulated self-expression and character analysis—on the verbal, as well as on the physical side—can be considered the groundwork of the vegetotherapeutic approach.

The goal of the therapy is not to produce an individual who conforms in all respects to the wants and wishes of society, nor to the nebulous ideals of fairy-tale figures. The goal in all cases must be self-acceptance, whatever the dynamics of disturbance may be, unless they are of destructive and disintegrative consequence—that is, *one must learn to accept oneself and live with oneself.*

Thus, finally, it is believed that the homosexual should be brought to a certain amount of self-realization and self-acceptance. The case history given here shows the relative success of the therapeutic approach attempted.

The application of vegetotherapy

A young university lecturer, aged twenty-seven, was referred to our vegetotherapeutic clinic by his general prac-

titioner, to whom he talked at length about his overwhelming fears in regard to his homosexuality.

At the first interview, we were faced with a normally built masculine young man with a certain amount of pomposity and a marked priest-like intonation in his speech; his features were rather sharp and Celtic, and he could be typed as an athletic person. His complaint at first was that of homosexuality, and he demanded a therapeutic maneuver which would alter this homosexuality into heterosexuality.

Already, at this juncture, it was made clear to him that any therapy which would promise, or even set out, to achieve that goal would be highly suspect, and that all therapy must find its goal in understanding of oneself and in self-acceptance.

The history which he gave was a very revealing one, and really focused, as one of the determining factors in his case, on the fact that his father was called into the army at the outbreak of World War II when he was roughly one year old. The mother and child were thrown entirely on their own company for four-and-a-half years, and the return of the father from the Far East after this period was a ghastly shock, a trauma of such a degree that nothing of that period remains in the patient's memory.

A brother—born nine months after the return of father —was forgotten to be mentioned by the patient. In fact, this first brother has never been, and is not now, accepted by the patient. During all therapeutic discussions, it was practically impossible to discuss the relationship to this brother; the patient maintains he does not even hate him, but still finds it impossible to deal with his brother as a living person in a normal human relationship.

The relationship to his father was a grossly ambivalent

one. There were clearly periods of sheer hatred and rejection on his part, but he soon developed, during his prepuberty, a rather sycophantic and conforming attitude which, at times, ran into quite unjustified adulation. The father was a very successful self-made businessman who moved up from shop-owning poverty to comparative wealth.

The marriage between the patient's father and mother became disturbed by numerous infidelities by his father, and his mother began to become a heavy drinker while he was in his teens.

The birth of his second brother, when he was between seven and eight, was much more accepted, and this youngest brother became, in some way, his primary love object. In fact, until the time of coming to therapy, the patient had no sexual experience whatsoever, neither heterosexual nor homosexual, barring masturbatory sex play with this younger brother. This began when the patient was aged twelve and his brother aged five, and this rather shy and masked sex play, on a pseudo-masturbatory basis, went on for about three or four years.

The guilt, fear, and shame accruing from this rather innocent sex play with his brother helped the patient to develop a very strong religious feeling, which he maintained all through puberty and his post-puberty years. He was befriended by several elderly priests who were very kind and understanding with him, and who were very close to him emotionally, but with none of them was there any homosexual play.

After a particularly brilliant school career, he went to the university for two years with the intention of studying for the priesthood. At this period, his first severe psychiatric disturbance began. His masturbation fantasies became more and more violent, and sadistic elements crept

in which made him so anxious that the number of masturbations increased to one or two daily anxiety-relief outlets. He decided that he was unsuited to become a priest, and began to read history, geography, and literature. His friendships at this time were exclusively male. His contacts with females were very restricted, very shy, and purely formal.

Whenever he visited home, his reaction to his father and mother became much more critical, because his father overtly lived with his mistresses, and his mother was becoming a very depressed alcoholic.

In his first university appointment, the patient met a very young student with whom he fell in love, and, in his rather clumsy and inexperienced way, he tried to declare his love to this boy on all occasions. Whenever they met in group meetings, or on excursions or socially, his controls became near breaking point. His masturbation fantasies now became more and more wild; he pictured the boy in sadistic scenes with bullwhips, lashing naked prisoners, and the literary description of scenes of that kind were also part of the masturbatory ritual.

The first vegetotherapeutic session revealed the following picture. A totally rigid tension over the whole body, a rather military posture with a drawn-in abdomen and expanded chest, pushed-out buttocks with a very tightly shut anal cleft. There was a continuous tendency to cross his legs in the horizontal position. The major regions of muscular tension were the shoulder muscles at the back, the neck muscles (very stiff), the frontalis muscles, and his masseters, which clenched and unclenched, especially when subjects were aired of great embarrassment, like his alcoholic mother or his first brother. His skin was clammy, and slightly inflamed around the anus and in the crutch; sweating in this region was very prominent.

On physical examination, he was found to be a very healthy young man without any organic defects in any system.

The vegetotherapeutic attempt, in the first instance, went against his breathing; in a few sessions, the posture was broken, and he learned to relax his abdomen, his chest broke up into its normal shape, and his breathing became became more and more abdominal, deeper, and it was ultimately felt by him as a tidal wave, in which inspiration was a wave from the periphery to the center, and expiration a wave from the center to the periphery.

The very strong pain felt at the first few sessions at the manipulation of the shoulder and neck muscles lessened; the spinal muscles could be worked upon with pleasure rather than with pain, and the general relaxation of the face became more and more constant; a rather supercilious frown disappeared, and his masturbation reduced to much more normal proportions of roughly twice a week.

The psychiatric attempts were directed toward the understanding of the sadistic content of his masturbation fantasies as directed against his father; that his homosexuality was basically a mother-fixated incest fear; that his general attitude of anti-sexuality (saintliness) has to be broken before he could decide to what extent he could start a heterosexual life. The formulation given here was that, without sexual experience, his fantasy masturbation life would always remain stronger; sexual reality has to be found one way or the other.

It was possible, after his vegetotherapeutic course, to achieve a certain amount of sexual experience, primarily on a homosexual basis. This in itself had a certain sobering effect on him. It meant that reality and fantasy were clearly at a gross contrast. It was possible, after this, for him for the first time to get into closer contact emotionally with

a female fellow lecturer, and, although he accepts himself as basically homosexually conditioned, it should be possible for him to achieve his desired goal—to live, marry, and have children happily without any subconscious interference from his homosexual make-up, which he has learned to understand.

We feel that this history and the short outline of the therapeutic approach as given here, seems to be the best present approach to the problem of homosexuality.

Case Histories

I 1: Aged twenty-one, single, obsessional state and schizophrenia, three suicidal attempts, severe depression, immature, incest with mother and sister in the presence of foreign soldiers, massive homosexuality and mutual masturbation experience since the age of nine. Emigrated at eighteen to Australia and was seduced by an uncle to regular homosexual activities. This was followed by a first rather severe schizophrenic breakdown, necessitating six months' hospitalization. He identified his penis with God and had visions in which Christ appeared involved in obscene activi-

ties. Further periods with strong obsessions and schizophrenic breakdowns followed his return to England. He had several homosexual relationships at the time of referral. This case shows very clearly the role of incest and early homosexual conditioning. At twelve he was seduced by his music master (case I 24) to anal intercourse with penetration. *Discussion of this case under Obsessional States and Schizophrenias.*

I 2: Aged thirty-nine, married, children, referred in acute anxiety state and with chronic alcoholism. Childhood incest with brother at seven to eleven, mutual masturbation and homosexual play in school at eleven to fourteen. Father, a publican and severe alcoholic, described by him as an "endless terror" to the children. Good response to psychotherapy on the equation Alcohol-Homosexuality. This case shows the correlation of early incest, juvenile homosexuality, and alcoholism. *Discussion under Acute Anxiety-States.*

I 3: Aged twenty-five, single, referred in acute anxiety with typical organ neurosis and hypochondriasis, continuous tension state. He was never able to contact girls. Homosexual activities during his naval service at seventeen to twenty. He feels and expresses great guilt on account of these events and has, since his demobilization, never entered overt homosexual activities. His illnesses and functional disturbances have, so to say, taken the place of a sexual outlet. *Discussion under Chronic Anxiety States.*

I 4: Aged nineteen, single, epileptic, court referral after indecent behavior with a man aged thirty-six; an unskilled laborer, an uncouth sulky youth with great disinclination to have any medical or psychiatric treatment. He admits years of incest with his brother. He maintained that he could abort his epileptic attacks by masturbation. His aura was based on temporal-lobe attacks in which he produced microptic visions of persons. This case shows the role of incest in the conditioning of juvenile homosexuality and, interestingly, the importance of orgasm as a bio-energetic-discharge mechanism substituting an epileptic attack. *Discussion under Organic Psychoses and Borderline Cases.*

I 5: Aged twenty-two, single, only child, I.Q. 130, referred as a case of migraine not responding to the usual medications. The history showed the following elements: father-hatred, mother-fixation, a very strongly marked narcissism which found its clearest expression in mirror-masturbation. He denied, however, any homosexual activity, even the possibility of such feelings, most energetically. Nevertheless, he has no contact wtih girls and is waiting with some tension for the return of his best friend from the army. His migraine attacks are regularly triggered off at weekends when his father, who works away from home during the week, returns there. He responded well to psychotherapy, and his medication with ergot preparations succeeded after he gained some insight into his personality structure. This case well shows the role of badly repressed homosexual features in preventing normal

maturation, the arrest in a narcissistic stage, and the precipitation of psychosomatic diseases. *Discussion in Borderline Cases.*

I 6: Aged thirty-two, single, referred with schizophrenia. Total withdrawal from reality and complete social isolation was noted. The illness was most clearly shown in gross religious obsessions and delusions. The symbols used by him were unambiguously oral, phallic, and ejaculatory. His history was vague but showed some undetermined seduction as an R.A.F. cadet at fifteen. He has practically no overt sexual drive—not surprisingly, as one finds quite often a fragmentation of the sexual organization in hebephrenics. He admits to rare nocturnal emissions. The case shows the role of juvenile homosexuality in forming the content of schizophrenic delusions and probably as trigger mechanism. *Discussion in Schizophrenias.*

I 7: Aged thirty-five, married with children, referred to hospital with a history of impotence over one year. A second presenting symptom was a badly controlled irritation and rejection of his son, aged nine. The patient was a teacher of very high intelligence. He was brought up very strictly and religiously in a sectarian faith. He gave a history of prolonged mutual masturbation and homosexual activities with a group of boys, mostly older than himself, which began at the patient's age of eight and lasted about five years. His identification with his son and the gross attempt to keep homosexual urges unconscious came very quickly to the fore in his insight, and he understood them as the causes of his impotence and irritation. Both symp-

toms disappeared very rapidly. *This case is discussed at some length under Sexual Disorders.*

I 8: Aged twenty-nine, single, referred to the clinic as homosexual with severe depressions. He gives a significant history of continuous homosexual play from the age of seven, which continued into puberty. His first firm overt homosexual friendship developed during his sixteenth year. However, single experiences of mutual masturbation and homosexual intercourse with foreign soldiers started two years previous to this overt homosexual relationship. He regarded his homosexuality as inborn but nevertheless tried endless treatments without success—this included years on Stilboestrol and psychotherapy for two years. He stated that he feels that his homosexuality is an incurable disease.

The therapeutic attempt was not directed toward a "cure" of his homosexuality, but toward the necessity to understand it as a neurotic illness and, moreover, as a safety valve, and it was meant to enable him to accept himself with his illness. Anti-depressive medication also helped in this case. This case clearly shows:

1. the basic misunderstanding of the homosexuals to regard their sexual direction as inborn and the alacrity with which they adopt this theory, but the contradiction between this hypothesis and their endless search for cures.
2. the role of very early conditioning and induction.
3. the help that can be given to the homosexual in explaining and making him accept his condition, if this is an endless and recurrent irritation reinforcing his neurotic illness. *Discussion under Sexual Disturbances and Depressions.*

I 9: Aged twenty, single, three times recidivist with exhibitionism, referred by the court. His father was a brutal and emotionally cold and callous man. He was an only child. His parents separated when the patient was aged seven and he lived alone with his mother. His I.Q. was 81. For the last three years he shared his room with a male cousin aged seventeen. Was seduced at the age of twelve by a foreign soldier in a cinema to an act of complete mutual masturbation. At fourteen he was caught exhibiting himself and sent to a reform school (cf. case A 117). From seventeen to nineteen he was in the army and had some heterosexual nonpermanent experiences. On his return home, he found a girl friend with whom he had regular intercourse. Nevertheless, he continued impulsively his exhibitionism and was caught twice. This case shows the continuation of infantile mechanisms which foremost seek his mother as primary love object, the strength of these mechanisms based on the magic of the penis and the continuation of masturbation as an addiction in the sense of Giese. *Discussion under Sexual Disturbances.*

I 10: Aged twenty-nine, married with two children, came to the clinic complaining of a heavy motor-tic: an explosive shooting forward of his head with hissing expulsion of air. His early history shows the father to be a cruel, brutal, and violent man. The patient was strongly fixated to his mother, a relationship which was reproduced regularly in his dreams. He was a premature baby and suffered from a pyloric stenosis, wet his bed until prepuberty, and had screaming fits and nightmares up to the age of eleven. At

the age of eight he saw a man killed by a horse and at twelve saw the corpse of his eldest brother brought into the house after a motorcycle accident. Early on he had continuous mutual masturbation and homosexual play with his brother, one year younger than himself. He reports mutual masturbation with other boys up to the age of sixteen. From then on, irregular intercourse with girl friends. He served in the navy, was an excellent sailor, and became flag bearer on ceremonial parades. His tic began as a head-nodding movement after his sergeant, with whom he quarreled, withdrew him from this honorable function. After his return to civilian life, he married but his sex life was not only irregular, with months and months without intercourse, but also unsatisfactory as coitus interruptus was practiced on these rare occasions. Three years after the marriage, the tic began to increase to its full extent and extreme tension, leading to the above-described explosion, was experienced, especially while having his hair cut, in buses, and in all closed rooms like cinemas. This case shows:

1. the symbolic terror reaction in the sense of Stekel.
2. the inborn neurosis and the infantile neuroticisms.
3. their reinforcement by incest with his brother and juvenile homosexuality.
4. the return of the pylorospasm in the sense of Kretschmer's reflex hysteria and its use as terror symbol.

Two years' psychotherapy combined with medication by phenothiazines and antispasmodics led to a marked improvement and better social integration. *Discussion under Compulsive-Obsessional Neuroses.*

I 11: Aged twenty-four, married, skilled printer, referred to outpatients' clinic with impotence and acute anxiety. It soon became clear that this was not a case of impotence but of premature ejaculation. He was the younger of two siblings, his sister being four years older. The patient was brought up in the usual conventional circumstances, and had massive and intensive homosexual relations, which were repeated twice weekly while going fishing with a friend of the same age. He was very fond of this friend, and they both married at the same time. Sexual intercourse with his wife was markedly hindered by homosexual fantasies; he had a full erection and practically immediate ejaculation, as the idea of the "horrible" smell of semen and vaginal discharge was "unbearable" and led to a nausea reaction which made his penis collapse at once and hindered any further coitus (cf. case I 20). This case shows fully the importance of juvenile homosexuality with orgastic disturbances; the role of smell is also noteworthy. After explanatory psychotherapy, the patient improved quickly and reported satisfactory intercourse with normal orgasm achieved by his wife and himself simultaneously, even two years after. *Discussion under Sexual Disturbances and Acute Anxiety.*

I 12: Aged forty-one, married, referred to the hospital with complete impotence, severe chronic anxiety from early childhood onwards, erection was not possible. His marriage collapsed after some years, and his wife was for years an inmate of the hospital with "malignant hysteria." He professed total amnesia of events of his infancy and

childhood. There was a clearly marked mother fixation. His only overt sexual experiences were rare masturbation from the age of twelve onwards and, later on, a single mutual-masturbation relationship at the age of seventeen. Since then, he had no sexual activities whatsoever. *Discussion under Sexual Disturbances and Chronic Anxiety.*

I 13: Aged thirty-three, married, two children, research chemist (I.Q. 135), referred in acute anxiety state. He could not concentrate on his work at all and he was totally preoccupied with masochistic, sadistic, and flagellation fantasies. He became progressively an alcoholic. An only child of lower-middle-class parents, he denied fiercely any juvenile homosexuality. This case shows how perversion can take the place of homosexuality in culturally conditioned neuroses. The patient refused further therapy which, in the first instance, was directed against his alcoholism. He had totally discolored and foul teeth but, here too, he refused any treatment in spite of strong pressure and the factor of self-devaluation made clear to him in his case. He took a job in the north of England and was reported to have broken down completely needing hospitalization for many years. *Discussion under Acute Anxiety-States and Sexual Disturbances.*

I 14: Aged sixteen, single, aggressive psychopath, I.Q. 86. Presenting symptoms were violence toward his two younger siblings, both of normal intelligence. He gave a history of complete homosexual activity with three other boys at the age of eleven to fourteen. His violence broke out after these homosexual activities ceased. During ther-

apy, he became a member of an intensely religious group and remained somewhat controlled during this period. However, a total breakdown with violence followed after he broke up psychotherapeutic efforts, which lasted roughly one year, and he was reported to have been violent to an extent which necessitated hospitalization for over a year in an institute for defectives. This case shows the role of homosexuality in the subnormal psychopath. *Discussion under Psychopathy and Subnormality.*

I 15: Aged thirty, single, referred to the clinic with acute over-chronic anxiety state and massive hypochondriasis. A Jew, an only child who lost his father when he was seven years old. Brought up exclusively by a domineering, neurotic, anxious mother, who concentrated her life totally on her son. His school performance began to deteriorate at twelve, and he became increasingly unable to work. He moved entirely in male company but admits only one experience of overt masturbation in the presence of another boy, who also masturbated at the same time, at the age of seventeen. He denies strongly any homosexual feelings or activities since then. He masturbated circa three times daily. This case shows especially clearly the castration of an only son by his widowed mother, the latent homosexual conditioning and, finally, masturbation as an addiction and relief mechanism in a malignant chronic anxiety. *Discussion under Chronic Anxiety.*

I 16: Aged twenty-eight, single, referred with chronic anxiety. The patient had severe panic attacks whenever he

passed public lavatories. He expressed overwhelming masturbation guilt with elaborate prevention rituals. Very indifferent unskilled worker in spite of a good intelligence. An only child. He hates his father and is clearly and strongly mother-bound. Sharp denial of any homosexual feelings or activities at any time. However, his own general practitioner referred him already as "latent homosexual." He lives exclusively in male company. Some neurotic chronic depressions have been noted. This case again shows the role of mother-fixation and masturbation-guilt (cf. cases I 3 and I 15). No real response to psychotherapy, indifferent prognosis. *Discussion under Chronic Anxiety States.*

I 17: Aged fifty-five, married, referred with prolonged depression lasting one year at referral, i.e., since his marriage. He was a practicing overt homosexual since his eleventh year, when he was seduced by an elderly man. At twenty-seven he became a lay preacher, and at that time he fully realized that he was a homosexual. This led to his first hospitalization in acute mania. Later on, he had to be hospitalized on two more occasions in depressive phases. His marriage he declared to be "nonsensical," his wife being seven years older; there is no love, affection, or sexual intercourse, but endless irritation. This case shows the constitutional homosexual who, in spite of his early seduction, must be understood as very early conditioned. It also shows the role of religiosity as a yardstick of his severe guilt feelings. Further, it shows the difficulties of diagnosis in depressive illnesses of that kind, as we deal here with a cyclo-

thyme, in whom homosexuality served as a trigger factor of his psychosis, once as mania and later on as depressions. *Discussion under Depressions.*

I 18: Aged seventeen, single, referred in acute anxiety state. In the fore is the symptom of the small penis complex. His early history shows incest play with his brother and sister. Mutual masturbation was admitted by the patient, but homosexuality in any shape or form denied. He avoided all open swimming pools, as he felt other boys and men would at once demonstrate how insufficiently equipped he was. He also thought he would be unable to go out with girls, as he was sure they would laugh at him in regard to the size of his penis. This, however, was totally unjustified, as examination showed his penis to be of normal length and consistency. Father hatred and mother fixation were features in his case, but he had a very strong urge for father figures; thus, he followed his doctor 300 miles to be readmitted into his hospital. He responded well to psychotherapy, and a successful heterosexual love affair, lasting some time, brought quick relief. This case shows the role of undervaluation of the penis as an equivalent to homosexuality. *Discussion under Acute Anxiety States.*

I 19: Aged nineteen, single, referred to the hospital with a diagnosis of impotence. A young Pole who, at the age of four, was evacuated to Siberia and who lived, up to the age of sixteen, in refugee camps, where he adopted firm homosexual habits from the age of seven. He continued these after his final settlement in England. He lives with his mother, is very religious, and suffers with acute guilt feel-

ings on account of masturbation and homosexuality. Each sexual activity, which begins normally, is suddenly interrupted before orgasm occurs, as he loses his erectile potency. This case shows especially clearly the extremely strong influence of very early conditioning by environmental factors, as well as the role of anxiety and the overanxious religiosity in the structure of orgastic impotence (cf. cases I 7 and I 11). *Discussion under Sexual Disturbances and Anxiety States.*

I 20: Aged twenty-three, married, referred with hysteria. He had panics, collapses and, while masturbating, had uncontrollable attacks of weeping. He fainted whenever he attempted sexual intercourse and maintained that these attacks were triggered off by the unbearable smell of his semen. His early history shows only long-lasting mutual-masturbation relationships in school. He is quite definitely a hysterical personality. This case also shows the influence of the sense of smell and the role of semen as a homosexual equivalent, as well as the importance of mutual masturbation in conditioning orgastic failure (cf. case I 11). *Discussion under Hysterias.*

I 21: Aged sixty-seven, married, very indifferent marriage of forty-five years, one married son. The patient is a highly intelligent retired teacher who was referred with involutional depressions. He admitted that he masturbated without any breaks since childhood. His homosexual prehistory was not quite clear. He admitted, however, that there was some undefined incest play between his brother and himself from the age of ten to twelve. Electro-

convulsive therapy brought a lasting improvement. This case shows how, in the predisposed personality, juvenile-homosexual and incest experiences can lead imperceptibly to involutional depressions. *Discussion under Depressions.*

I 22: Aged forty-six, married with two children, the elder boy sixteen. By profession, a civil servant in a high position, referred to the clinic in acute anxiety. His history was fundamental for our study here. He had early homosexual activities in his school years from the age of twelve to seventeen. Although he married young and his marriage must be declared as a very happy one, his heterosexual activities have been grossly disturbed from the very beginning by everlasting homosexual fantasies, and he was always tempted, for this reason, to have them as rarely as possible. Thus, he usually had twice-monthly intercourse with his wife. He fought all his married life against the temptation to masturbate with homosexual fantasies. This led increasingly during the last twelve years to spontaneous ejaculation without erections whenever he sat in public transport, cinemas, or railway compartments, next to attractive young men. He also felt that the way he treated his younger and more attractive subordinates showed that his feelings corrupted him. He lived for many years in great fear that his strong homosexual inclinations would be noticed by others, and he very often had acute anxieties that these could be discovered. In his case, psychotherapy of some depth showed elements of earlier neurotic maladjustment in the way both parents handled the child, and the process of conditioning by his juvenile homosexuality

was laid bare. The explanation that we deal in this case with a mass fate which, in his particular case, is most clearly expressed, permitted the patient at least to get insight into his condition and to be able to accept himself with his illness completely. *Discussion under Acute Anxiety and Depressions.*

I 23: Aged twenty-three, married with one child, referred by his general practitioner as a hysterical psychopath. He gives a history of uninterrupted homosexual activity from the age of eight. These activities were usually accompanied by blackmail, on the one hand, and police informing, on the other. He spent more than three years in a reform school. However, he continued all these activities after his discharge. His marriage is a very unhappy one; in fact, the wife is also a psychopath under treatment, and they have a girl of two years, whom the authorities were advised to take in custody. He usually enters public lavatories, solicits men with whom he then commits fellatio or mutual masturbation, or with whom he goes into parks, where he practices active or passive buggery. He usually tries blackmail afterwards or, if it fails, informs the police. His acute hysteria broke through after he received a very severe beating up after such a blackmail attempt. This case shows the importance of early homosexual conditioning, the ambivalence in regard to authorities, and the questionable role of reformatory institutions. *Discussion under Psychopathy.*

I 24: Aged forty-seven, bachelor, admitted to hospital with general progressive paralysis and homosexuality. He

practiced homosexuality since the age of twelve and is very proud and brags about his homosexual conquests, which number far over 100. He contracted syphilis by anal coitus. By profession, he was a highly intelligent music teacher who lost several teaching jobs through his homosexual conduct, and he was the man who seduced case I 1. He stated to be totally fixated to both his parents. His father, who was an actor, was said by him to be his idol and the quintessence of a gentleman; his mother, the ideal and only woman in his life. His love for her is so strong he could never dare to touch another woman. This case shows the role of family dynamics and the conditioning to complete homosexuality, especially through early preadolescent activities. This case is a classic example of the constitutional homosexual. *Discussion under Organic Psychoses and Sexual Disturbances.*

I 25: Aged nineteen, single, referred to the outpatients' clinic with epilepsy. The attacks began in the sixteenth year of life at a date when his friend, two years older than himself, with whom he had a homosexual friendship over the last four years, was called to military service. His E.E.G. showed epileptic dysrhythmia. At a later revision of this case, roughly one year after his marriage at the age of twenty-one, he showed complete absence of further epileptic fits, and his E.E.G. at that time was read as normal. This case shows the role of juvenile homosexuality and the correlation between sexual activities and epileptic attacks. *Discussion under Organic Psychoses.*

I 26: Aged fifty-five, married, former army officer, now in a clerical position. A classical paranoid schizophrene. He was continuously exposed to homosexual attacks by either invitations or gestures; spies and secret agents surrounded him. He systematized genuinely all events in his life and interrelated them to his paranoid delusions. In this case, no attempt at a homosexual prehistory could be made. The case shows the role of homosexuality as a content of paranoid psychoses. *Discussion under Schizophrenia.*

I 27: Aged twenty-four, married, bookkeeper with I.Q. 130. Malignant chronic anxiety state. He gives a single occurrence with a complete homosexual contact in a swimming pool at the age of nine. Since then, he avoids any contact with swimming baths or roads which lead to such. But in contrast to the obsessional neurotic, he is completely aware of the cause of this avoidance. He also shows markedly the small penis complex (cf. case I 18) and severe masturbation guilt. In spite of a good marriage and the birth of two children, he remains fixed in endless preoccupation on this homosexual event. We have in this case a very interesting reversal of fixation: father adores his son. This case shows the role of the penis, the role of early seduction in prepuberty, and the importance of the locality of such seductions in the repressive mechanisms against homosexual urges. *Discussion under Chronic Anxiety States.*

E 28: Aged thirty-four, married, referred to the hospital with impotence and hysteria. He admits that he has strong homosexual feelings and that he masturbates at times with

great guilt feelings. He maintains that masturbation especially makes him unable to have normal intercourse. Although he denied at first any active homosexuality, he admitted under sodium amytal a history of active homosexuality during one and a half years in the army. Low average intelligence with I.Q. 90. Psychotherapy was not very successful. This case shows the role of juvenile homosexuality in hysteria and impotence, which must be conceded as the only factors in his later breakdown. *Discussion under Hysteria.*

E 29: Aged twenty-nine, single, referred to the outpatients clinic in acute anxiety state and severe depression. He gives a history of homosexual incest with his father in an air-raid shelter at the age of sixteen. His prehistory shows the usual mutual masturbation at school with some homosexual activities. He has a long-lasting affair with a girl friend, but every sexual activity unavoidably evokes the incest scene and ends with severe depressions. His mother is described by him as domineering and overanxious. She separated from his father, as he chose to live an overt homosexual life after eighteen years of marriage, in which there were two children. This case shows the importance of juvenile homosexuality and incest with a parent, as well as the endless repetition of the traumatic key event as an element of depressions. Also, interestingly, that his overt sexual feelings and desires were clearly heterosexual. *Discussion under Depressions and Acute Anxiety States.*

E 30: Aged twenty-four, married, a butcher by profession, referred to the outpatients' clinic with a nervous breakdown and diagnosed as a paranoid schizophrene. He had massive delusions in regard to overdeveloped buttocks which, in fact, were quite normal. This, however, began at the age of thirteen, as he maintains that his brother, two years older than himself, continuously teased him in regard to his big buttocks. He gives a history of mutual masturbation in his sixteenth year, and he maintains that he was seduced as a hitchhiker on a lorry at the age of twenty-one. He maintained that his sexual potency is periodically grossly inhibited in his young marriage by the unbearable swelling of his buttocks. This case shows the role of the parasexual importance of parts of the body as symbols in paranoid illness. *Discussion under Schizophrenia.*

E 31: Aged nineteen, single, printer's apprentice with very high I.Q., referred in acute anxiety state to the clinic. His presenting symptoms were lack of concentration, massive phobia against all kinds of noises but quite especially the noise of a paper-cutting machine. Whenever this machine is working, he feels severely faint and begins to tremble, sweats, and gets into a state of agitation which parallels his inner panic. He has a domineering father whom he fears since very early childhood and thus shows some disturbed family dynamics. In his exterior, he is a typical "Teddy Boy," and his behavior with girls shows a Don Juan sexuality. He has at least four girl friends and has

sexual intercourse with one or another girl practically every evening. He gives a history of mutual masturbation in school and homosexual seduction in a swimming bath. This case shows the role of Don Juanism firstly as an anxiety-relief mechanism, secondly as an equivalent of conditioned homosexuality, which has been induced already in childhood by extremely strong father fear, and thirdly it shows the contempt of women typical of the Don Juan. *Discussion under Chronic Anxiety States.*

E 32: Aged thirty, bachelor, chronic paranoid schizophrene. He lives with a schizoid mother, separated from his father, who was a high-ranking army officer. He was induced to homosexual practices in preparatory school in India at the age of eight, and these activities were continued in his boarding school in the form of mutual masturbation and homosexuality from the age of thirteen to eighteen. He masturbates two to three times daily and is unable to contact girls. Periodic paranoid breakdowns usually led to hospitalization. In his psychotic episodes, he clearly shows his homosexuality, whereas in his periods of remission he attempts a heterosexual sex life, at least in his masturbation fantasies. This case shows the importance of homosexual activities in the content of paranoid schizophrenias and the addictive habit of masturbation in gross anxiety, which is part of the schizophrenic illness in this case. *Discussion under Schizophrenia.*

E 33: Aged forty-nine, twice divorced, high bank official, acute and chronic anxieties, two sons of his first marriage which he dissolved after eighteen years. He entered

a second rather ridiculous marriage with a mother figure fifteen years older than himself. This second marriage broke up more or less immediately. His education was overstrict and rigid, and led to clear-cut mother fixation and father-hatred. He had with his brother, two years older than himself, for many years rather poorly disguised homosexual games, and his relationship to this brother shows very strong hate-love ambivalence. His masturbation guilt, especially in adolescence, was enormous. During the Second World War, as an officer, he had his first minor nervous breakdown, as he felt completely unable to carry the responsibility which went with his position. During his first marriage, he felt very often that his heterosexual relations left him comparatively cold. He masturbated at times and admitted that this was done with overt homosexual fantasies. He was very strongly fixated to his second son, with whom he identified to a great extent. He had a very high I.Q. He responded extremely well to psychotherapy. This case shows the influence of rigid Edwardian education, the role of fixation and incest play with his older brother (cf. Spencer's study). It also shows the continuation of homosexual conditioning by unsuccessful repression (cf. case I 22). *Discussion under Acute and Chronic Anxiety States.*

E 34: Aged seventeen, single, referred to the clinic as classically depressed. He had repeated complete sexual intercourse with a girl friend, aged fourteen. He gives a history of mutual masturbation in school at the age of twelve and mentions severe guilt feelings in regard to it. He had

to be hospitalized and later responded successfully to electro-therapy and anti-depressive medication. This case shows the role of sexual activity as a trigger factor in depressive illnesses. *Discussion under Depressions.*

E 35: Aged forty-seven, he married two months before referral to the clinic with impotence. He was a sailor in the merchant navy. He gives a history of mutual masturbation and homosexuality as ship's boy from the age of fourteen to seventeen. He maintained that, between seventeen and forty-seven, he had some single erratic visits to prostitutes and brothels. His history appeared, however, quite untrustworthy. This case shows the role of juvenile homosexuality and its probable continuation as the cause of impotence. *Discussion under Sexual Disturbances.*

E 36: Aged thirty, a dwarf-like married man with four children, came to the clinic in an acute anxiety state with gross venereophobia. He, in fact, has had venereal disease as a soldier. He was, however, completely cured, but over 60 Wassermann reactions, all negative, could not convince him. He also showed the typical hypomania and bounce of the little man. His prehistory was rather confused and vague. He mentions some kind of sexual games with his brother and does not deny the possibility of mutual masturbation at school, but denies strongly any homosexual activity (cf. case R 78). Here the role of venereophobia is shown especially after a real infection as a symptom in latent homosexuals leading to acute anxiety. *Discussion under Acute Anxiety States.*

E 37: Aged twenty-three, single, referred by the courts to the clinic as fetishist. He wears female underwear, is very religious, and completely dominated by his mother. His father was a very old man and died when the boy was aged ten. He declared every sexual feeling in respect to the female sex as sin, lives and moves exclusively in male society, especially the society of old men. He, so to say, collects father figures. He denies all homosexual feelings most severely. This case shows the role of early induction and badly repressed masturbation fantasies with identification with his mother, which explains his continuous hankering after female underwear. It shows hyperreligiosity as an anxiety-decreasing safety valve and his rather naive subconscious homosexuality. *Discussion under Sexual Disturbances.*

E 38: Aged fifteen, single, referred to the clinic by the juvenile courts as a hysterical psychopath, with theft, violence, and an impossibility to settle down to any kind of work. The question of whether he blackmailed older men after prostituting himself was put by the court but could not be proved. A rather callous and cold youth. He gives a history of seduction in a swimming pool at the age of nine. This case shows the strength of early induced and later conditioned homosexuality as an element of illness in the psychopath, but also the difficulty of a differential diagnosis of simple schizophrenia (cf. case E 47). *Discussion under Psychopathy.*

E 39: Aged twenty-two, single, on probation under the condition of psychiatric treatment, referred by the courts

as transvestist, exhibitionist, and homosexual. He was highly intelligent. There was little effeminization, and he showed the above impulses at varying times with various strengths. He very interestingly feels, whenever he dresses as a woman, a clear-cut heterosexual desire, but, on the other hand, as he expresses it clearly, "like a boy of twelve" if he masturbates in front of boys of this age and exhibits himself. Homosexual activities have been practiced by him without a break since his eleventh year. His father, an actor, was his major love object. This case shows the importance of induced immature sexual patterns and their exchangeability. *Discussion under Sexual Disturbances.*

E 40: Aged forty-seven, bachelor, reactive depression after the breakdown of a six-year long-lasting homosexual relationship. Effeminized constitutional homosexual. An asthenic, full of tensions and neurotic mannerisms. He gives a history of uninterrupted homosexuality since his thirteenth year. All potentials of homosexual intercourse, including sado-masochistic acts, are practiced by him. This case shows the role of depression in the homosexual and vice versa. Furthermore, the relative small importance of the variations in homosexual activities as such, irrespective of their very great importance as indications of underlying character formation. *Discussion under Depressions.*

E 41: Aged thirty-nine, alcoholic psychopath whose marriage broke up and whose violence, especially against his three children, brought him to the clinic via the courts. He refused point-blank any discussion about his personal circumstances and history. We only knew from his prehistory

that he served twelve years in the navy and army. He denies abruptly any kind of homosexual activity. To judge from his military papers, it is clear that he was continuously in difficulties and that a great number of anti-social activities were committed after alcoholic excesses (cf. case R 59). This case shows the role of alcoholism on the basis of a latent homosexuality or its substitution. His wife, however, maintains that he has not had any heterosexual intercourse over many years. *Discussion under Psychopathy.*

E 42: Aged seventeen, acute anxiety with impotence while love making with his girl friend. He admits massive mutual masturbation and homosexuality at the age twelve to seventeen. Explanatory psychotherapy soon brought back his heterosexual orgasm. This case shows the influence of conditioning processes still at work in the formation of orgastic disturbances and the repeated precipitation of acute anxiety states by such disturbances. *Discussion under Sexual Disturbances and Acute Anxiety States.*

E 43: Aged twenty-three, single, a typical engagement neurosis with acute anxiety. A long prehistory of mutual masturbation during his school years and masturbation with mixed homosexual and heterosexual fantasies. His major symptom was premature ejaculation. This case responded at once to psychotherapy and shows the role of mutual masturbation with strong anxiety and guilt feelings and the way in which these lead to premature ejaculation, also in heterosexual relationships, and, in turn, to orgastic disturbances, or vice versa. *Discussion under Acute Anxiety States.*

E 44: Aged thirty-nine, bachelor, referred to the clinic with chronic anxiety. Intelligent bookkeeper who lives completely alone and who maintains he is a mysogynist. He states he has no sexual activity whatsoever, not even nocturnal emissions. He admits, however, to rather vague homosexual fantasies which make him very anxious and depressed and which he feels he must completely master and repress. This case shows the role of homosexual fantasies leading to self-castration, which in this case seems to be the basis for his chronic anxiety state. *Discussion under Chronic Anxiety States.*

E 45: Aged thirty-four, married with two children, on probation, referred from the courts. He was a recidivist who stole female underwear and masturbated in it. As a child, he was hospitalized from the age of seven to fourteen with a bone disease, and during his hospitalization had massive mutual-masturbation and homosexual experiences. He also repeatedly observed during the night scenes of sexual intercourse of a heterosexual kind in his ward. His key event, however, was when, at the age of fifteen, he observed together with a workmate a servant girl undressing herself. Both got very excited and masturbated in each other's company. This scene remained of a compulsive influence, and he felt he had to repeat this rather immature and infantile act over and over again. This case clearly shows early conditioning, especially through premature sexual experiences in institutions, and the reinforcement of such events with mutual masturbation. Explanatory psychotherapy was very successful in this case, and he re-

mained free of further breakdowns for four years, to our knowledge. *Discussion under Sexual Disturbances.*

E 46: Aged twenty-seven, single, referred from prison to hospital with a rather severe prison psychosis—he was serving a two-year sentence for breaking and entering. He presented as an acute paranoid schizophrene. He had overt incest dreams and articulated these as being directed toward his mother, and fantasies about very active homosexual seduction attempts of a nonexistent man called Sam. Most astonishingly, during his acute illness, he wrote a number of extremely good poems which all referred to Sam. As he was completely uneducated and normally neither read nor understood poetry, these achievements remain quite unexplained. After successful treatment with high-dosage phenothiazines he remitted completely and became a rather kind but cunning trader type. A homosexual prehistory could not be gained from him, as he became completely vague and blocked whenever this subject was mentioned. Meanwhile, he married very successfully. This case shows the role of homosexual and incest (?) fantasies as precipitating factors in schizophrenic illness. *Discussion under Schizophrenia.*

E 47: Aged sixteen, referred to the clinic as maladjusted by the juvenile courts. A chronic anxiety state was diagnosed. A very perturbed family—the mother, an alcoholic who brought up four illegitimate children, every one of them from a different man. The patient was the eldest of these four. He was a male prostitute and a pimp. He was unemployable but of quite good intelligence. Sexual feelings

were more directed toward the females, and he preferred them for his own sexual activities. Nevertheless, he maintained his orgastic potency with men and he expressed this as—"from time to time having a bit of the other gives me a kick." In his case, innumerable childhood, prepuberty, and puberty experiences in a heterosexual and homosexual sense were the background of his conditioning, and his induction must be understood as having taken place in infancy in a more or less permissive environment. This case shows the role of early homosexuality and maladjustment in the juvenile delinquent (cf. Wyss's study on young male prostitutes). *Discussion under Chronic Anxiety States and Hysteria.*

E 48: Aged twenty, single, referred in chronic anxiety state, public schoolboy, father a high-ranking civil servant in the colonial service who lived most of the time abroad. Strong mother fixation. An athletic sportsman and very gifted artist. High intelligence but unable to concentrate on any kind of routine work so that he had lost, at the time of referral, some very good positions. He admits a history of regular mutual masturbation with other boys in preparatory school and an intensive homosexual relationship with a young teacher in his public school. This case shows the roll of conditioned homosexuality in the crises of maturation in late adolescence. *Discussion under Chronic Anxiety States.*

E 49: Aged thirty-four, a bachelor, a paranoid schizophrene. A vague but rather clear-cut history of prolonged homosexual activities in prepuberty with enormous guilt

feeling. Typically aggressive and hyperreligious. He lives exclusively with male companions. He denies most energetically all homosexual tendencies, but some of his most marked paranoid features show unambiguously their gross repression. This case shows the role of juvenile homosexuality as a trigger factor in paranoid illnesses. *Discussion under Schizophrenia.*

E 50: Aged thirty-eight, married, public school teacher, very severe acute-anxiety attacks brought him to the clinic. These attacks repeated periodically. He has been very strictly brought up by a very domineering mother. His father was mostly absent as he worked in the Indian Civil Service. He could be typed an asthenic and highly sensitive person, and clearly a constitutional neurotic. His anxiety states started usually with hypnagogic hallucinations in which elements of homosexual scenes were repeated, which played a role for many years in his preparatory school days. Explanatory therapy helped in this case only to a certain extent (cf. I 7 and E 48). Here, one can show the influence of prepuberty conditioning to homosexuality and its further development to acute anxiety states. *Discussion under Acute Anxiety States.*

E 51: Aged forty-nine, bachelor, referred with chronic anxiety state, a restless lecturer who shifts from one technical school to another. An eccentric, scurrilous personality. He maintains that his masturbation, which he practices nearly every day since infancy, must be the reason for his neurasthenia. A very vague history of mutual masturbation in school. This case shows the role of masturbation

as an anxiety-relief mechanism and the way it leads to addiction. *Discussion under Chronic Anxiety States.*

E 52: Aged sixteen, brought to the clinic in total collapse. The main symptoms were asthma attacks, which were followed by fits of fainting with clear-cut peripheral circulatory disturbances and double incontinence. The boy suffered from an enormous father fear and was completely blocked against any sexual activity or thought. Compare Goldstein's catastrophic reaction and Kretschmer's autonomic-reflex hysteria. He was neither psychotic nor epileptic, but shows the role of violent sexual repression leading to extreme anxiety states, panics, as well as the twofold psychosomatic disturbance as masturbation substitute. *Discussion under Borderline Cases.*

E 53: Aged twenty-seven, single, he presented himself in the clinic as homosexual and very strangely expected to be cured of homosexuality by one visit and in one interview. He was a quite normal masculine man, in no way effeminized. He was a bookkeeper who every night took a train from London to the provinces. He found over the years three different partners for homosexual activities during the train journeys, with whom he continued this practice three or four times a week over five years. He gives a history of mutual masturbation and homosexual activity in his preparatory school and public school. He lives with his mother and sister, who, he maintains, domineer him strongly. At the age of twelve, his mother separated from his father. From that time onwards, the father completely disappeared out of the life of the patient. He complained

about his homosexuality because he recently met a very nice girl in his office with whom he wanted to enter into a much more intimate friendship, but it became clear to him through this that he had no heterosexual interests. It was found that, in the years of conditioning, he had become a constitutional homosexual. Psychotherapy, which was offered to him, lasted through three interviews. As he quite honestly felt after these that he does not wish to give up his homosexual activities, this case shows how easily early conditioned homosexuality can lead to a firm disposition. *Discussion under Sexual Disturbances.*

E 54: Aged thirty-one, married, referred to the clinic with severe depression. He was totally impotent with normal intercourse but absolutely potent while having anal intercourse with his wife. She was a very neurotic woman herself and not only allowed the patient to have anal intercourse but even agreed to have lesbic intercourse with another woman in his presence. Both husband and wife showed phases of very severe depression. Patient reports a very unhappy infancy and childhood. His father died when the patient was four years old, the second marriage of his mother was not a happy one, and the stepfather disappeared after leaving the mother with another son. He gave an early history of mutual masturbation with his young half-brother, and gives very extensive descriptions of his semi-incestuous relationship with his aunt, the younger sister of his mother who was roughly twenty years old, while he was fourteen. He was a very successful businessman, a great perfectionist, and in spite of a high in-

telligence, his anal character structure made insight very difficult, but he slowly began to accept himself and understood his symptoms to a certain extent. Both husband and wife were under treatment for quite a while, and their relationship became better. In fact, after the birth of their first child, both seemed to settle down quite harmoniously. This case shows the role of the anal character in the sense of Wilhelm Reich in the causation of depressive illnesses and the projection of an unacceptable homosexuality and anal perversions onto the female partner. *Discussion under Depressions and Sexual Disturbances.*

E 55: Aged twenty-three, single, depression in a passive homosexual. Homosexuality has been practiced by him since his ninth year. He was very masculine looking, in no way feminized, but considered himself a constitutional homosexual. His depressions came in cycles at times when he could not find any suitable sexual partners and, usually, also after a hypomanic period when he was sexually overactive. Depression usually tailed off these cycles. He was a classical unfaithful homosexual who did not tolerate lengthy relationships. In some way, he showed very clear-cut anal-perfectionist features. He declared at the very first interview that he only wishes his depression to be treated, as he was in no way willing to change his sexual direction. This case shows the role of anal-character formation in a homosexual and equally in the formation of depressive illnesses (cf. case E 54). *Discussion under Depressions.*

E 56: Aged sixteen, single, he came to the outpatients' clinic with reactive depressions and anxiety hysteria. He

was a mildly feminized constitutional homosexual, only interested in passive homosexuality. At the age of seven he began mutual masturbation and homosexual play. At the age of thirteen he was introduced in a north-Irish town into homosexual circles and became an amateur prostitute. He was not really interested in the financial aspect of prostitution but only in the endless repetition of passive homosexual excitement. In him, the histrionic aspect of the homosexual secret society was clearly expressed, and the endless jealousies and emotional crises were the content of his whole life. He was reported to be a very good clerical worker. He attempted suicide three times. From his childhood history, it was learned that he lost his mother at the age of six and could under no circumstances accept his stepmother. His intelligence was high. This case shows the role of early induction in childhood, massive conditioning in adolescence, as well as the predisposed neurotic personality in the make-up of the constitutional homosexual. *Discussion under Depressions, Hysterias and Sexual Disturbances.*

R 57: Aged seventeen, a hysterical psychopath, the typical "Teddy Boy" of low social grouping and rather inadequate intelligence. He complained about his massive irritations and uncontrollable tempers and rages. He was very violent with his pregnant girl friend, aged sixteen. Extremely good-looking youngster who gave a history of being seduced by a seventeen-year-old girl when he was eleven. He maintained—and probably quite truthfully—that since that age girls chased him in great numbers. He

also reports several rape scenes whereby, on at least three occasions, several boys forced girls in parks to have sexual intercourse with the boys present, with all observing their sexual activities. All attempts at treatment were without success, and his voluntary entry into the army lasted about three months. He was very vague in regard to homosexual activities but admits that mutual masturbation has happened at times. This case shows clearly the role of the psychopath, the masked forms of latent homosexuality in rape scenes, but also the direction toward heterosexual feelings and desires being conditioned early on by heterosexual intercourse. Unfortunately, he was also conditioned by a great amount of sadistic explosions. *Discussion under Psychopathy.*

R 58: Aged fourteen, referred to the clinic from the school authorities with acute anxiety and total decline of his school performance. Red-haired, normally developed youngster who blushed very easily. Father and mother have been separated for about eight years; the patient lives with his mother and a mentally defective sister three years younger than himself. Very nervous child, nail biter and bed wetter up to his ninth year. At the time of referral, he was overattached to a young unmarried vicar, with whom he went sailing at least once a week. In this case, one could show the role of masked homosexuality in the overattachment to a man old enough to act as a father substitute. Further, it shows the importance of sexuality as a primary agent for the production of anxiety and the preoccupation with sexual matters as an element in the breaking up of

social achievement in puberty. He responded very well to gentle guidance and an understanding of the sexual aspects of life. *Discussion under Acute Anxiety States.*

R 59: Aged thirty-six, divorced, referred from the courts as an aggressive psychopath. He was on probation after having spent at least seven periods in jail. He was an alcoholic who stole motor cars, invited boys at the age of twelve to fifteen on trips. During these trips, he usually burgled shops, drank with the boys, and, in the state of multiple excitement, used them homosexually. This was the fourth case of that pattern in two years. He was of very good intelligence, the son of a headmaster who died when the patient was nine. He admits, however, that before his father's death, he was already in trouble at school for theft of bicycles and other minor criminal activities. He adopted firm mutual-masturbation and homosexual habits from the age of twelve in boarding schools, reform schools, and from the age of seventeen aboard merchant navy ships. He was sent home on several occasions from several outposts of the empire when he was found out doping race horses and involving himself in drug traffic. After four months of treatment, he repeated the pattern as described above and was sentenced to a very long term in prison. This case ideally shows the psychopath and the role of homosexuality in the psychopath. *Discussion under Psychopathy.*

R 60: Aged eighteen, referred with acute-anxiety hysteria. This began promptly at his engagement. He started to wet his bed and showed a whole spectrum of hysterical conversions. His first attack happened two years before his

referral—the patient was then sixteen—at the marriage of his three-year-older brother. His father was termed by him "a psychopath," and the patient was totally fixated to his mother. He had complete amnesia and absolute vagueness in regard to the relationship with his brother, with whom he shared one bed up to his marriage. *Discussion under Hysteria.*

R 61: Aged twenty-nine, single, a simple schizophrene. A clear prehistory could not be elicited. He tramped around without any volition and more or less accidentally landed in homosexual circles. His homosexual drives were in no way clearly marked, and altogether his sexual activities were, so to say, fragmented. He practiced mutual masturbation but even that only rarely. In his case there was a family history of schizophrenia. *Discussion under Schizophrenia.*

R 62: Aged forty-eight, married, he complained about his impotence. He admitted mutual-masturbation friendships in his puberty, but in this case it became clear that he was a biologically weak man on whom an involutional element was superimposed. In fact, the mutual-masturbation element did not appear to be very essential in his case, and he responded successfully to medical treatment of the depression and the administration of Methyl-Testosterone. *Discussion under Involutional Depressions and Sexual Disturbances.*

R 63: Aged seventeen, referred from the juvenile courts with exhibitionism. He masturbated in a cinema in the presence of a middle-aged woman. A borderline case of

mental deficiency and very low I.Q. He was an illegitimate child who had no understanding or sympathy from his adoptive parents. He was quite clearly a terrorized liar who could not be made to give a credible history. He refused any discussion about his sexual development or his early history. *Discussion under Subnormality and Sexual Disturbances.*

R 64: Aged twenty, single, he complained about his homosexuality. He appeared to be a male prostitute who was on the verge of being prosecuted by the police as he, true to type, very likely was attempting blackmail. He was a fully conditioned constitutional homosexual. His prehistory showed that he shared his bed from the age of eleven to seventeen with his slightly older brother, and that he had complete homosexual intercourse with him during this period. His desire to be cured was lost after two visits. *Discussion under Sexual Disturbances.*

R 65: Aged twenty, single, referred with severe psychogenic asthma attacks. He was a classical example of the autonomic-reflex hysteria in the sense of Kretschmer. He was totally fixed to father and mother. A motor mechanic with I.Q. of 125. He showed certain hysterical features, most of all a dissociated blandness. He had mild breathing difficulties in early childhood, but his asthma began seriously at the age of nine when his father, who at that time was under treatment as a paranoid schizophrene, took the boy into a tool shed, stripped him naked, and beat him mercilessly for what appears to be a very small disobedience and, worst of all, in front of the child killed his favor-

ite cat. Life in the house is described as an endless battle between father and son, and any increase in the tension of this ambivalent love-hate relationship led regularly to very severe asthma attacks. There were already apparent signs of physical damage to his bronchi.

His relationship with his slightly older brother remained very vague and undefined in spite of prolonged and intensive psychotherapy. The patient denied any kind of homosexual feelings or play at any time but became visibly disturbed whenever this theme was mentioned during discussions. At the age of fourteen, he followed a boyfriend to an Irish boarding school at his express wish and remained there for about two years. At the beginning of psychotherapy, he masturbated daily, sometimes as often as three times. This in itself is a good example of the role of masturbation as anxiety-relief mechanism and also shows the importance of severely repressed juvenile homosexuality as well as the trauma by his father in the precipitation of hysterical and deep-seated psychosomatic reflexes. *Discussion under Borderline Cases.*

R 66: Aged twenty, single, referred in acute anxiety state. A case of a narcissistic adolescent whose tension and anxiety states drove him to pseudo-suicides. He was a scenic painter with quite good talent who worked at the theater. He hails from a very perturbed, very snobbish, middle-class family. He had a rather strange relationship with a fifteen-year-old girl with whom he lived, with the connivance of her mother, especially at all times when the circumstances in his own home became unbearable. He

was brought up in Japan and Malaya, changed his schools continuously, and had innumerable substitute-mothers and-fathers whenever his parents separated and mistresses or lovers appeared on the scene. He admits having adopted masturbation very early in childhood, roughly at the age of three or four. He denies most energetically ever having had any homosexual feelings or experiences. Nevertheless, his behavior and his whole appearance were mildly effeminate, and his very strong narcissism as well as the endless repetition and exaggeration of his sexual potency in regard to his girl friend showed that this was only a secondary adjustment to a rather deep-seated personality disorder. This case shows, in the sense of Reich, the early character formation—in this case a narcissistic one—and probably kept going as a preventive mechanism against badly repressed homosexuality. *Discussion under Acute Anxiety States.*

R 67: Aged twenty-three, single, a Persian Jew who was baptized in the Christian faith, referred in acute anxiety state. He lived roughly one and a half years in England to finish his education as a radio engineer in the technical college. He described his Jewish father as brutally patriarchal, who dominated and ruled his family with an iron fist. The patient was the eldest of three children, the younger two being girls. The father is described as having a practically insane ambition for the son, which led the boy at the age of twelve to a suicide attempt. He suffered from an enormous degree of masturbation guilt and admits mutual masturbation and homosexual play in puberty. He denied most violently any homosexual tendency and went into great detail

in regard to his experiences with girl friends. He responded somewhat to explanatory therapy. *Discussion under Acute Anxiety States.*

R 68: Aged thirty-nine, single, referred with obsessional neurosis. This was most preponderant in the presence of his mother, when he broke out in compulsive swearing. By profession, a barman of low average intelligence and mildly alcoholic. He is a good example of a mother castrate. In spite of all advice which had been given to him throughout psychiatrical treatment lasting practically twenty years, he could not tear himself away from his mother, who was now seventy-six years old. He maintains that he masturbates from time to time, denies energetically all homosexuality, and has been trying over the last fifteen years to find "the right woman" through marriage bureaus. This case shows the role of mother castration and the formation of compulsive obsessional patterns by massive incest anxiety. *Discussion under Obsessional Neuroses.*

R 69: Aged thirty-nine, married (second marriage), referred in acute anxiety state. He suffered from massive masturbation guilt. This situation was the more perturbing for him as his masturbation fantasies related to his twenty-three-year-old stepdaughter. History of prolonged mutual masturbation in puberty and prepuberty is given by him, and he describes himself as overburdened by guilt feelings throughout his life. As long as his sex life functioned normally during the first two years of his marriage, he remained well adjusted, but the moment he again took to

masturbation in early middle age, his acute anxiety state at once broke out. *Discussion under Acute Anxiety States.*

R 70: Aged thirty-three, single, referred to the clinic and later hospitalized with an exacerbation of his obsessional neurosis, which paralyzed him increasingly for the last fourteen years. His illness began at the age of nineteen. He then had to give up his work as a coal miner, as he could not tear himself away to lose sight of gas- or water-taps, and it became impossible for him to cross roads. He then got a severe hypochondriasis, which progressively developed into a complete delusional psychosis. He was absolutely certain that he was dying of cancer. During the fourteen years of his illness, he had been treated with all known physical, medical, and psychotherapeutic methods by a great number of psychiatrists, and he was finally leucotomized—none of these methods showed any success.

The early history of this patient is of the greatest theoretical interest. He slept all through his childhood in the same bed with his brother, who was two years older, and practically from childhood onwards up to his eighteenth year of life had regular complete homosexual intercourse with him. It seems most remarkable that his illness broke out less than a year after his separation from his brother. Also of interest is the fact that his brother is a very happily married man who, however, is very warmly interested in the patient. The father, also an old retired miner, is a very neurotic man who, after the death of his wife (the mother of his sons), is completely under the influence of the patient

and, in some of the obsessional neurotic symptoms, has already developed a *follie a deux.* This case shows the role of intensive and prolonged incest experiences in the formation of obsessional neuroses, and also shows the prepsychotic basis of this illness. *Discussion under Obsessional Neuroses and Schizophrenia.*

R 71: Aged nineteen, prehistory of mutual masturbation and homosexuality during school days. Grandiose exhibition of girl friends and masturbation fantasies on a heterosexual basis but clearly a case of hebephrenic schizophrenia. He shows no deep-going sexual interests and is a very good example of the goalless, fragmented sexuality of the schizophrene which, in the best of cases, expresses itself in undirected, merely physical, masturbation. *Discussion under Schizophrenia.*

R 72: Aged fifteen, I.Q. 68, referred from the juvenile courts in respect of truancy from school and gang violence. It was impossible to persuade him to do any kind of work. It was equally impossible to get any kind of history from him, but he described himself, and was also stated by his parents to be, of high moral character. During his gangster period, he disappeared sometimes for as long as three day and nights with younger boyfriends and lived in tents or old disused houses, or slept in forests or on the beach. He has never developed any kind of friendship with girls. This case shows the role of badly repressed homosexuality in puberty leading to violence and showing off as part of the prolonged gangster state. *Discussion under Mental Subnormality.*

R 73: Aged eighteen, paranoid schizophrene. He shows the intensive religiosity of a sectarian Protestant. Very good I.Q. of 120. His symptoms were delusions with ideas of reference and persecution from his colleagues and the devil. Concomitant with treatment of high-dosage phenothiazines and E.C.T., intensive and continuous psychotherapy was given. During the latter, three main factors crystallized:

1. usual history of masturbation and homosexuality during his school time
2. mainly incest-masturbation play in his thirteenth year of life with his eight-year-old sister
3. a hyperreligious father, a sectarian, with whom the patient remained all the time in a very ambivalent relationship.

His masturbation fantasies showed preoccupation mostly with nine-to-eleven-year-old girls and quite clearly showed a fixation to his sister at the age when he made his incest attempts. He also described in great detail two attempts of somewhat older men to persuade him to homosexual intercourse while he was living in London as a lodger during the last year before hospitalization. This case shows how, in the schizophrene, all sexual experiences influence the content of their symptoms in the sense of a general conditioning process. *Discussion under Schizophrenia.*

R 74: Aged twenty-seven, married, referred with impotence. A severe hysterical illness broke out two years after his marriage with pseudo-impotence as the main and remaining symptom. Anamnesis showed mutual masturba-

tion from the age of eleven to sixteen, and further on, active homosexual friendships in the army at the age of eighteen to twenty-three. Intensive psychotherapy helped this very intelligent baker to a complete acceptance and insight into the factors of his homosexual background, and he became sexually completely potent without further disturbances. *Discussion under Sexual Disturbances.*

R 75: Aged thirty, married, seven years under psychiatric treatment and diagnosed as a psychopath. An illegitimate child, a weak, whining, uncontrolled man. For many years he was an active male prostitute of the occasional type. His marriage is on the verge of breaking down. He is unemployable, has depressions; suicide attempts are his usual reaction to any kind of stress. *Discussion under Psychopathy.*

R 76: Father and son, aged forty-two and fourteen. Fa-
R 77: ther referred with chronic anxiety state. His marriage is not very happy, with intercourse only every two or three months. Prehistory showed anxiety states since infancy. He always suffered severe guilt feelings after masturbation and was completely unable to give any homosexual prehistory. He spent four years as prisoner-of-war in Germany and, on one occasion, was beaten up very badly when he was caught while trying to escape. Modern medication and normalization of his sexual life helped considerably. *Discussion under Chronic Anxiety States.*

The son was a high-grade mental defective and came into the juvenile court on account of stealing women's underwear, in which he masturbated. The boy suffered from

severe panic attacks. In several interviews, father, mother, and son were given explanations for these fetishistic activities, and it was attempted to convince them as a group that one must accept masturbation without anxiety and guilt feelings as a normal outlet in a boy of his age. The boy also gives a history of mutual masturbation and homosexual play in school. *Discussion under Subnormality and Sexual Disturbances.*

R 78: Aged thirty-one, single, referred with hysteria. A successful owner of his own building firm, he was a former boxer in the army and a cunning show off. He shows bizarre hypochondriacal symptoms, which brought him to numerous neurologists, surgeons, and other specialists. He bragged about innumerable relationships with girls, the typical Don Juan who fundamentally despised all girls. He lives in the same house with his mother and an asthmatic invalid brother. Whenever one of the more energetic girl friends threatens him with marriage, he responds at once with severe neurological illnesses. He mentions, in a later psychotherapeutic attempt, the possibility of one form or another of mutual-masturbation relations with his brother. However, any firm memory is impossible. He was disgusted with the idea of having had, in any shape or form, any masturbation or homosexual relations with other men. During his military service, he was a corporal in the Medical Corps and, in fact, was in charge of a clinic for venereal disease in Germany. He showed quite a good standard of medical knowledge, especially of the male sex organ. An important part of his personality was a very marked nar-

cissism. He responded relatively successfully to psychotherapy and, at least during the last 2 years, lived only with one girl friend. *Discussion under Hysteria.*

R 79: Aged twenty-seven, engaged, son of a mining family from Wales. He had gross paranoid delusions and maintained that he stank, especially exuding a fecal smell. He expressed severe masturbation guilt and gave a history of homosexual incest with his brother at the age of nine to twelve (cf. cases I 11, I 20, A 118). The breakthrough of his schizophrenic illness coincided with his attempt to have intercourse with his fiancée. He responded very well to massive medical and electric treatment as well as psychotherapy. *Discussion under Schizophrenia.*

R 80: Aged twenty-two, divorced, a psychopathic personality with paranoid schizophrene elements, referred by the courts on account of nonpayment of alimony. Prehistory shows active and passive homosexuality in school and during National Service in the army. During the last five years, he was hospitalized on three occasions with a diagnosis of schizophrenia. The psychopathic symptoms show homosexual and sadistic content. It was difficult to differentiate the psychopathic personality features from the psychotic ones at times. Strangely, however, the patient, during his psychotic periods, showed clear heterosexual direction, whereas during remissions, homosexual features demonstrated his return into psychopathy (cf. case E 32). *Discussion under Paranoid Schizophrenia and Psychopathy.*

R 81: Aged thirty-five, single, epileptic psychopath with a slowly progressing brain-stem atrophy. A pedophile, an

addicted masturbator, who seduces children of both sexes. A questionable occurrence of intercourse with animals has also been mentioned in the early history. Massive medical treatment, especially with Orphenadrine, phenothiazines, and barbiturates showed success to such an extent that it was possible to send him to a rehabilitation colony for just such cases. *Discussion under Borderline Cases.*

R 82: Aged fifty, divorced, referred by his general practitioner on account of chronic anxiety state. He married at the age of thirty-five but could not tolerate his marriage, so that after one year a separation was sought, and a divorce followed. He maintained that his palpitations, severe tension states, the dysfunction of his viscera, began with his marriage. He was a typical restless bachelor, a suspicious personality, full of paranoid reactions, of gross hypermorality. He denied violently any masturbation and found homosexuality disgusting. An attempt to clear up the history of his marriage was extremely difficult, but there remains no doubt that the very idea of having sexual intercourse with a woman, in this case even his wife, evoked in this predisposed personality massive anxiety states. *Discussion under Chronic Anxiety States.*

R 83: Aged twenty-eight, single, classical simple schizophrene. History of ten years' illness. He gave an early occurrence of mutual masturbation and homosexuality in his school days. His volition was so destroyed that the patient showed, according to the famous dictum, "only the outer hull of normality and nothing behind it." In this case, the sexuality played a very small role in both his personality

and in the process of his illness. *Discussion under Schizophrenia.*

R 84: Aged twenty-two, single, acute anxiety state. He reports duodenal ulcers, attacks of gross sweating. He also had a very sensitive skin; dermatographia was easily demonstrated. He denies any homosexual feelings but is totally unable to find any relationships with the other sex. At later psychotherapeutic attempts, he admitted a mutual-masturbation occurrence at one time and two homosexual events with friends with whom he spent some nights in a youth hostel. *Discussion under Acute Anxiety States.*

R 85: Aged sixty-seven, married, referred in reactive depression, very rare case of a man who, at this age, admits that he secretly practiced homosexuality since he was a young soldier in the First World War and was seduced by the officer whose batsman he was. In fact, this homosexual relationship lasted during four war years. Nevertheless, the patient was married twice and states that he had numerous guilt feelings and massive anxieties, which were coupled to his secret homosexual fantasies. He maintains that the homosexual impulses are the reason for this partly involutional, partly reactive depression (cf. additional case Z 8. 126). *Discussion under Depressions.*

R 86: Aged thirty, single, referred with chronic anxiety state. Young farm laborer of normal appearance and physique, living with his mother, to whom he is strongly fixated, and also with an unmarried brother. At the age of twelve he was seduced by his uncle in the chicken run to a complete homosexual intercourse. He had never had any

female company and lived with a group of bachelors varying in age from twenty-five to fifty in a rather isolated rural community. He stayed behind with his forty-two-year-old friend roughly once a week in a club house and regularly had mutual masturbation or intercrural intercourse with him. The symptoms of his illness were nausea, anorexia, and panic attacks, especially when entering restaurants or other public buildings. He is the classic "naive" homosexual. Therapeutic attempts to correct his sexual direction had, up to the present, remained without success. Although he responded to symptomatic treatment and reassurance at times, he nevertheless needed a few months' stay in a hospital to overcome some of his major symptoms. *Discussion under Chronic Anxiety States.*

R 87: Aged twenty-one, single, a young miner, an adopted child but giving no relevant traumata of his childhood. His breakdown occurred after a rather heavy injury in the mine, which was followed by an injury neurosis. The suspicion that this could be related to a compensation neurosis was never proved. The patient admits some mutual masturbation in his school years but, at the time of referral, had regular sexual intercourse with girl friends, mostly in the house of a workmate who has intercourse, as he says, at the same time but in another room. His prolonged back pains, which quite often prevented him from working, could not be cured in any way, and it was also very doubtful, in spite of massive X-ray investigation, whether a clear-cut organic basis for the pain could be shown. Extensive psychotherapy, in which the correlation

between his illegitimacy and probable defects of sexual adjustment in later puberty have been thoroughly discussed, led to quite a substantial improvement. *Discussion under Borderline Cases.*

R 88 and R 89: Two brothers, twenty-three and sixteen. The elder brother was married; his illness has been diagnosed as acute anxiety state in a schizoid personality. The marriage was rather perturbed, and he masturbated quite frequently with rather mixed hetero- and homosexual fantasies. A prehistory of mutual masturbation and homosexuality has been given by him.

His sixteen-year-old brother showed a clearly marked sexual disturbance. He broke down regularly after masturbation with severe stomach pains, which led to colic and collapses. He, too, was thought to be a schizoid personality, very shy, somewhat withdrawn, and apprehensive. He, too, gives a history of mutual masturbation at school. The possibility of some incest play between these brothers has been most violently denied by both. *Discussion of these cases under Acute Anxiety States.*

A 90: Aged thirty, married, after his referral, hospitalized and diagnosed in hospital with malignant anxiety hysteria. His panic attacks were combined with tremors, complete weakness, inability to stand, and collapses. He was unable to keep himself at work and to support his family even with very light hotel work. His father died when the patient was eight years old, and the mother died a few years ago in a mental hospital, where she had been under certifi-

cate since the patient was eleven. His foster parents maintained they could not control him, so that after half a year he had to be brought into a Catholic reform school. Minor thefts were his major crimes in childhood. He married a woman who was also under treatment with severe hysteria. During their three years of marriage, the couple had no sexual intercourse whatsoever, and the patient masturbated daily. It was incredibly difficult in this case to elicit a sexual prehistory. Only after the fourth interview did the patient give the usual history of massive mutual masturbation and homosexual activities, which lasted through his school time and later in his work in hotels as page boy and room waiter. He denies, however, any homosexual practice during the last five to six years. *Discussion under Hysteria.*

A 91: Aged forty, married, a borderline case between mental deficiency and very low average intelligence. He was referred by the courts to the clinic as he solicited in public lavatories other men to mutual masturbation. His wife has been hospitalized on three occasions for several months with a schizophrenia. Strangely enough, their sixteen-year-old daughter is of very high intelligence and got a grant for a grammar school with reasonable prospects of entering a university. The patient was an illegitimate child and grew up in the country. He only remembers masturbating by himself during his school years. As a boy of sixteen, he went into the army and was seduced by his sergeant to homosexual intercourse, a practice which was repeated regularly over two years, and during which all possible variations and perversions were practiced. He mar-

ried at the age of twenty and, during the first years of marriage, he had neither homosexual intercourse nor mutual masturbation. He maintains that he was only seduced again when his wife had to go to the mental hospital for the first time. This was done by a much younger workmate with whom he practiced mutual masturbation over many years. When his colleague left the factory and moved to another place, the patient began to search in public lavatories for new partners. He was detected very quickly by the police. After the return of his wife, a return to normal sexual intercourse was more or less forced upon him by very direct psychotherapy, and during the last two and a half years he has not fallen back, as far as one knows, on homosexual practices. *Discussion under Sexual Disturbances and Mental Deficiency.*

A 92: Aged forty-one, radio operator, married with two girls, aged fifteen and eleven, referred to the clinic with acute claustrophobia. He found it impossible to use underground trains and had fainting fits and had to leave trains whenever he had to travel by underground. This history was given to be a consequence of his war service—after a four-year period as prisoner-of-war which finally led him to Berlin, where he was liberated in 1945. Born in an Irish village, he was one of four children and remembers only some "innocent" play with sister at night time. He began to masturbate at the age of thirteen and was very much frightened of masturbation as, by that time, his eldest brother had become a priest. His upbringing was of the most strict Catholic order. Nevertheless, at the age of four-

teen he was befriended by a nineteen-year-old laborer who, over four years, had regular complete homosexual intercourse with the boy where the latter usually acted as passive partner. He was also regularly given a substantial sum of money for this. He maintains that this was very frightening and shame making to him.

A highly intelligent man, he went through technical college, where he perfected his trade as radio operator. At the age of nineteen, he joined the merchant navy, as war had broken out during that period. He was torpedoed once and later on—after about a year—was taken prisoner-of-war. He states truthfully that he had no homosexual intercourse either in the merchant navy or for four years as prisoner-of-war. However, during the very last months as prisoner-of-war, he and a very good friend suddenly began a very intensive homosexual relationship which lasted for a few weeks until the liberation. His first attack of claustrophobia and other rather severe neurotic symptoms were naturally blamed on the prisoner-of-war time, and he was given a 100% pension. He returned for a year to Ireland, sometimes had intercourse with prostitutes, returned to England, found a very well-paid job, and married. The marriage was considered by him to be happy, intercourse was normal but slackened off after the children were born. Shortly after the birth of the second child, he became terribly restless, frustrated, complained about massive tension states, headaches, and the only remedy proposed by him and his medical adviser was to return to sea. He did so, stayed in Canada, and in fact, all in all, spent three and a half years away from home. On his return-journey home,

staying at a New York Y.M.C.A., he met a man, slightly younger than himself, who had the room next door to him, during a shower bath. They immediately felt an enormous attraction to one another and had one night together in which complete homosexual intercourse occurred, where both alternated as active and passive partners.

He agreed at once that his first argument, that this was for lack of finding a woman, is patently nonsense, and he agreed that his tension state and acute neurotic symptoms, especially the claustrophobia, have a direct bearing on his mounting homosexual urges, which he tries to repress most violently. He maintains he has never been able to give this history in full to anybody—not even in confession. He responded rapidly to psychotherapy, and his symptoms began to dwindle. *Discussion under Acute Anxiety States.*

A 93: Aged thirteen, referred from the juvenile courts on account of attempted rape of a nine-year-old boy, the patient played truant and stole. He has a low I.Q. bordering on subnormality. Oldest of six children whose father died suddenly a year ago. His brother, next in age, eleven, practically shows the same symptoms. The boy admitted that all the children had massive sex play, which was always done secretly and at night and involved practically all of the brothers and sisters. He also gave a history of mutual masturbation in school and of one homosexual seduction at the age of twelve by a somewhat older boy. His delinquency and truancy really only came to the fore with the complete breakup of the relative security of the family by the sudden death of his youngish father, which at once led

to manifold uncontrolled rebellious reactions, of which stealing, lack of sexual control, and destructive behavior were only a part. The boy responded very well to admission into a special children's home and has been reported as having settled perfectly normally. *Discussion under Subnormality and Sexual Disturbances.*

A 94: Aged forty-two, married, recurrent referral to outpatient clinics with severe chronic anxiety states. The patient was dismissed from the army as a psychoneurotic with a 20% pension. At the start of his second marriage, his acute anxiety states recurred. During his first marriage, the patient had been totally impotent, which led to his divorce. He remarried after he had informed his second wife of these circumstances. She was the widow of a sex maniac who, after many years in prisons and Broadmoor institutions, committed suicide. As this woman was strongly traumatized by the uninterrupted attacks of her first husband, she very eagerly agreed to remarriage in these circumstances. The patient was brought up by his mother alone, as his father died before his birth at the end of the First World War. He was an only child whose extremely strict and rigid mother brought him up practically as a girl. He was never allowed to go out and never allowed to play with other boys. In spite of long discussions and manifold attempts to elicit any kind of sexual activities or even feelings in the patient, this very long-lasting psychotherapeutic attempt clearly showed that he credibly stated never in his life to have had any sexual activities, which included not even nocturnal emissions or pseudo-masturbatory activities.

He must, without doubt, be designated as the completely successful mother castrate. His genitals were perfectly normal. *Discussion under Chronic Anxiety States.*

A 95: Aged thirty-six, married, the patient appeared as a clearly marked schizoid personality, asthenic physique, multiple depressions and many signs of acute anxiety states. He was an author and a poet from overseas who lived in his own country abroad for seven years as a hermit in a mountain hut. Prior to his referral, he had several admissions to mental hospitals. The marriage of his parents showed many severe disturbances; the father is described by him as an intolerant patriarch whose will could in no way be disobeyed. From the age of eleven, the patient suffered from overwhelming masturbation guilt, which was accompanied by acute panic attacks. He admits that he had early sex play with his brother and sister. Although he is completely potent in his marriage and momentarily shows no overt homosexual feelings, he maintained that all during his life he has masturbated with mixed homosexual and heterosexual fantasies. Especially with respect to his very long seven-year-withdrawal period, it was found very difficult to diagnose this case clearly. The patient was finally admitted to the hospital as a borderline case of a schizophrenie-form illness with acute anxiety state. *Discussion under Acute Anxiety State.*

A 96: Aged nineteen, hospitalized at once with acute obsessional neurosis. His I.Q. bordered on subnormality. His obsessional ideas, preoccupations, and ruminations revolved around knives, violence, and the unabated anxiety that he

could suddenly murder somebody. In his early history there was some sex play with other children of both sexes, an overwhelming anxiety state following these, especially as his father was described by him as very intolerant and aggressive. All this was reinforced in puberty when he, on at least six occasions, entered into mutual masturbation and homosexual relationships with other youngsters. Psychotherapy enabled him to return quickly to a normal working life, and it was in fact possible for him to enter into new friendships, mostly homosexual ones, without guilt feelings, and his obsessional ideas virtually disappeared. *Discussion under Mental Subnormality and Obsessional Neurosis.*

A 97: Aged thirty-nine, bachelor, the patient appeared in the clinic with a mixture of acute anxiety states and severe paranoid reactions. He suffered strong panic attacks which repeated with the accuracy of a barometer every time his very prolonged friendships with girls reached the point of sexual activity and therewith the danger of an impending marriage. There was clearly a great amount of dissociative illness in this case, as he showed a well-nigh complete amnesia in regard to any occurrences of his childhood right up to late puberty. During the interviews, he was always just on the verge of remembering important events but just as regularly blocked them out. It was slowly worked out that he masturbated with homosexual fantasies, and he also maintained some vague memories in regard to the thirteenth year of life of having had homosexual play with a younger boy. The same homosexual play is vaguely re-

membered as a possibility between himself and his somewhat older uncle when the patient was seventeen. Nevertheless, he could give no details at all—he only knew that something of the kind had happened. He lived in complete social isolation in a very derelict hut for three years after the death of his mother, in some neglect. He was of high intelligence and adjusted himself very well to his rehabilitation courses and training. In his case, one could only really expect a total adjustment if he would be able to find a somewhat older mother-image. *Discussion under Acute Anxiety States.*

A 98: Aged eighteen, an imbecile with I.Q. 50, referred from the juvenile courts with theft and bestiality. He responded very well to sex-repressive medication like Stilboestrol and tranquilizers like Thioridazine, but was potentially a rather dangerous case if sudden sexual stimulation should arouse him. He described, for instance, that in spite of his intercourse with cows and pigs, he went into maniacal furies with violence when, on one occasion, a homosexual man tried to seduce him. *Discussion under Mental Subnormality and Sexual Disturbances.*

A 99: Aged twenty-seven, married, hospitalized with severe obsessional neurosis. A schizoid personality whose phobias and panic attacks began at the age of twenty-one while serving with the army in Austria. There he had a secret love affair with the wife of his sergeant, which suddenly brought on his acute panic attacks. With that, his venereophobia developed rapidly, leading to his discharge from the army. After a four-year period of a good and

normal marriage and the birth of his two sons, he again suddenly became totally wrapped up in his obsessional ruminations and anxieties. He became unable to go to work at all, and after months of unsuccessful treatment, had to be hospitalized. After a high-dosage phenothiazine course, he became more amenable to a deeper psychotherapeutic attempt. He then gave the history that the real cause of his overwhelming panics, attacks, and obsessions were the incessant homosexual fantasies which he tried to repress but which were much stronger than his repressive abilities. From his sixth up to seventeenth year of life, he slept in the same bed with his brother, who was one and a half years younger than himself, and with whom he initially had regular masturbation play; but this relationship led in later years to regular complete homosexual intercourse in which both brothers reached orgasm. When his brother left home, he continued his homosexual activities for two years with a school friend, until at the age of nineteen he entered the army. All through these years, he suffered severe guilt feelings and anxieties, which more or less absorbed themselves to any kind of sexual activity with such strength that even his secret heterosexual love affair triggered off a wave of acute anxieties and phobias.

Of special interest here is the appearance of venereophobia, which so frequently masks badly repressed homosexuality. Improvement after treatment was really astonishing. He learned to accept his conditioned homosexuality in his personality structure and recognized that this in no way contradicted regular and successful marital intercourse. He adjusted to a very good career as a traveling

salesman. His I.Q. was 135. *Discussion under Obsessional Neurosis.*

A 100: Aged twenty-five, single, referred from the Skin Dept. with severe eczema, which did not respond to any of the modern methods of treatment. The supposed cause of his recurrent skin disease was a reaction to any stress, and that finally led to referral to psychiatry. He was a blond giant of extremely good exterior, with I.Q. of 130. He was the son of a high-ranking police officer. He describes a very deep-going mother fixation, but also very positive and good relationship to his father, who was in no way rigid or a strict personality. His major trauma in childhood is his very intensive jealousy toward his two-year-older brother. He denied, however, having at any time homosexual feelings or urges and gives a long Leporello list of numerous short-lived relationships with girl friends since his sixteenth year of life. The patient was working at the time as farm laborer but usually lived a tramp's existence, sometimes working for a circus, sometimes on boats with the merchant navy, and in similar occupations, all of which are in complete contrast to his excellent education, his social status, and his intelligence. He blames his eczema, which obviously was carried over from an infantile eczema, for all failures and disappointments since early childhood. On account of the eczema he was refused by the navy and the air force, and he lost the possibility to join a big oil company. It is probable that here one deals with a vicious cycle. His description of his early sexual experiences was very vague, and he maintained even during years in public

schools never to have entered any kind of homosexual friendships or relationships with even the remotest homosexual connotation. He discovered masturbation spontaneously and maintained that he accepts this fully without guilt or fear. On the other hand, he gives a very long history of a four-month tramping trip through Belgium, where he openly lived in homosexual circles into which he was absorbed for this period. Unfortunately, the patient left the district before a thorough therapeutic attempt could be made. He seems to be a typical case of the mother-fixated pseudo-homosexual who represses homosexuality *in toto* and expresses it by secondary heterosexual Don Juan adjustments. Here, one can also mention the possibility that the deeply repressed homosexuality in him found its outlet in the continuation of psychosomatic symptoms. *Discussion under Borderline Cases.*

A 101: Aged sixteen, high-grade mental defective with pesudo-psychosis. The trigger element in this case was the inability to cope at the same time with his overwhelming sexual urges and to adjust to even the simplest work processes. He withdrew into a fantasy life, accompanied by endless playing of rock 'n' roll records. He never went out and was only referred to the clinic when he suddenly attempted to grip his mother's breasts. He admits massive masturbation roughly three times daily, and there is also a prehistory of mutual masturbation in school and the impossibility of adjusting himself normally to female company. He belonged to a gang of youngsters who more or less pushed him out of their circle, as he was in no way their intellec-

tual equal. Thorough tranquilization and E.C.T. broke up his pseudo-psychosis and he was able to be reinstalled to very simple routine factory work. *Discussion under Mental Subnormality and Schizophrenia.*

A 102: Aged sixty-five, married, referred by the relevant authorities questioning whether he should continue as a teacher and whether psychotherapy in his case would be of any help. His is a life-long history of highly eccentric behavior with factors of fixation to buttocks as well as gross masochism. Five attempts have been made to alter his disposition psychotherapeutically. In his professional life, he varied between acting and school teaching. He was discharged from the army in 1916 with neurasthenia. He was married for over thirty years, but very rarely lived together with his wife as his profession made him either travel around with repertory companies or he worked as a teacher in preparatory schools. His highly intelligent and academically educated wife brought up their only child, a mental defective. The occurrence which brought the patient under treatment at that juncture was a masochistic episode during which he took his trousers down, exposed his buttocks, and asked the schoolboys who were in his charge to beat him heavily with hockey sticks. He then showed them the bruises and explained the purpose of these activities as being his particular idea of education and, that with it, he wanted to evoke the spirit of Christian tolerance, especially in the more violent boys. It was well-nigh impossible to get a believable prehistory, especially as he suffered temporarily from rather severe persecutory delu-

sions and became very easily confused. *Discussion under Sexual Disturbances.*

A 103: Aged forty-five, single, six times recidivist with exhibitionism and referred to the clinic. High-grade mental defective, socially totally isolated, farm laborer who showed no sex differentiation in his acts of exhibitionism. Of the six occasions on which he exhibited himself, he masturbated three times with boys and three times in front of girls. A practically identical case of a thirty-four-year-old cable layer is treated together with this case. Both cases show, besides the classical nondifferentiation of the subnormal, also the preponderant role of socially induced homosexuality in the choice of partners. *Discussion under Mental Subnormality and Sexual Disturbances.*

A 104: Aged fifty, married, two sons aged ten and eight, referred to the clinic with very severe chronic anxiety state, which began to undermine his position as a high-ranking employee. He comes from a Scottish Puritan family and gives a prehistory of homosexual play and, later on, intercourse with his brother from the age of four to eighteen. This conditioning produced in him endless feelings of guilt, anxiety, and desperation, and on four occasions very nearly brought him to total breakdowns with suicide attempts. He unfortunately never had occasion to discuss this aspect of life with medical advisers but understood at once the correlation between his anxiety states and his badly repressed homosexuality. He maintains that the memory of this very intense and deep-going love of his brother and the implied homosexual strivings regularly broke into

his married life in the form of interfering fantasies, all repeating his fourteen-year-long love life with his brother. He also understood how these occurrences and the resulting anxieties are projected by him onto both of his boys. Catharsis which followed the articulation of his basic problem promoted a very rapid amelioration, and therapy in this case could be discontinued after three interviews (cf. case I 7). *Discussion under Chronic Anxiety States.*

A 105: Aged twenty-three, single, builders' laborer, red-haired, pyknic, a very manly type. His general practitioner referred him with obsessional delusions, lack of concentration, loss of energy, inability to make social contacts. One year before referral, his state led to the suspicion of a brain tumor and he underwent two lumbar punctures. Massive reassurance and tranquilizers remained without success.

First Interview: he maintains that he is always quite dazed, unable to concentrate, he thinks he is losing his identity and that everything that happens around him is not real (derealization and depersonalization). Born in a Sussex fishing village, at the age of three moved with his parents to this district, school up to fifteenth year, average scholar, father died one and a half years before referral at the age of fifty-four with coronary thrombosis, mother alive and well, aged fifty-four, the patient an only child living with his mother. Patient describes the father as soft and kind, more a brother than a father. Mother is characterized as good but overanxious and a rather strict woman. After his school years, he worked for a few years on the land, spent fourteen months in the merchant navy, and three years in

the army—five months in Cyprus. After his return, he found himself jobs in the building industry. He maintains that his illness started roughly two and a half years ago. He has no girl friends and masturbates roughly three times a week. He maintains he has no interest in sexual matters and especially that he has no homosexual feelings; he also states that, during his time in the merchant navy and the army, he went very rarely and irregularly to prostitutes. Minor tranquilizers were given to him.

Second Interview: he feels a little better and less tense but also finds he is getting more depressed. He suddenly gives the following occurrence from his life. At the age of twelve, he and a schoolmate had daily mutual masturbation and sex play, and they very soon discovered that mutual fellatio was the most satisfactory way to them. During two years, this became a regular habit. For three or four years, he had no homosexual relationship, but during his army life, he again began to enter fellatio relationships. After his return to civilian life, he began to drink. When half-drunk, he went to a well-known meeting place of homosexuals in a coastal resort and found there at least once weekly partners who satisfied him by fellatio. This went on for roughly three and a half years, in fact, right up to the time of his referral. He described the domestic scene in his childhood as directly anti-sexual, and although nobody actively hindered him, he was most forcefully discouraged against finding girl friends or having anything to do with girls. In his rare experiences in heterosexual intercourse, he is completely potent with women, and he admits that his sexual deviation is an endless source of irritation. He feels be-

smirched and wishes strongly to normalize his sexual urges. Interestingly, his case belongs to the group of naive homosexuals who are not overtly disquieted over the legal consequences of their actions, although they are fully conscious of them. It is also very probable that this factor does play a role in his anxiety state. This case shows with great clarity all elements of the thesis here given. We find early mother fixation, father fixation, very early sexnegating induction, and the well-nigh compulsive conditioning in early puberty, the mild neurotic predisposition which makes it difficult for such a person to mature fully sexually and to cut loose from these conditioned homosexual activities. *Discussion under Acute Anxiety States.*

A 106: Aged twenty-seven, married, referred from the courts as a psychopath with severe depression and violence against his wife. His history is almost self-explanatory. He is the illegitimate child of a prostitute who had intercourse with her clients in the presence of the boy and his half-brother. From the age of seven on, he had regular incest relations with his half-brother until, at the age of thirteen, he was sent to a remand home on account of theft and violence in homosexual attacks. Since this time (aged fourteen) he has been in and out of prison and, in between, worked as a male prostitute and a blackmailer. His marriage was deeply perturbed as he tramped around for months without trying to keep in contact with his wife and, during this time, was occupied with active and passive homosexual adventures. He appeared the type of a weak psychopath with only little aggressivity but totally

uncontrolled sexuality and equally uncontrolled criminality. His marriage, in which he is fully potent, had no influence on his personality. After two months in a mental hospital and treatment with tranquilizers, sedatives, and psychotherapy, not the slightest change could be observed. After his discharge, he continued his homosexual activities and thefts. He is perhaps one of the best examples for the thesis that homosexuality in the psychopath is one of the major elements of this personality disorder. *Discussion under Psychopathy.*

A 107: Aged thirty-seven, married, a case of periodic endogenous depression, a highly intelligent and well-placed electrical engineer, comes from a small-town family in the west of England. His response to the ordinary medical and physical treatment was rather indefinite, as he became very blocked whenever his relation to his brother was under discussion, with whom he slept in the same bed for many years. In spite of prolonged interviews, he never denied or admitted sex play with his brother; also, his memory of all early events was disturbed, and he denied any kind of homosexual or mutual-masturbation relationships. In one interview, he startlingly and suddenly remembered a scene which he maintained has never occurred to him as significant and which he had completely forgotten. He was at the time eleven and a member of a gang of boys whom he numbers as four. They built a hut of old bricks and corrugated iron and, on one occasion, a man of around thirty befriended the boys. They all went into the hut and they masturbated this man in turn. This, however, did not trig-

ger off mutual masturbation of the gang, or at least he says he cannot remember this; he began to masturbate on a self-discovered basis at the age of twelve. When he was seventeen, an elderly canteen waiter seduced him to a complete mutual masturbation. Although he fought against the significance of these occurrences, his response to medical treatment became very much better, and his depression did not return over a period of at least two years. *Discussion under Depressive Illnesses.*

A 108: Aged thirty-four, married, referred with a diagnosis of anxiety hysteria, a regular army officer, whose personality and behavior disorders came very much to the fore after his discharge from the army after fourteen years' service. He was a classical Don Juan who had numerous extramarital relationships in spite of a very good marriage of ten years' standing with an understanding and helpful wife. There were two children of this marriage. He tried three times to hold his position, but it became impossible for him to concentrate on his work. It was equally impossible for him to control his massive sexual adventures with equally numerous and willing women. In spite of good intelligence and great efforts to break up these incessant sexual adventures, which in his case had the character of repetitive-obsessional compulsive acts, no therapeutic effort was of any use. His compulsive preoccupation with these conquests excluded the possibility of reorientating him toward normal work processes. He produced fainting fits to rationalize his social failures, and a very serious prognosis was given on his discharge from the hospital.

Compare here the case of P. A. Fischer.[11] These cases show the Don Juan neurosis—here accepted as an equivalent to homosexuality. *Discussion under Hysteria.*

A 109: Aged twenty-seven, married, referred in acute anxiety state, this broke out suddenly after a mass X-ray showed some lung disorder. Although no pathological findings were made on the occasion of the repetition of his X-ray, it was impossible to convince him that there was no organic illness, and it became more and more difficult for him to keep his good position as bookkeeper and traveler to a firm for whom he worked for over thirteen years. His interest toward his wife and children became much less, and his indifference was the more startling as he had been an excellent husband and father. He changed his job without success, and in spite of very intensive and lengthy anamnesis and therapy, no valid psychopathology could be produced. He admitted mutual masturbation in school but stated quite credibly that he had no homosexual feelings and was not involved in any homosexual activities. In spite of massive medical treatment, there was little improvement of his panic attacks. In this case, it is probable that the possibility of an undefined primary neurotic induction of sexual infantilism formed the basis for his later illness. *Discussion under Acute Anxiety States.*

A 110: Aged forty-five, married, referred in acute anxiety state. In spite of years of quiescence, he suffers from massive repetitive attacks with acute anxiety tensions and the recurrence of phobias, which were all related to knives and could be interpreted as badly masked aggressivity di-

rected against his wife and children. He was the butler and chauffeur of a rich old bachelor, and these attacks appeared usually if and when he had been hindered in indulging in exclusive male company. Thus, his first attack appeared after the war, that is, after he had left the army. Repetition of this occurred when he changed his domicile shortly before his second attack and through this lost contact with his very far-spread social life. He was the typical "joiner" who belonged to all voluntary old comrades' clubs, fire services, sports clubs, etc. Psychotherapy was very difficult with this man, because it was practically impossible to make him aware of the implications of a deeply repressed homosexuality, especially as he was a very religious man of high moral tone. Through continuous tactful going over of the ground of this setting, it was possible to give him a certain degree of insight, and the panic states could be broken up with the help of mild sedatives and tranquilizers. *Discussion under Acute Anxiety States.*

A 111: Aged thirty-eight, married, this case was one of an old hospital and outpatients' habitué with a very long history of complete impotence. He is blocked against any discussion of his sexual history, which is rather astonishing in view of his endless attempts to get a cure for his impotence. Every method known to cope with his impotence has been tried, including a double herniography. He suffers from massive breathing disturbances, trembling attacks, pouring sweat—and every visit to the outpatients' clinic regularly provoked this histrionic performance. Even discussion of childhood events without any depth was impos-

sible. Treatment remained only symptomatic and showed very little success. *Discussion under Hysteria.*

A 112: Aged thirty-five, single, patient lived with an old aunt who brought him up since childhood. Diagnosis was a recurrent paranoid schizophrenia. His delusions referred to a nonexisting skin disease of his genitals and his face. He maintained that he never had intercourse with a woman or had any kind of sexual feelings or urges. His amnesia was unbreakable, and no events from childhood or adolescence could be discussed. Of significance here is the referral of his delusions to his genitals. *Discussion under Schizophrenia.*

A 113: Aged forty-three, married, a twenty-year history of chronic anxiety whose presenting symptoms were unbearable headaches which began with his marriage in his twenty-third year of life. This pain increased progressively. His wife was no help to him, as she herself was under psychiatric treatment for fifteen years—also on account of her severe neurotic anxiety. In her case, illness could be explained by a practically complete, insoluble mother fixation. The patient was leucotomized ten years ago. At later psychotherapeutic interviews, he admitted mutual masturbation with other boys in school but maintained this was of no consequence or interest for his further development. One of the main criteria in the continuation of his illness was the relationship to his only daughter, a highly intelligent, nineteen-year-old bank employee. Between these two, there existed a high-pitched battle with numerous tensions that made the atmosphere at home nearly unbearable. This case shows, in the predisposed neu-

rotic personality, the absence of primary adjustment and only temporary and perhaps unimportant conditioning processes. Nevertheless, even these allow only a secondary heterosexual adjustment, which is so unsatisfactory that love-hate relationship with his daughter, in fact, takes the place of a normal orgastic sex life. *Discussion under Chronic Anxiety States.*

A 114: Aged twenty-six, married, aggressive psychopath, history of numerous hospitalizations in psychopathic special units, in between reform schools, prisons, and Broadmoor institutions. He blames his aggressive attitude exclusively on his massive and long-lasting incest relationship with his brother. The classical type of the aggressive psychopath who had to be removed even from the special units on account of attempted murder. He also shows the notorious feature of the psychopath to shock by giving a blood-curdling history, which is partly true and partly false, and by this maneuver, to keep himself away from any serious therapeutic attempt. He had to marry a psychopathic female whom he made pregnant in this special psychopath unit. He continued his numerous homosexual activities and blackmail attempts and has recently again been in jail (cf. case A 106). *Discussion under Psychopathy.*

A 115: Aged twenty-three, married twice, referred as an aggressive psychopath from the courts. In contrast to the above cases (A 106 and A 114), he comes from a normal middle-class family and is the second of three boys. In his case, there was no prehistory of incest between the boys, but a rather intensive jealousy between them. He recalls in-

cessant homosexual activities from the age of sixteen. His first marriage ended in divorce when he was jailed for blackmail. Further prison sentences show that he worked as a pimp. The second marriage became completely untenable and was just on the verge of breaking up, for the wife refused to be exploited as a prostitute and was not willing to suffer his continued homosexual relationships. *Discussion under Psychopathy.*

A 116: Aged seventeen, referred in chronic anxiety before entering the army. This boy was a chronic bed wetter and was very seriously traumatized by his very aggressive and cruel father. He beat him literally from earliest childhood onwards and maltreated him right up to the present on account of his bed wetting. In spite of all that, the boy developed comparatively normally. He agrees to a prehistory of mutual masturbation and declared that he never wet his bed when he was sexually active. Usually the bed wetting occurred with nocturnal emissions and was usually accompanied by dreams of brutalities which, in some cases were directed toward himself and sometimes against others. During the last eight months, he had some sex play with his girl friend of the same age up to the point of orgasm, and the bed wetting disappeared. However, he was re-referred after a short time with the recurrence of bed wetting and some minor depressions. A further anamnesis brought to the fore a very prolonged and very intensive homosexual activity which he was not willing to talk about on the first few occasions. This was a relationship with another boy which usually led to active and passive

buggery, and the anxiety attached to these continuous homosexual activities, together with the overwhelming father fear, led to the continued bed wetting. After several interviews, he maintains that the understanding of these key events has prevented him so far from wetting his bed again. *Discussion under Chronic Anxiety States.*

A 117: Aged eighteen, referred from the juvenile courts for repeated assaults on little girls. I.Q. 71. High-grade mental defective, severe masturbation guilt, and intensive hatred against his highly intelligent younger sister. He began sex play with girls of the same age at eleven. When he went into puberty at fourteen and a half, he was not content with these play activities and tried to lure little girls into parks or onto playing grounds to assault them sexually. He was caught at this activity at the age of fifteen and sent to a reform school. There he learned mutual masturbation and homosexual activities. He developed the very typical vicious cycle of an anxiety tension leading to massive masturbation, which, in turn, did not bring any satisfaction, which finally led him again to attempts to assault little girls. Homosexual activities and the usual mutual masturbation were only rarely continued by him, less out of his own sexual urges than out of habit. His main sexual interest remained his urge to assault little girls. Psychotherapeutic treatment and sex-repressing medication played only a minor part, but during this time, he at least avoided direct play with the genitals of little girls. He was caught after the first few months of treatment with a little girl in a park and sentenced for a further six months in a Borstal

institute. After his return, he refused further treatment or medication. He was influenced in this act patently by his father, who gave him a beating after this recurrence, and stated that this was much more effective than psychiatric treatment. This case is of special interest, as he represents the type of subnormal who, in an acute attack of panic, is quite able to destroy the evidence of his activities suddenly, thus, for instance, would be quite capable of committing murder to escape further punishment. *Discussion under Subnormality and Sexual Disturbances.*

A 118: Aged twenty-three, single, hospitalized with massive delusions that he always stank of feces and that everybody could smell that. He was a psychotic of some severity. He three times seriously tried to commit suicide. Massive treatment with E.C.T. and high-dosage phenothiazine were not able to destroy his delusions, but his behavior became less self-destructive. His prehistory is classical in our sense. He slept in the same bed with his two-year-older brother for many years and continued regularly complete homosexual play up to his sixteenth year. He then went into the merchant navy and had four long-lasting active and passive homosexual friendships. At twenty, he returned home and became a miner. During the last few years, he had at least six heterosexual friendships and became engaged roughly two years before his final breakdown. In spite of his engagement and his heterosexual relationships, he regularly visited public lavatories and tried at least monthly to engage in mutual-masturbation relations therein. He was nearly caught by the police at this activity

and since that time concentrated on the sexual intercourse with his fiancée. Six months before his final breakdown, he maintained that his fiancée has continuous incest relationship with her brother, a very interesting projection similar to the one in case E 54, which, in his case, became a complete delusion and also shows homosexuality as a basis of aggressive jealousy. From this time on, he maintained that everybody noticed how he stank and he attempted suicide (cf. cases I 11, I 20, R 79). *Discussion under Schizophrenia.*

Additional cases

Z 1.119: Aged eighteen, highly intelligent public schoolboy with great gift for writing and of good personality. He complained about inability to concentrate and to continue with his studies. He was lost in immature daydreams and harvested "advance laurels." This ended usually in depressive phases with suicidal ruminations. Psychiatric examination showed no disorders of thought, affect, or volition, nor any kind of depressive illness. During the last year in his public school, while he was seventeen, he fell in love with a boy of fifteen with whom he had, on several occasions, homosexual intercourse in a normal position. He suffered increasingly from anxiety attacks and ruminated continuously whether he is a homosexual or not (cf. Robert Graves' autobiography "Goodbye to All That"). Intensive psychotherapy helped him to a very great extent to further maturation. This case shows the role of the strength of juvenile, emotional love relationships and the enormous

difficulty to overcome this without repression. *Discussion under Acute Anxiety States.*

Z 2.120: Aged twenty-seven, single, the oldest of fourteen children, referred for psychotherapy in acute anxiety and with severe depression. He had given up his position, showed uncontrollable restlessness, suffered from palpitations, and sweated. The outbreak of his illness coincided with the dissolution of his third engagement. His anamnesis showed that he had an intimate homosexual relationship from the age of seven up to the age of seventeen with an elderly lodger. The older man committed fellatio on the boy and, later on, they had mutual masturbation. The patient also remembers one occasion when a boy of the same age committed fellatio on him, very probably at his own invitation. After his seventeenth year, the patient had a very perturbed period in which he had incest relationship with his three-year-younger sister, however, not *per vaginam.* At this time he suddenly felt the compulsion to powder his body and his face. This, however, lasted only a short time, and his official reason was that he hoped girls would find him more attractive. From that period on, he strongly repressed all homosexual desires and fantasies, and he maintains that, during his three-year service in the army in England and overseas, he had no further homosexual activities. After his discharge from the army, a homosexual tried to seduce him, but he repelled him with great sharpness. Although in his childhood sometimes three or four siblings slept in one bed, he maintained there was never any sex play between them. He was engaged three times;

first to a girl whom he describes as a hysteric. She never allowed him sexual intercourse but encouraged him to very intensive sex play. His second fiancée was a woman with whom he lived for some months, but he lost all interest in her when he gained the knowledge that she was a divorcée. Finally, he lived for three months with a girl who allowed him sexual intercourse but who disappointed him with the discovery that she had slept with other men before. The girl broke up the engagement when one of her old boyfriends reappeared. After some improvement with psychotherapy, he suddenly broke up in a complete persecution psychosis. *Discussion under Anxiety States and Pseudo-Psychosis.*

Z 3.121: Aged twenty-one, single, highly intelligent young man with very delicate girl-like features. He was the only son of a miner's family who, from childhood onwards, admired his wisdom and importance in a grossly exaggerated way and spoiled him mercilessly. His older sister played no role in his life, but his three-year younger sister, with whom he slept in the same bed from the age of six to seventeen and with whom he had regular intercrural intercourse—while he played with her genitals she stimulated his penis and masturbated him. Other sexual-conditioning patterns were early sex play in a gang of boys and girls at the age of eight to twelve. Strange to say, he never allowed boys to masturbate him, but he had done that quite often to others. Besides these play relationships, which could nearly be described as normal childhood play, the

incest relation with his sister was of greatest psychopathological importance. The early induction to narcissism, naturally, also plays a major role.

His first breakdown occurred during his service in the air force when a homosexual merchant gave him a ride in his car and tried to seduce him. The patient did not allow him any sex play and forced him to stop the car, but the man kissed him when he left the car. This was the beginning of his illness, which led him twice to psychiatric special units in the air force, and a final third breakdown brought him into the hospital. Diagnosis was recurrent schizo-affective psychosis. His very heavy depressive rumination rotated around the idea that he is a homosexual, is recognized by others at once as such, and for that reason he is being avoided. At every interview he repeated that he felt he should have beaten up this man when he tried to kiss him. He showed manifold signs of withdrawal and had grandiose daydreams that all referred to greatness and importance, which he maintained should be recognized by all other persons. He had four girl friends with whom he had regular sexual intercourse, but he maintained that these forceful sexual displays of overactivity had no emotional depth but really only constituted a test of his virile strength and masculinity. *Discussion under Acute Anxiety States and Pseudo-Psychoses.*

Z 4.122: Aged twenty-three, single, three hospitalizations with schizophrenic episodes. First short breakdown occurred at the age of seventeen but was not seen by any doc-

tor. The second breakdown led him into a special psychiatric unit of the air force, and he had two hospitalizations, with short intervals, with an acute schizophrenia. He had massive ideas of reference and references directed toward himself by magic signs. Some of his delusions were typically hebephrenic. He maintained, for instance, that a broken washbasin, which he found on a scrap heap, was a special sign that Mr. Khrushchev is going to drink water and this will promote world peace. The patient hailed from a problem family and conducted an uninterrupted fellatio relationship with his brother from the age of eight until fourteen. The first breakdown, according to a statement, was produced by the impulse to commit fellatio with a workmate, which became so overwhelming that he could think of nothing else day or night. Later on, he tried with good success to have sexual intercourse with girl friends. His second breakdown occurred when he practiced fellatio, in fact, with a fellow air-force man. Although this had no legal consequences for him, luckily it was nevertheless quite unambiguously the precipitating factor of an open schizophrenic attack. The third breakdown was not only triggered off with the above-mentioned hebephrenic symptoms, but also by his endless attempts to seduce his seventeen-year-old cousin to have fellatio with him. He was completely uninhibited in endless discussion of his fellatio addiction. For instance, he gave this history at great length without any inhibition in front of a class of male and female nurses to whom he was demonstrated as a classic case of schizophrenia (cf. cases 105, 120, 128). *Discussion under Schizophrenia.*

Z 5.123: Aged twenty-seven, single, hospitalized with acute schizophrenia. He was hallucinated and acutely terrorized because he was convinced that his girl friend, who threw him over recently, was trying to murder him. In his prehistory, he twice mentioned sex play with his two-year-younger sister and mutual masturbation with at least three other boys during lengthy periods in his puberty. He was not very selective in his sexual differentiation and described, for instance, that once when his girl friend stood him up, with whom he had regular sexual intercourse, he met her brother at home and masturbated mutually with him instead. Nevertheless, his conscious sexual drive was directed toward women. An earlier breakdown happened in consequence of a very complex situation. He was given the freedom of a farmer's wife, for whom he worked, in exchange for passive homosexuality. Since that time, every heterosexual situation brings a perturbance, which usually ends in hallucinations in which ideas of reference and acute persecution stand in the foreground. The latter trend, however, was, so to say, wrongly defined and directed against the girl with whom he had had sexual intercourse. This case clearly shows the role of prolonged homosexuality in the formation of paranoid illnesses. *Discussion under Schizophrenia.*.

Z 6.124: Aged twenty-seven, married, referred in chronic anxiety state, a miner who could not work any more underground because he uninterruptedly expected explosions and waited for them. He could not concentrate on his work and went into acute panic states the moment he heard

loud noises. He remained practically without sleep because he tried to escape a dream which recurred regularly every night. In this dream an experience from his service in Korea was repeated which happened in reality: he was lying next to his best friend when a grenade exploded and virtually tore his friend to pieces.

The marriage of this patient was a very happy one, and his relation to both children excellent. His history is doubly interesting, because the superficial trauma of the episode in Korea could easily be accepted as the cause of his anxiety neurosis. After lengthy interviews and very good rapport, the patient gave, however, a history of very deep-going and emotional love relationship to a two-year-older boy, with whom he had regular homosexual relations between the ages of nine and fourteen. When the other boy left the house where both families lived, the patient felt himself completely lost; he clearly remembers that he was seriously and suicidally depressed. Since that time, he had many friendships without any homosexual connotation, but the friend in the army whom he lost so tragically was bound up to him in very deep friendship. For instance, during their service, they always went out together, and in Korea visited brothels and slept with the same girl. Explanatory psychotherapy helped this highly intelligent man to a great extent and enabled him to start new work as a baker. *Discussion under Chronic Anxiety States.*

Z 7.125: Aged forty-six, twice married. Born in London in 1914. His father, a soldier in the First World War, was killed two years after his birth, his only sister was born six

months after the father's death. The patient was brought up by a domineering mother, very strictly, and shows a complete amnesia in regard to his childhood, especially to the relationship with his sister. Without being asked, he denied any kind of incest play with his sister, which may partly show him to be an habitué of psychiatric treatment but may also partly show a gross complex in his sister relationship. From all this it was deduced, together with the form of his illness, that incest play must have played a great role in his personality structure. His first sexual experience was the self-discovery of masturbation in his ninth or tenth year spontaneously, and at once with masturbation appeared the uncontrollable impulsive action to grasp little girls' buttocks and try to reach their genitalia. This brought him at that period in sharp conflict with his church-choir, and he was promptly expelled. He gives a history that at the age of twelve, three somewhat older boys tried to seduce him but he ran away, screamingly as he said, when they tried to pull his trousers down. At the age of sixteen, he suffered from appendicitis and peritonitis and was seduced in a hospital by a twenty-year-old man to mutual masturbation and active and passive homosexuality. He worked as a clerk and was seduced to regular mutual-masturbation sessions with an unmarried office superintendent who was aged forty-eight and was so fond of him that he sometimes followed the patient right into his home. He was seriously warned because he spent too much time in the private office of this man. However, parallel to these activities, he continued his obsessional activities and did everything to enable him to look at girls' legs and under

their skirts and, whenever possible, to touch their buttocks and genitalia. Here again he was caught and lost his job at once. At this time he also began a six-year-long relationship with a somewhat older boy-scout leader with whom he had continuous mutual masturbation.

During this time, the attention of the police was drawn to him, as he continuously tried to contact young women and little girls and tried to touch them. His first sentence was a one-year probation period. He then moved to the west of England. He had no further homosexual experiences. However, he masturbated at least once a day, always with fantasies in which a couple had sexual intercourse or where he was trying to touch young women or girls on their genitals. At this time he was a bank employee, was caught again, and this time condemned to fifteen months in prison. After his discharge from prison, he entered his first marriage, which lasted three months. He then joined the air force but was discharged, after six months, as a psychoneurotic. After the war, he had numerous nervous breakdowns, which were all officially blamed on overwork; he had at least six admissions to mental hospitals with malignant, chronic anxiety states and as a sexual deviationist.

In 1950, he married for a second time, on this occasion, a widow with two grown-up girls. In 1961, he had a further breakdown, and again a diagnosis of overwork was made. He agrees, however, to be continuously obsessed or under the impulse to touch girls in his office, but most of all he is totally preoccupied day and night with sexual fantasies in regard to his eldest stepdaughter. All this made it impossible for him to concentrate on his work. He already began

to show the first signs of an involutional depression. He responded relatively well to explanatory psychotherapy and E.C.T. He is one of the very interesting cases which show the interchangeability of heterosexual and homosexual sex objects due to infantile early induction. We have here homosexual activity running parallel to heterosexual infantilism, voyeurism, and the impulse to touch the buttocks and genitals of young girls. *Discussion under Chronic Anxiety States and Sexual Disturbances.*

Z 8.126: Aged sixty-seven, widowed, three times recidivist in soliciting young men in public lavatories, he was referred from the courts to the clinic. He was born in 1894 in a small industrial town in the Midlands as the eldest of three children. Up to his nineteenth year he slept with his brother in one bed. However, he maintains that only innocent sex play and pillow fights occurred during these years. Besides that, mother and father slept in the same room, only separated by a curtain from their children, who were regularly able to listen to the sexual intercourse of the parents. Mutual masturbation began at the age of twelve in school and continued with a somewhat older friend in the church choir, with whom he maintained these activities up to his sixteenth year. He became a barber's assistant at the age of fourteen and, at that period, was seduced by a man twice to passive and active homosexual activities. In all his further professional career and as a soldier during the First World War, he maintained numerous mutual-masturbation relationships. At the age of thirty-six, he married his fourteen-year-older housekeeper. Before marriage they had

no sexual intercourse, but after marriage intercourse was practiced at least once a week or every second week. His wife died in 1954, but his first sentence occurred one year before her death. During his marriage, he masturbated roughly every six weeks with homosexual fantasies and, in fact, had a number of friends with whom he regularly masturbated mutually in public lavatories. He maintains that at least twelve men were participating in these extramarital adventures. In 1960, a prostatectomy was performed, as his medical advisers thought this might correct his sexual deviation. This, however, proved to be a complete failure. He responded well to Thioridazine and Stilboestrol. This case is worth mentioning because it shows that here a naive homosexual tendency continued in a relatively elderly man from his early conditioning up to his late middle age. He can be quoted as proof that these activities must have played an equally great role in all periods of strong sex-negation and, in former days, must have been hidden much more, mainly by the excessive brutality of public opinion on this subject. *Discussion under Sexual Disturbances.*

Z 9.127: Aged sixteen, a boy with mild spasticity, I.Q. of 80. He was referred from a special psychiatric juvenile unit with a diagnosis of acute schizophrenia with a bad prognosis and he was to be tried on high-dosage phenothiazine therapy and E.C.T. He was the only child of an elderly professional couple. The diagnosis was rejected by the author, and it was possible to show in numerous interviews the hysterical basis of this pseudo-psychosis and to dissolve it. As a spastic, at the age of twelve, the boy was sent to a

special school and was very soon introduced there to mutual-masturbation relationships. He was intensely religious, and the conflict between the moral demands of his religion and his sexual urges became unbearable. During the last nine months, this situation became utterly untenable, because he not only fell in love with another boy but engaged in very prolonged and intensive homosexual activities with him. He made an enormous effort to break up these activities and his masturbation. In this state, he suddenly had visions and hallucinations; God's voice spoke to him with thunder and lightning, and the patient heard himself called "John, the Spastic." After explanatory therapy, which was purposely kept to a very slow pace, repeating the arguments over and over again, the pseudo-psychotic state of the patient broke up completely without any further treatment. During the therapy, the role and function of sex was explained, masturbation declared to be a normal outlet in that particular age group and in our society, and homosexual relationships in puberty as a very frequent phenomenon which is completely harmless but not very desirable. This case shows especially the role of pseudo-psychosis. *Discussion under Subnormality, Hysteria, and Pseudo-Psychoses.*

Z 10.128: Aged thirty-one, divorced, referred to the clinic for three reasons: chronic anxiety state, inability to keep his jobs, and severe asthmatic attacks which, during the last years, led to serious illnesses of his chest. In his early history we find extremely strong traumata, as his father was so brutal and sadistic that the three eldest of the six

children had to be sent to a county children's home because, on three occasions, they were seriously in danger of their lives. The father then left his wife and the marriage was dissolved. The mother married again but very shortly lost her second husband as the result of an accident. In these circumstances, the patient remained in the care of his children's home up to the age of fourteen. There were no homosexual activities during his schooling. He began to masturbate during his twelfth year and remembers the normal superficial sexual play with other boys and girls in the home. He recalls that, during this period, his masturbation fantasies were clearly directed as much toward girls as boys. At the age of fourteen he returned to his home town, a port in southeast England, and was introduced to a mutual-fellatio relationship with a workmate of the same age. This at once became the sex activity of his choice. He was quickly drawn into a very far-spread homosexual circle in this town and had fellatio relationships with other men of every age at least three times a day. He changed his work very frequently but remained in some positions for longer periods wherever his fellatio addiction could more or less be fulfilled without any friction—for instance, as ship's steward or in hotels. His longest job lasted two years in the canteen in the army barracks of foreign soldiers. During this time, a process of feminization broke through, enhanced by the continuous life in overt homosexual circles and the implied necessity to offer his services. He described himself and his friends as "screaming lulus." It is also quite interesting that during this period he began to develop signs of transvestitism. He declared verbally

"At times I love to go out for a drag." He lost some of his hair and is now wearing a reddish toupee. He appeared at the clinic in very tight jeans, suede shoes, and a pink pullover, and wears a number of quite big golden rings and golden bracelets. He maintains he is not now practicing homosexuality, he cannot be bothered, and masturbates about two to three times a week with overt homosexual fantasies. He has returned to his mother and does not accept the necessity to work or, in fact, to do anything for his living. With his infantile trauma, he developed severe asthma in the sense of Kretschmer's autonomic-reflex hysteria, which means that whenever there are any difficulties, he falls back on severe asthmatic bouts. His marriage was a travesty. During the one and a half years of his marriage, however, he had intercourse with his wife at least once a month. He said that she bored him beyond measure, and the marriage broke up. His asthmatic bouts and the multiple superimposed chest infections had led, in fact, to some fibrosis of the lung, and emphysema and empyema have appeared during the last years. The recent lapse into his rather severe neurotic illness may, in fact, be partly conditioned by a progressive toxic state. The prognosis of his asthma and of his very deep-seated neurotic illness is very bad. *Extensively discussed under Borderline Cases.*

Z 11.129: Aged forty-eight, married with four children, high government official, an intellectual of very superior intelligence. He was born the second son of three children, with a brother two years older and a sister two years younger. Father was a high-ranking civil servant who died

recently. His parents divorced when the youngest of the three children was twelve years old, and the children remained in the care of the mother. Father saw the children regularly during their vacation. He married his mistress. The mother also remarried, but at that time the children were already grown up. The patient came for therapy because he felt that his partial obesity, attacks of palpitations, minor but persistent precardial pains, his eating, drinking, and sexual habits were all interrelated and partly due to prolonged tension states, all ending with mild but persistent depressions. Of his early history, it is only remarkable that, unlike the custom of youngsters of his class, he joined a radical youth movement at the age of thirteen and remained keenly interested in it. Political events forced him into very dangerous situations and maneuvers, but he succeeded in surviving the Second World War. His academic career was very successful, and his political ambitions were partially satisfied. However, boredom and disillusion were, in fact, partly responsible for his giving up his political career and his return to an administrative position. Key events of his youth were some incest play with his sister. He had very numerous heterosexual relationships in the youth movement, and from the age of thirteen onwards, he clearly displayed numerous Don Juan qualities. He had some intensive friendships with boys, only on one occasion amounting to mutual masturbation, but he admits conscious repression of homosexual impulses. He maintains that his massive heterosexual activities made this comparatively easy. He married young, sexual intercourse was practiced daily as a necessity for both partners, and the marriage was

relatively happy, but became more and more insecure when he had to keep up two households in two different parts of the country. A motorcar accident made it clear to the wife that excessive drinking and eating were also accompanied by the keeping of mistresses, which led to severe tension and unhappiness and, in fact, would have led to a divorce had two of the four children not been very young. On several occasions he had very young girls as mistresses which, in his case, led to severe anxiety in regard to public exposure.

The main interest in this case is the fact that he used all his influence and position to recall all his friends from his youth to him and offer them one or two of his mistresses, spending one or two nights with them in the same bed, participating and touching them while they had intercourse; also, that he organized these occasions compulsively for an increasing circle of political friends. In fact, he was partially impotent, masking this from his wife and mistresses by intensive love play. However, watching his friends having intercourse restored him more or less to full erectile potency. His fantasy life was full of images of the strength and vigor of his friends at intercourse.

This case is of greatest theoretical interest—it shows induction and conditioning, it shows the unreliability of secondary adjustment, the intimate relationship between the Don Juan and the homosexual, or, even stronger, the homosexual basis of the Don Juan. Environmental manipulation and insight therapy were successful. *Discussion under Sexual Disturbances.*

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