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HOMOSEXUALITY

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Table of Contents

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The definition of homosexual and homosexuality can well be preceded by definitions of sexual, heterosexual, and heterosexuality.

Sexual reproduction was antedated by asexual reproduction or fission, that is, one cell splitting into two identical cells. The word *sexual* is derived from biology and refers to a form of reproduction occurring between two cells which are different from each other. Their combined nuclear material resulted in a completely new individual cell and this became the basis of all evolutionary development. Sexual development began solely as reproductive activity. It was later enlarged to include sexual pleasure activity with or without reproduction.

Heterosexual object choice is determined by two-and-a-half billion years of human evolution, a product of sexual differentiation. At first based solely on reproduction, it later widened to include sexual gratification: from one-celled nonsexual fission to the development of two-celled sexual reproduction, to organ differentiation, and finally to the development of two separate individuals reciprocally adapted to each other anatomically, endocrinologically, psychologically, and in many other ways.

In man, heterosexual object choice is not innate or instinctual, nor is homosexual object choice; both are learned behavior. The choice of sexual object is not predetermined by chromosomal tagging. However, most significantly, heterosexual object choice is outlined from birth by anatomy and then reinforced by cultural and environmental indoctrination. It is supported by universal human concepts of mating and the tradition of the family unit, together with the complementariness and contrast between the two sexes.

Everything from birth to death is designed to perpetuate the male-female combination. This pattern is not only culturally ingrained but anatomically outlined and fostered by all the institutions of marriage, society, and the deep roots of the family unit. The term "anatomically outlined" does not mean that it is instinctual to choose a person of the opposite sex (heterosexuality). The human being is a biological emergent entity derived from evolution, favoring survival.

In man, due to the tremendous development of the cerebral cortex, motivation—both conscious and unconscious—plays a crucial role in the selection of individuals and/or objects that will produce sexual arousal and orgastic release. Where massive childhood fears have damaged and disrupted the standard male-female pattern, the roundabout method of achieving orgastic release is through instituting male-male or female-female pairs

(homosexuality). Such early unconscious fears are responsible not only for the later development of homosexuality but of all other modified sexual patterns of the obligatory type.

The term “standard pattern” was originated by Rado to signify penetration of the male organ into the female at some point before orgasm and, of course, carries with it the potential for reproduction. Within the standard pattern, from which the foregoing characteristics are never absent, there are innumerable variations dependent upon individual preference. Homosexuality is a modified pattern because it does not conform to the essential characteristics of the standard pattern. Other modified sexual patterns, also referred to as perversions or deviations, are fetishism, voyeurism, exhibitionism, pedophilia, etc. Individuals suffering from these conditions have in common the inability to perform in the standard male-female design and, as one of their aims, attempt to achieve orgastic release in a substitutive way. A homosexual is an individual who engages repetitively or episodically in sexual relations with a partner of the same sex or experiences the recurrent desire to do so, as explained in the section on classification. If required to function sexually with a partner of the opposite sex, he can do so, if at all, only with very little or no pleasure.

Biological Studies

There have been numerous chemical, genetic, and somatic studies over the past century in an effort to establish that homosexuality has an organic or non-psychogenetic origin.

In 1896, Krafft-Ebing suggested that homosexuality is an inborn characteristic due to large amounts of male and/or female substances in the hereditary composition of the brain. Mantegazza, in 1914, explained homosexuality as a genital malformation caused by the fact that sensory nerves, normally originating in the penis, are displaced to the rectum and the erogenous zone is correspondingly shifted. Hirschfeld stated that "Homosexuality is always an inborn state, conditioned by a specific homosexual constitution of the brain." In 1940, Glass et al. cited hormonal or endocrine factors. H. Ellis agreed with Krafft-Ebing's theory of hereditary composition.

Contemporary scientific findings clearly establish that homosexuals can have endocrine dysfunction, as can any individual, but that the androgen-estrogen ratio among male homosexuals usually falls within normal limits. Large doses of androgens or estrogens influence the strength of the sexual drive but cannot change the sexual object choice.

In 1941, Henry studied 250 adult patients grouped according to the predominance of heterosexual or homosexual tendencies. He observed that

homosexuals had considerably greater constitutional somatic deviations on average than had heterosexuals, but could not conclude from this finding that homosexuality was organically determined. In fact, he tended to the opposite point of view. Parenthetically, it is of interest that he found when personality disorders do occur, heterosexuals tend to develop "benign" psychoses, while homosexuals are prone to paranoiac and schizophrenic illnesses.

Kallman's studies on the genetic predetermination of homosexuality in identical twins show "concordance as to the overt *practices* of homosexual behavior after adolescence." However, these statistical studies must be viewed with caution. The behavior may be due to the temperamental similarity of identical twins and their reacting similarly to environmental influences. More revealing would be studies made on identical twins who have been separated at birth and brought up in divergent environments. Kallman himself, in the same paper, states that the "project was extremely difficult. . . . It is fair to admit that the question of the possible significance of a genetic mechanism in the development of overt homosexuality may still be regarded as entirely unsettled."

Rainer and co-workers described seven cases of monozygotic twins without concordance. It would seem that concordance does not prove a biogenetic etiology since the developmental history of monozygotic twins is uniquely different from that of other individuals.

Assumptions as to the origin of human homosexuality cannot be based on the study of lower primates, because in man the enormous evolutionary development of the cerebral cortex has made motivation, both conscious and unconscious, of overwhelming central significance in sexual patterning. Below the level of the chimpanzee, sexual arousal patterns are completely automatic and reflex. One of the world's outstanding experts on animal behavior, Beach, commented in a 1971 interview: "I don't know any authenticated instance of males or females in the animal world preferring a homosexual partner—if by homosexual you mean complete sexual relations, including climax. . . . It's questionable that mounting in itself can properly be called sexual."

A. Ellis studied forty-eight cases of hermaphrodites from the medical literature. He reported that heterosexuality or homosexuality in hermaphrodites is caused primarily by environmental rather than hormonal or physiological factors. Since, however, the hermaphrodite's environment conspicuously includes the somatic anomalies, he concluded that the problem of "normal" and "abnormal" sexual behavior among hermaphrodites is a psychosomatic one, as is true of psychosexuality in normal human beings.

Kolodny et al. reported that thirty-five exclusively homosexual subjects had a lower amount of testosterone in the bloodstream than would be found in heterosexual males. Evidence of the inconclusiveness of this finding is seen

by the authors' statement in the same paper: "There is no suggestion that endocrine abnormalities will be found in the great majority of homosexuals, or that endocrine dysfunction is a major factor in the pathogenesis of male homosexuality."

Various objections were raised in connection with the Kolodny material. For example, Barry and Barry wrote: "Their data showed that most of their subjects whose homosexuality had been rated as moderate to predominant had plasma testosterone levels within normal limits. Subjects with extreme degrees of homosexuality did have significant decreases in testosterone levels. . . ." The relation between decreased testosterone levels and decreased libido in heterosexual males is well known, the objection continues, so that it is not necessary to attribute any of these endocrine findings to homosexuality.

Commenting on Kolodny's alternative theory—that decreased testosterone levels could be a result of homosexuality rather than a cause and could be mediated through hypothalamic mechanisms—Barry and Barry point out that the life style of persons with "obsessive-compulsive" homosexual activity could also be involved. Many such subjects have said that while "cruising" and patronizing "gay" bars, they frequently averaged less than four hours of sleep. Testosterone levels normally decrease during the day by some 30 percent, and the high early morning levels are presumably

restored during sleep. “Might not the result reported have been due to the cumulative effects of sleep deficits? . . . Kolodny et al. did not mention any alcohol consumption . . . although an association between heavy alcoholic consumption and homosexuality is not uncommon, and alcohol is believed to have adverse effects on the testes and male sexual activity. In view of the lability of testosterone level and their wide variations owing to environmental factors, the reported decrease among adult males is more likely to be a result than a cause of homosexuality.”

The entire issue was succinctly resolved by Rado: “If a person of the opposite sex is available, why should a male choose another male or a female another female ... or even, sometimes, a lock of hair or a piece of underclothing?” The answer is to be found in the history of the individual’s psychic development.

Cultural Studies

Homosexuality, present throughout the ages, can be found in almost all cultures. It has been treated in ways ranging from acceptance to hostile rejection. Efforts to deal with it can be traced to some of the earliest writings, for example, to the laws of Hammurabi (second century b.c.) in Babylon, to Egyptian papyri, in which it is referred to as an ancient custom of the gods, to the Old Testament, where it is described as a “sin and scourge,” e.g., Sodom

and Gomorrah. Under Roman law, many aspects of homosexuality were ignored, especially female homosexuality. Early Anglo-Saxon laws were not as lenient, but it has been inaccurate to regard taboos against homosexuality as deriving entirely from the Judeo-Christian code. During the Dark Ages, homosexuality was regarded as a form of heresy and those "afflicted" were burnt at the stake.

Fisher states that physical relations were definitely a part of the homosexuality of the Greeks (Athenians). "The evidence is strong that homosexuality in the form of pederasty came later and flourished in the historic period from the 6th century B.C. on, coinciding with the development of a monetary, commercial, enslaved form of society."

In the Homeric period, the absence of pederasty coincided with the more elevated status of women, whereas in the historic period, the presence of pederasty coincided with the degraded status of women. According to Fisher, "This pattern suggests that in approaching the problem of homosexuality today, it is not enough to deal with the so-called 'instinctual' and interpersonal factors; social factors must be taken into account as well."

A most comprehensive and scholarly examination of family life in ancient Greece was published by the brilliant Cambridge investigator, W. K. Lacey. He writes:

We are sometimes told that the Greeks were fully bisexual, enjoying both homosexual and heterosexual intercourse, and that romantic love in Greece was associated with attachments to boys and not to girls. Whatever the truth of the latter statement, there can be no doubt that, while the Greeks had a deep admiration for the physical beauty of the young male, in Athens the practice of sodomy was strictly circumscribed by the law.

Boys still at school were protected against sexual assaults by a law (said to go as far back as Dracon and Solon), and we hear of strict regulations about schools with this in mind; schoolboys always had a *paidagogos* escorting them; in art the *paidagogos* is always depicted as carrying a long and heavy stick; what was this for if not to protect their charges?

Sodomy was thought reprehensible for older men even when the catamite was not a citizen, as is clear from the speech of Lysias, but it was not illegal; it may be thought that the law in this field is likely to have been similar to that about adultery; what was quite legal with slaves and other non-citizens was illegal with citizens, and the law took notice of the private morals of individuals, and punished offenders.

Pederasty was expensive; whether this was because the youths' admirers wanted to compete in generosity for favors or the youths were able to use the law virtually to blackmail their admirers no doubt varied in individual cases, but the result of the expense was to make paederasty a habit of the upper class and of those who imitated them, and hence suspect to the common people and a means of arousing prejudice in legal cases. Plato's attack on sodomy, especially in the *Laws,* reveals that the practice was not unknown to him, and that it was more repugnant to his ideals than heterosexual intercourse outside marriage, since this latter (if secret) was tolerated in the *Laws* as a second-best to the ideal of virginity till marriage and sexual intercourse only within marriage for the purpose of breeding children.

Opler concludes from anthropological and cross-cultural studies that "Actually, no society, save perhaps ancient Greece, pre-Meiji Japan, certain top

echelons in Nazi Germany, and the scattered examples of such special status groups as the berdaches, Nata slaves, and one category of Chukchee shamans, has lent sanction in any real sense to homosexuality. Regardless of what may be said concerning all the factors—social, legal, and psychodynamic—entering into homosexual behavior, one thing is clear: in the absence of an organic or hormonal basis, homosexuality in practically all cultures is regarded as a deviation from the major values and norms of conduct." He points out that in nonliterate hunting and gathering societies homosexuality is generally rare and in some instances virtually non-existent, e.g., the Mescalero and Chiricahua Apache.

Kardiner, in a psychoanalytic study of anthropology, has shown that in the Comanche tribes of the mid-western United States there was no homosexuality; an occasional transvestite was treated like a foolish old woman. It was completely unadaptive for a young man to be homosexual in the Comanche tribe. The tribe was geared for warfare and for hunting. All children were bound physically close to the mother for the first year or two of life. Boys were thereafter turned over to the father and the other men to begin training and cultivation of those attributes and skills leading to being successful warriors and hunters.

Observers of kibbutz-reared children in Israel have reported that there was no evidence of homosexuality in adulthood.

Developmental Factors

The experientially derived nature of homosexuality was explicated in 1905 by Freud. He, Sadger, and Ferenczi had penetrated the interconnection between infantile sexuality, perversions, and neurosis, and arrived at the conclusion that the latter represents the negative of perversion. A formulation of the essential psychological developmental factors in homosexuality was described by these foremost psychoanalytic investigators of their time, circa 1910. For example, they stated that the homosexual has experienced an excessively intense mother fixation during the first three years of life. He continues thereafter to identify with the mother, taking himself narcissistically as a sexual object. Consequently, starting in adolescence, he searches for a male resembling himself whom he attempts to love as he wished his mother had loved him. In addition, an unloving, cruel, or absent father increases the difficulties in the formation of male identification.

The clinical papers of the era focused almost exclusively on the failure to resolve the Oedipus complex as the causative factor in homosexuality. Freud himself was not content with this application of the oedipal theory as the definitive answer and stressed the necessity to seek out other determinants, namely, the psychic mechanism responsible for homosexuality and an explanation of what determines this particular outcome rather than another. He concluded that homosexuality represents an inhibition and

dissociation of the psychosexual development, one of the pathological outcomes of the oedipal period.

Freud stated that in cases where exclusiveness of fixation (obligatoriness) was present, we are justified in calling homosexuality a pathological symptom. He maintained that constitutional factors played a part in sexual perversions, but that they played a similar role in all mental disorders. This in no way indicated any repudiation of psychological factors, which are responsible for a predisposition to homosexuality. In actuality, he was thereby emphasizing precisely the psychological developmental factors which remain. (For a complete summary of Freud's contributions to the subject of homosexuality see *The Overt Homosexual,* Chapter III.)

Castration fear is of major importance in the development of homosexuality. However, in this writer's view, it is a nonspecific agent, being present as well in neurotic or other types of deviant sexual development. In male homosexuality, the hated rival appears to be transformed into the love object, in contrast, for instance, with the paranoiac whose male love object becomes the unconscious persecutor.

In a 1915 footnote to the *Three Essays,* Freud added an observation of paramount importance: "The connection between the sexual instinct and the sexual object" is not as intimate as one would surmise. They are merely

"soldered together." He warned that we must loosen the conceptual bonds which exist between instinct and object. "It seems probable that the sexual instinct is in the first instance independent of its object, nor is its origin likely to be due to the object's attraction." These conclusions have been largely ignored by research investigators as regards the independence between the sexual instinct and sexual object, which further clarifies the etiology of homosexuality.

Those who stress a basic biological tendency toward heterosexuality commit the same error as advocates of the theory of constitutional bisexuality. Rado puts "constitutional bisexuality" in its proper place.

> In both lines of experimental study, the available evidence points to the same conclusion: the human male and female do not inherit an organized neuro-hormonal machinery of courtship and mating. Nor do they inherit any organized component mechanism that would—or could—direct them to such goals as mating or choice of mate. In the light of this evidence, the psychoanalytic theory of sexual instincts evolved in the first decades of this century has become an historical expedient that has outlived its scientific usefulness. Each of the sexes has an innate capacity for learning, and is equipped with a specific power plant and tools. But in sharp contrast to the lower vertebrates, and as a consequence of the encephalization of certain functions first organized at lower evolutionary levels of the central nervous system, they inherit no organized information.

In Anna Freud's opinion, the crucial factor in homosexual behavior is the search for male identity through identification with the partner of the same sex in sexual contacts.

Documentation as to the experientially derived origin of homosexuality has been provided by numerous clinicians. Bychowski cited similarities between homosexuals and schizophrenics in terms of psychic structure, especially “infantilisms in the libidinal organization and certain primitive features of the ego.” The boundaries of the homosexual ego lack firmness, which makes possible fleeting identifications.

Most cases of homosexuality reveal a basic structural psychological pattern. The intense attachment, fear, and guilt in the boy’s relationship with his mother bring about certain major psychic transformations which are effective through the mechanism of the repressive compromise. It is a solution by division, whereby one piece of infantile sexuality enters the service of repression (that is, is helpful in promoting repression through displacement, substitution, and other defense mechanisms). Pregenital pleasure is thereby carried over into the ego, while the rest is repressed. This is one of the major mechanisms in the development of homosexuality and is known as the “Sachs mechanism.”

The breast-penis equation is utilized against the positive Oedipus complex.'' Because of his attachment to his mother, and hatred for his father, and punitive aggressive-destructive drives toward the body of his mother, he substitutes the partner’s penis for the mother’s breast. Other mechanisms are psychic masochism and, of crucial importance, identification with the male

partner, his penis, and his body in the sexual act.

This writer introduced the concept that in all obligatory homosexuals there has been an inability to make the psychological progression from the mother-child unity of earliest infancy to individuation (preoedipal theory of causation). As a result, there exists in homosexuals of the preoedipal type a partial fixation, with the concomitant tendency to regression to the earliest mother-child relationship. This is experienced and manifested by the homosexual as a threat of personal annihilation, loss of ego boundaries, and sense of fragmentation. This position was documented by a substantially large number of cases of obligatory homosexual patients who had undergone psychoanalysis with this therapist.

To assume that homosexuality is experientially derived means that once the anxiety which originally caused the inhibition of development and the later appearance of homosexuality is removed through suitable psychological measures, the attainment of heterosexuality and heterosexual object love is possible. This has been verified in approximately one-third to one-half of all such patients who were motivated to undergo depth therapy and to seek change.'"

Bieber et al. presented a systematic study of 106 male homosexuals and 100 male heterosexuals in psychoanalytic treatment with 77 members of the

Society of Medical Psychoanalysts in New York. Of the homosexual patients treated, 60 were in analysis less than 200 hours and 46 received 20 treatment hours. In the control group of heterosexual cases, 40 had less than 200 treatment hours and 60 were in treatment for at least 200 treatment hours.

According to this report, the outstanding behavior of mothers of homosexuals was an excessive intimacy with their sons. These mothers exerted a binding influence through preferential treatment and seductiveness on the one hand, and inhibiting, over-controlling attitudes on the other. In many instances, the son was the most significant individual in their lives. Their husbands were usually replaced by the sons as the primary object for libidinal investment. These findings are consistent with those of other psychoanalysts and psychiatrists treating homosexual patients in depth. The son often felt that he had usurped his father's position, and consequently felt guilty and uncomfortable with him.

The Bieber study also found a seriously defective father-son relationship; detachment and rejection by the father, as well as reciprocal hostility. This contrasted markedly with the close-binding maternal intimacy. The father had discontinuous contact with his son, which represented a fear of closeness on the father's part to his own family.

Classifications

Nearly seventy years ago, Freud proposed a classification based on both conscious and unconscious motivation:

1. Absolute inverts whose sexual objects are exclusively of their own sex and who are incapable of carrying out the sexual act with a person of the opposite sex or derive any enjoyment from it.

2. Amphigenic inverts whose sexual objects may equally well be of their own sex or of the opposite sex because this type of inversion lacks the characteristic of exclusiveness.

3. Contingent inverts, whose circumstances preclude accessibility to partners of the opposite sex, may take as their sexual objects those of their own sex.

Current research has prompted the present author to outline five major types of homosexuality as follows.[1]

1. Preoedipal Type

   a. This type is due to a fixation to the preoedipal phase of development (age, birth to three).

   b. It is unconsciously motivated and arises from anxiety. Because non-engagement in homosexual practices results in intolerable anxiety, and because the partner must be of the same sex, it may be termed obligatory homosexuality. This sexual pattern is inflexible and stereotyped.

   c. Severe gender identity disturbance is present: in the male, a

faulty and weak masculine identity; in the female, a faulty, distorted, and unacceptable feminine identity derived from the mother who is felt to be hateful and hated.

d. Sexual identity disturbance is due to a persistence of the primary feminine identification, as a result of the inability to traverse the separation-individuation phase (age, one-and-a-half to three) and develop a separate and independent identity from the mother. In the female, there persists an identification with the hated mother which she must reject. It is essential here to differentiate between primary and secondary feminine identification. Following the birth of the child, the biological oneness with the mother is replaced by a primitive identification with her. The child must proceed from the security of identification and oneness with the mother to active competent separateness; in the boy, toward active male (phallic) strivings; in the female, to active feminine strivings. If this task proves too difficult, pathological defenses, especially an increased aggressiveness, may result. These developments are of the greatest importance for the solution of conflicts appearing in the oedipal phase and in later life. In the boy's oedipal phase, under the pressure of the castration fear, an additional type of identification, secondary identification, with the mother in a form of passive feminine wishes for the father is likely to take place. However, beneath this feminine position in relation to the father one may often uncover the original passive relation with the mother, i.e., an active feminine preoedipal primary identification. In the oedipal phase of the girl, fear emanating from both parents—a conviction of

rejection by the father because she is a female, and by the mother because the latter is hateful and hated—leads to a secondary identification. This results in passive feminine wishes for the mother and in a masculine identification superimposed on the girl's deeper, hated feminine identification, in order to secure the "good" mother (the female homosexual partner later in life).

e. The anxieties which beset persons of this type are of an insistent and intractable nature, leading to an overriding, almost continual search for sexual partners.

f. Persistence of primitive and archaic mental mechanisms, leading to an abundance of incorporation and projection anxieties.

g. The anxiety which develops is due to fears of engulfment, ego dissolution, loss of self and ego boundaries. The homosexual act is needed to insure ego survival and transiently stabilize the sense of self. Consequently, the act must be repeated frequently and out of inner necessity to ward off paranoidal and incorporative fears. (The rare exceptions in this type, who cannot consciously accept the homosexual act, struggle mightily against it and, therefore, the symptom remains latent, as explained in Type 5.)

h. The homosexual symptom is ego-syntonic, as the nuclear conflicts, e.g., fears of engulfment, loss of ego boundaries, loss of self, have undergone a transformation and disguise through the mechanism of the repressive compromise,

allowing the more acceptable part of infantile sexuality to remain in consciousness. (See Sachs mechanism in section on Developmental Factors).

i. There is a predominance of pregenital characteristics of the ego; remembering is often replaced by acting out.

j. Aim of the homosexual act: ego survival and a reconstitution of a sense of sexual identity in accordance with anatomy. The male achieves "masculinity" through identification with the male sexual partner; reassures against and lessens castration fear. The female achieves "resonance" identification with the woman partner; reassures against and lessens castration fears. She also creates the "good" mother-child relationship.

2. Oedipal Type

a. This type is due to a failure of resolution of the Oedipus complex and to castration fears, leading to the adoption of a negative oedipal position and a regression in part to anal and oral conflicts (a partial preoedipal regression). The male assumes the role of the female with the father (other men); the female the role of the male to the mother (other women).

b. Homosexual wishes in this type are unconsciously motivated and dreaded; engagement in homosexual practices is not obligatory. The sexual pattern is flexible in that heterosexuality can be carried out and is usually the conscious choice.

c. Gender identity disturbances of masculine sexual identity in the male (or deficient feminine sexual identity in the female) are due to a secondary identification with a person (parent) of the opposite sex in this type. (This is simply a reversal of normal sexual identification in the direction of the same-sex parent.)

d. The anxiety which develops in the male is due to fears of penetration by the more powerful male (father); the female fears rejection by the more powerful female (mother). Common to both are shame and guilt arising from superego and ego conflicts, conscious and unconscious, attendant to engaging in homosexual acts in dreams and fantasies and, occasionally, in actuality, under special circumstances of stress. Homosexual acts in this type are attempts to insure dependency and attain power through the seduction of the more powerful partner.

e. Primitive and archaic psychic mechanisms may appear due to regression. These are intermittent and do not lend a stamp of pregenitality to the character traits of the individual, as they do in the preoedipal type.

f. The homosexual symptom is ego-alien. Although unconsciously determined, it is not the outcome of the repressive compromise (Sachs mechanism), as described in Type 1 above. The symptom may remain at the level of unconscious thoughts, dreams, and fantasies, as it is not a disguised, acceptable representation of a deeper conflict. When it threatens to break into awareness, anxiety develops.

However, under certain conditions, e.g., defiant rage overriding the restraining mechanism of conscience, periods of intense depression secondary to loss, with resultant needs for love, admiration, and strength from a person of the same sex, homosexual acts may take place. Such acts, however, do not achieve the magical symbolic restitution of the preoedipal type. They may exacerbate the situation through loss of pride and self-esteem.

g. Aim of the homosexual act: to experience dependency on and security from "powerful" figures of the same sex. The sexual pattern of the negative oedipal type is not as inflexible or stereotyped as in the preoedipal type. There are exacerbations and remissions in the sense of masculine identity (in the female, in the sense of pride and achievement in feminine identity) secondary to successful performance in other (non-sexual) areas of life. Such feelings of success diminish any fantasied or actual need for sexual relations with persons of the same sex.

3. Situational Type

a. Environmental inaccessibility to partners of the opposite sex.

b. The behavior is consciously motivated.

c. Homosexual acts are not fear-induced but arise out of conscious deliberation and choice.

d. The person is able to function with a partner of the opposite sex.

e. The sexual pattern is flexible and these individuals do return to opposite sex partners when they are available.

4. Variational Type

a. The motivations underlying this form of homosexual behavior are as varied as the motivations which drive men and women to pursue power, gain protection, assure dependency, seek security, wreak vengeance, or experience specialized sensations. In some cultures, such surplus activity is a part of the established social order; in others, entirely a product of individual enterprise, contrary to the general social order. The homosexuality practiced in ancient Greece was in all probability variational in type. There were strict laws against it (except for its practice during a brief period in late adolescence). Penalties included disenfranchisement of those engaged in catamite activities (anal intercourse). Sentiments expressing admiration and affection for youth (so-called homosexual sentiments), short of homosexual relations, were allowed. In ancient Sparta, homosexuality could be punished by death.

b. The behavior is consciously motivated.

c. Homosexual acts are not fear-induced, but arise out of conscious deliberation and choice.

d. The person is able to function with a partner of the opposite sex.

e. The sexual pattern is flexible, and these individuals do return

to opposite sex partners when they so prefer.

5. Latent Type

a. This type has the underlying psychic structure of either the preoedipal or oedipal type, without homosexual practices.

b. There is much confusion in the use of the term "latent homosexuality," due to the erroneous and outmoded concept of constitutional bisexuality, which implies that side-by-side with an innate desire for opposite-sex partners there exists an inborn or innate desire for same-sex partners. Correctly, latent homosexuality means the presence in an individual of the underlying psychic structure of either the preoedipal or oedipal type, without overt orgastic activity with a person of the same sex.

c. The shift from latent to overt and the reverse is dependent on several factors:

i. The strength of the fixation at the preoedipal level (quantitative factor), severity of anxiety, and the intensity of regression from the later oedipal conflict.

ii. The acceptability of the homosexuality to the ego (self), the superego (conscience mechanism), and the ego ideal.

iii. The strength of the instinctual drives, i.e., libido and aggression.

These individuals may never or rarely engage in overt homosexual

activities.

d. The latent homosexual may or may not have any conscious knowledge of his preference for individuals of the same sex for orgastic fulfillment. On the other hand, there may be a high degree of elaboration of unconscious homosexual fantasies and homosexual dream material, with or without conscious denial of its significance. They may live an entire lifetime without realizing their homosexual propensities, managing to function marginally on a heterosexual level, sometimes married and having children.

e. Another pattern is that of the individual who, fully aware of his homosexual preference, abstains from all homosexual acts. Others, as a result of severe stress, infrequently and transiently do engage in overt homosexual acts, living the major portion of their lives, however, as latent homosexuals. In the latent phase, they may maintain a limited heterosexual functioning, albeit unrewarding, meager, and usually based on homosexual fantasies. Or, they may utilize homosexual fantasy for masturbatory practices or may abstain from sexual activity altogether. These individuals are, of course, truly homosexual at all times; the shift between latent and overt and the reverse constitutes an alternating form of latent homosexuality.

f. All forms of latent homosexuality are potentially overt. Social imbalance—where severe inequities exist between one's survival needs due to the failure of society to ensure their adequate satisfaction—has a precipitating effect in some

> borderline and/or latent cases of both preoedipal and oedipal homosexuality. Such imbalance also brings a flight from the female on the part of the male, a flight from all aspects of masculine endeavor, and a retreat to a less demanding role. This is a possible explanation of the apparent rise in the incidence of male homosexuality during periods of social turbulence when many traditional roles, privileges, and responsibilities are overturned. The same factors may cause an increase in female homosexuality.

Discussion

Preoedipal and oedipal homosexuality are reparative in nature, and "ushered in by the inhibition of standard performance through early [childhood] fears." Preoedipal homosexuality may be compared to the narcotic addict's need for a "fix." The purpose of the homosexual act is to maintain the equilibrium of a highly disturbed individual.

In connection with the situational type, Bieber reported that men who had not been homosexual prior to military service were found not to have engaged in homosexual activity throughout their tour of duty, despite the absence of female partners, with rare exceptions. This finding suggests a possible revision of the concept of situational homosexuality in instances where the coercive factor is absent. Much of the so-called situational factor in prisons is an outcome of the struggle for dominance and is, in fact, rape. The

infrequency of validated situations in which heterosexuals engage in homosexual relations reaffirms the strength of the male-female design, once it has been established in the human psyche; parenthetically, it explains the popularity of the “pin-up” during World War

Undoubtedly, sexual outlet was achieved under those trying conditions of sexual deprivation via masturbation, within the fantasy twosome of heterosexual relations abetted by photographs of artistically posed semi-nude females.

Variational homosexuality may occur in individuals who seek to gratify the desire for an alternation of sexual excitation, often for reasons of impotence or near-impotence in the male partner of the heterosexual pair. Much of the heterosexual group sex activity currently reported includes homosexual behavior between male and female participants, and is of this type. In some instances, individuals with unconsciously derived homosexual conflicts take part in such group activities, in order to act out their homosexual wishes and simultaneously to deny their homosexual problem.

Variational homosexuality may also be seen in the neurotic, psychotic, and sociopath. It frequently occurs in those suffering from alcoholism, as well as in depressive states.

Psychopathology

Pathology, whether somatic or psychic, is defined as failure of function with concomitant pain and/or suffering. It is this failure, its significance and manifold consequences, which is so obvious in obligatory preoedipal homosexuality—a failure in functioning which, if carried to its extreme, would mean the death of the species.

A number of items serve as indicators of psychic pathology in the obligatory homosexual. They may not appear in all cases, and they may differ qualitatively and quantitatively from patient to patient:

1. A lifelong persistence of the original primary feminine identification with the mother, and a consequent sense of deficiency as regards one's masculine identity. The end result is a pervasive feeling of femininity or a deficient sense of masculinity.

2. A fear of engulfment and consequent extreme anxiety whenever an obligatory homosexual attempts to establish any sexual relatedness to a woman.'

3. A persistence of archaic and primitive psychic mechanisms, e.g., the presence of incorporative and projective anxieties.

4. There is often present a deficit in the body ego boundaries, with fears of bodily disintegration and unusual sensitivity to threats of bodily damage by external objects.

5. In the dream life of all obligatory homosexuals lies the fear of

engulfment. This is commonly symbolically represented by fears of encasement in caves, tunnels, whirlpools, deep immersion into bodies of water, etc. with a threat of personal annihilation and loss of self. These derive from the fear of engulfment by the body of the female.

6. Sexual acts can be carried out only with a person of the same sex or through the combined use of other perversions.

7. Beneath the surface rationalizations of "love and affection," severe, damaging, disruptive, aggressive impulses threaten to destroy both the relationship and the partner.

8. Homosexual acts are sometimes carried out to avoid a paranoid development or a paranoid psychosis.

9. The homosexual act itself may be likened to the effects of the opium alkaloids in their magical restorative powers: the optimum "fix," reinstating the body ego and sense of self against a threat of disruption, and in severe cases, imminent disintegration of the personality. Homosexual acts, therefore, are intense, impulsive, their urgency deriving from the emergency need of survival for the ego of the homosexual.

10. Beneath the male homosexual's apparent affection for men lies the search for love from the father or father-surrogate and a concomitant wish to wreak vengeance upon him, the son's wish for masculine identification having been frustrated by the father's absence, coldness, apathy, or disdain. Furthermore, the father fears his phallic, castrating wife and

does not interfere with her domination of the child. The son harbors deep distrust, rage and resentment toward men, because the father failed to protect him from the engulfing mother.

11. All obligatory homosexuals suffer from a deep sense of inferiority, worthlessness, and guilt because of their inability to function in the male role. These feelings are not caused by societal attitudes but are aggravated by them.

12. Most homosexuals suffer from a considerable degree of psychic masochism. The aggressive assault toward the mother and secondarily toward the father is drained off into a psychic masochistic state. All homosexuals deeply fear the knowledge that their homosexual behavior constitutes an eroticized defense against this more threatening masochistic state. The masochism seeks discharge through homosexual activity.

13. In most homosexuals, anxiety derived from preoedipal and oedipal conflicts undergoes an eroticization or libidinization.

14. Homosexuals tend to suffer from concomitant psychiatric conditions. For example, a large number of paranoid schizophrenics, paranoiacs, and pseudo-neurotic schizophrenics have a homosexual conflict, and many manifest homosexual behavior. Freud first called attention to the possibility that certain neurotic and psychotic symptoms were the expression of an underlying homosexual conflict. In the schizophrenic, homosexuality may be an outgrowth of a

confused, chaotic, and fragmented psychic organization. The desperate need to make human contact on any basis leads the individual to engage in all forms of sexual activity, including homosexual acts. These may be spasmodic attempts to experience relatedness, and there is often no consistency or specific quality to these episodes.

15. It is characteristic that upon attempting interruption of homosexual activities, severe anxiety, tension, depression, and other symptomatology will make a dramatic appearance, therefore underscoring a function of the homosexual symptom, namely, that it is a compromise formation against deep anxieties. This outcome of such interruption is consistently seen in the course of treating homosexuals in depth.

16. A frequent finding is that additional sexual deviations occur simultaneously, or sometimes alternate, with homosexuality; the most common are fetishism, transvestitism,' and exhibitionism.

Clinical Symptoms

To ensure completeness, in addition to the items set forth in the preceding section on psychopathology, a comprehensive listing of the symptomatology of obligatory preoedipal homosexuality is outlined below:

a. Symptoms arising out of the failure to make the intrapsychic separation from the mother:'

i. Excessive clinging to the mother in infancy and early childhood.

ii. Severe anxiety upon separation from her, noticeable from earliest childhood ("screaming phenomenon"), and continuing throughout life.

iii. Merging and fusion phenomena; fear of the engulfing mother; faulty body ego image because of the failure to separate, and the lack of delineation of one's own body from that of the mother; there may be a consequent inability to appreciate body-space relationships.

iv. Intensification of primary feminine identification.

b. Symptoms arising from the predominance of archaic, primitive psychic mechanisms:

i. Incorporative anxieties (fears of swallowing parts of one's own body, fears of internalized harmful objects, etc.).

ii. Projective anxieties (paranoidal anxieties, e.g., fears of poisoning, bodily attack, and persecution),

c. Symptoms arising from faulty gender identity:

i. Continuation of the persistence of primary feminine identification with the mother (inner feelings of femininity).

ii. Corresponding feelings of a deficit in masculinity with anxiety appearing when faced with attempted performance in the appropriate gender role.

d. Symptoms which are manifestations of the negative Oedipus complex:

i. Wishes to replace the mother in sexual relations with the father by vaginalizing the anus.

ii. The sexual wish for intercourse with the father is realized in fantasy or is enacted vicariously in the homosexual act with another male.

e. Symptoms representing castration anxiety:

i. Fears of penetrating objects, accidents, open wounds, haircuts.

ii. Other symbolic representations of the forceful removal of the penis.

f. Symptoms arising from the wish for and fear of extreme closeness to the mother, the intense dependency on her for a feeling of well-being and survival, and the intense identification with her:

i. Intense oral-sadistic relationship with the mother (intense sadism toward her is disguised by its opposite, a masochistic attitude toward her).

ii. Passive homosexual feelings toward the father, often repressed (taking the place of the mother in sexual intercourse, both to protect and supplant her and to wreak vengeance on the father through appropriating his penis).

iii. Maintenance of a position of optimal distance from and/or closeness to the mother and other women.

iv. Fear of the sudden approach of the mother, as if she would devour, engulf, and incorporate him. (This fear of the mother's engulfment and control, which in part reflects his wish for and dread of her domination, is then generalized to a fear of all women and engulfment by them, especially by the female genitalia and pubic hair.)

g. Symptoms relating to the father, arising from persistent primary feminine identification and the father's failure to provide appropriate masculine identity and protection from the mother:

i. Hostile, contemptuous attitude toward the father.

ii. Yearning for lost, masculinity and attempts to find it by soliciting affection and admiration from other boys during childhood.

iii. Development of unconscious wishes to control older boys (the father) through feminine-like seductiveness and sexual fantasy.

h. At puberty and in early adolescence, the response to hormonal stimulation and anatomic growth is an intensification of anxiety due to a deficient masculine identity and inability to perform in the masculine anatomic, physiological, and psychological roles:

i. Powerful feelings of inferiority, shame, and guilt.

ii. Hostility toward his penis and masculinity, which reinforces aspects of his feminine identification (mood, manner, stance, posture, dress, voice, facial expression, hand gestures, areas of interest—a psychophysiological "molding" of appearance or "psychosomatic compliance").

iii. Sensing of defect in masculinity; may engage in a compensatory "masculinization" through weight-lifting, body-building, and a heightened narcissistic overvaluation of the body.

iv. Onset of experiencing the insistent internal need for "filling up" the emptiness of his masculine ego (self) through the incorporation of the body of a male partner, especially of the latter's penis; full-scale homosexual activity usually begins in adolescence to alleviate the defects of the masculine ego and to acquire a sense of masculine self in accordance with anatomy.

i. Symptoms present in adulthood:

Constant yearning and search for masculinity; by engaging in homosexual acts, he incorporates the male partner and his penis, thus strengthening himself.

ii. Every homosexual encounter first concerns itself with disarming the partner through one's seductiveness, appeal, power, prestige, effeminacy, or "masculinity." This simulation of the male-female pattern (active vs. passive, the

one who penetrates vs. the one who is penetrated) should not lead to the conclusion that the motivation of either partner is to achieve femininity; both partners are intent upon acquiring masculinity from each other. To disarm in order to defeat is the motif, and if one submits in "defeat," gratification is nevertheless obtained by the victim vicariously, through identification with the victor. Despite any surface manifestations to the contrary, *to disarm and defeat* invariably characterizes all encounters between homosexuals.

iii. Many homosexual acts are purely egocentric. Tender, affective reciprocity, when present, is frequently based on the need for parental care, economic security, or magical fulfillment. Quite commonly, some homosexuals prefer to achieve contact anonymously, even to the use of an aperture in a toilet stall wall, extending one's own penis and/or grasping the other's penis without face-to-face encounter. This is the enactment of the fundamental nature of their object relationships, namely, relating to part objects, not whole objects.

iv. Both one-to-one as well as multiple homosexual contacts between a variety of partners assembled in a group have as their aim the immediate gratification and alleviation of urgent destructive feelings threatening extinction to the self, were they to be contained; other individuals are the instruments through which the homosexual seeks expression of and release from oppressive and importunate anxieties, guilts, incestuous feelings, and feelings of

aggression.

v. This stereotyped compulsive searching for sexual gratification with individuals of the same sex may completely dominate the life of the homosexual, not allowing him to invest his interest in other important activities, a realization which is often the source of great personal anguish to him.

vi. Chronic psychic masochism.

vii. Whenever homosexuality is not engaged in for any reason, including self-denial or lack of opportunity, there is a mounting tension, anxiety, and depression. If the homosexual act does not take place, severe anxiety will result, other perverse activities may be pressed into service, and other signs of neurotic conflict may appear, e.g., psychosomatic symptoms.

viii. Deep, unconscious sense of worthlessness and consequent inability to function well in other major life areas.

ix. Chronic paranoid anxiety of mild to severe degree is often present.

x. Deep-rooted sense of guilt and shame derived from aggressive impulses toward parents and from inability to fulfill biological gender role; societal guilt may be superimposed.

xi. Premature attempts at sexual relations with women may result in severe anxiety, fears of engulfment, a sense of bodily disintegration, other regressive symptomatology. It

must be remembered that the homosexual act "magically" produces a psychic equilibrium in order to temporarily withstand the multiple anxieties which beset the homosexual.

Female Homosexuality

Kinsey's statistical compilations show that among females the cumulative evidence of homosexual responses was 28 percent, and those to the point of orgasm, 13 percent. He reported that homosexual responses occurred in about only one-half as many females as males, and homosexual contacts between women to the point of orgasm in about one-third as many females as males. Compared to males, there were only about one-half to one-third as many females who at any age were primarily or exclusively homosexual.

To the present author, these statistics are of questionable validity, as female homosexuality may exist largely unnoticed. The changing psychoanalytic concepts of male and female homosexuality have been summarized by Wiedeman and Socarides. In these reports, it was pointed out that while the literature on male homosexuality has been rather extensive, that on female homosexuality has been relatively neglected. Its literature is meager both quantitatively and qualitatively, with some notable exceptions.

Many scientific writers prefer to use the term "Lesbianism" to describe

the clinical condition of female homosexuality. This reflects an attempt to romanticize and minimize it. In most instances, female homosexuality is pictured as either a psychosis or a case of "perverse morality" which ultimately becomes good morality through the love of a man. An alternative depiction is that of the unfortunate woman virtuously fighting off her homosexual desires but remaining emotionally unfulfilled. Men themselves generally consider homosexual relations between women as providing only superficial pleasure at best, and some do not even consider female homosexual contacts as sexual at all, despite intense orgastic experiences between the women involved.

In contrast to the frequent interest of the male homosexual in young adolescents, the female homosexual is seldom attracted to early post-pubertal girls to the point of actual seduction.

Very often, a homosexual woman will view her future with more anxiety than will the heterosexual woman. She will, therefore, undertake marriage for the sake of economic security, to overcome a sense of inner and social isolation, and to satisfy the expectations of family and society. Once married, her sexual life with a partner of the same sex may of necessity become a highly clandestine one. A wife may have a female lover completely without her husband's knowledge. Many homosexual women marry and are regarded as heterosexual, although they remain sexually unresponsive to their

husbands.

It is difficult to ascertain how many marriages are ultimately dissolved because the female partner is an overt or latent homosexual. Occasionally, a homosexual woman may marry simply to have a child whom she then treats as she wished to have been treated during her childhood. She will divorce the husband and thereafter lead a completely homosexual life. In general, homosexual men do not ordinarily view marriage as a social or economic solution, nor feel impelled to it in order to achieve fatherhood.

Of crucial importance is the fact that women can have sexual intercourse without desire. This aids in both the conscious or unconscious self-deception on the part of the woman as to her homosexual feelings and wishes. She may not even know that her resentment and lack of love for her husband are due to her homosexual conflict. A man, however, requires the preliminary presence of desire in order to achieve erection; in its absence, he must perforce appear inadequate and face the loss of sexual pride and the esteem of the partner. Women may successfully submit to a sexual life which they find meaningless and even distasteful, and still manage to hide their narcissistic mortification, humiliation, and resentment, living out a masquerade of womanliness.

Female homosexuality has important and significant social and

psychological effects. It is severely disruptive of the family unit. Any child of an overtly homosexual mother is exposed to a variety of psychological traumata of intense proportions.

Psychodynamics of Female Homosexuality

Obligatory female homosexuality is always reparative in function, as already explained in the discussion on obligatory homosexuality in the male. In female homosexuality, only the organs of the female partner are desired, while those of the male are abhorred and feared. These women react to penetration by, at best, little or no sensation; at worst, with pain and fantasies of invasion.

In the female, preoedipal and oedipal phase conflict (age, birth to five) may be reanimated and has to be overcome every time a new sexual stage, such as puberty, menstruation, sexual intercourse, pregnancy, childbirth, occurs. This is a tremendous complication, and in those women whose sexual functioning has already been weakened by infantile conflicts, female homosexuality may be activated at any point.

Female sexuality is further complicated by the fact that girls do not develop directly toward femininity; they make a roundabout detour through masculine attitudes, not only in childhood but often in puberty.

A still further complication is the fact that the little boy can inspect his genital to see if any consequences of masturbation or castration fear have occurred, whereas the little girl cannot thus reassure herself. Her anxiety and guilt may cause her to assume a fictitious male role for varying periods of time.

In 1931, in his article on female sexuality, Freud stated that if the girl clings in obstinate self-assertion to masculinity, we may see that the hope of acquiring a penis is prolonged to an incredible age and may become the aim of her life. The fantasy of really being a man in spite of everything may dominate her, and may result in a homosexual object choice.

Clinical Picture

A female homosexual usually does not seek treatment because of homosexuality. She may have been forced into therapy by pressure from her family, by depression over the loss of a love partner, or a concomitant neurosis and/or psychosis. The homosexuality itself may be a partial expression of the underlying neurosis and/or psychosis which may have been temporarily warded off through homosexual activities.

Usually, she suffers from feelings of depression or anxiety, arising from insecurity about the loyalty of her partner. Often, she suffers from suicidal ideas. In many instances, therapy reveals an unconscious aggressive,

murderous hatred against her mother. Sexual excitement is bound up with maternal prohibition. Aggressive impulses are resisted, and as a reaction to them an intense sense of guilt toward the mother appears. This leads to the transformation of hate into a masochistic libidinal attitude. This libidinal relationship, although masochistic, appears in place of the anxiety and hostility which would have caused openly neurotic symptoms. In later life, the mother-substitute (homosexual partner) pays off the infantile grievances by granting sexual satisfaction.

Some overtly homosexual women recognize the mother-child relationship implicit in their partnerships. In all of them, sexual satisfaction is obtained from close embrace, sucking of the nipples and genitals, anal practices, mutual cunnilingus, or the use of phallic devices. Often, there is a double role casting for both partners, one now playing the male and the other playing the female. In other pairs, there can be a consistent male or female role for each partner.

In those cases of overt female homosexuals who are borderline schizophrenics, conscious or nearly conscious thoughts of killing the mother and the siblings are present.

During sexual experiences between women, both partners are able to transform the hate of the mother into love, while simultaneously receiving

the “good” mothers (partner’s) breast. Each of them thereby obtains what she wished so much to have had—the “good” mother—during the early years of life.

Almost always, there is an intense conflict over childhood masturbation. In the sexual act, the “mother” sanctions masturbation through a mutuality of action and sharing of guilt by the partners.

The homosexual woman is in flight from the man. The reasons for this flight are childhood feelings of guilt toward the mother, and fears of disappointment and rejection by the father if she dared to turn to him for love and support. On the other hand, she may expect that he would even gratify her infantile sexual wishes, thus incurring for her a masochistic danger. If he refuses her, it would constitute a narcissistic injury. The resolution of these dangers is to turn to the earlier love object, the mother, in the form of a homosexual partner. It is a reversion to a fantasied previous pleasure. “The economic advantage of this new turning to the mother lies in the release from a feeling of guilt. But it seems to me that its most important accomplishment lies in the protection from a threatened loss of object: ‘If my father won’t have me and my self-respect is so undermined, who will love me, if not my mother?’ ”

In other cases of female homosexuality seen by the present author,

preoedipal fears of the primitive type described by Melanie Klein appear, especially when a threat of rejection by the partner occurs. Fears of being poisoned, devoured, attacked, contaminated, or dismembered by the partner (preoedipal mother) are evident in dreams and in the waking state. In childhood, the original flight to the mother was an attempt to gain her love ("buy protection"), alleviate feelings of murderous aggression toward her, and to protect the self against the assumed murderous impulses of the mother. This is what is reenacted in the adult female homosexual relationship.

The homosexual woman is prone to experience a crisis state first described by Jones in 1927 as "aphanisis." While castration is a partial threat, aphanisis is a total threat—a threat to survival, involving total extinction and abandonment. Having renounced all interest in men and believing themselves hated by women, female homosexuals very often become suicidal if faced with loss of the love object.

Homosexual women who do retain any interest in men have as their underlying goal to be accepted by men as one of them.[2] These are the women who often complain of the unfairness of their lot, and of unjust and ill treatment meted out to them by men. Others, with little or no interest in men, vicariously enjoy femininity via their women partners.

Those who desire penetration by the tongue or finger (some female homosexuals object to any form of penetration) require that this be done only by a woman. Seemingly the "most homosexual," these patients have the best prognosis of all female homosexuals. Quite commonly, the identification with the father is present, which serves to keep feminine wishes in repression. This identification is also for the unconscious purpose of giving a child to the mother.

The female homosexual projects her femininity onto the mother, and then onto other women who continue to represent the mother. She may see herself mirrored in other women who have a high degree of feminine narcissism. In effect, she has projected her femininity onto others and enjoys an identification with herself. This femininity sometimes is projected only onto women who are known by her to cause men to suffer and refuse them satisfaction; with them she has an "ideal" partner.

Homosexual women play a "mother and child" relationship to the exclusion of the intruding father. Those who identify themselves with the active mother may be attracted to very young girls, although they do not attempt to actively seduce them. Conversely, those who continue to act the child are attracted chiefly to older, maternal, protective women, toward whom they are very passive. On occasion, both active and passive attitudes are evident in the same person or alternate between the partners. It is

striking in those who identify as the child that any device substituting for the penis is abhorred, and no masculine clothing is worn at any time by either individual of this pair.

Other homosexual women wear masculine clothing, including ties, and strive to act the man in relation to the partner. These women have double identifications, one superimposed upon the other. They identify with the father and with the "good" mother who cares for the child. They find it extremely difficult to admit to any passivity or wish to be caressed themselves.

The most difficult of all women to treat are those who ostensibly give up "loving" mother (other women), and take the father as their love object. They cannot tolerate any love object without a penis, perceiving this as a severe inferiority. They unconsciously cling tenaciously to the idea that they themselves possess a Active penis; at times, this may become a conscious fantasy. Although they may engage in heterosexual intercourse, they are ambivalent in the extreme in their relationship to their male partners and experience intermittent intense unconscious and conscious homosexual wishes. On occasion, when tense and depressed following a rejection or failure, they may briefly engage in an actual homosexual encounter.

It is important to note that some female homosexuals may appear

extremely feminine. These women choose the opposite extreme of masculine-appearing homosexual women for their partners, seeking from them the attention they wished to have had from their fathers.

Therapeutic Considerations

Psychoanalytic Therapy

In 1905, Freud wrote that the only possibility of helping homosexual patients was to demand a suppression of their symptoms through hypnotic suggestion. By 1920, he believed that psychoanalysis itself was applicable to the treatment of perversions, including homosexuality, but later expressed caution about the possibility of complete cure. His criterion of cure was not only a detachment of cathexis from the homosexual object but also the ability to cathect the opposite sex.

In 1950, Anna Freud lectured in New York on the recent advances in treatment of homosexuals, stating that many of her patients lost their inversion as a result of analysis. This occurred even in those who had proclaimed their wish to remain homosexual when entering treatment, having started only to obtain relief from their neurotic symptoms.

It subsequently became the consensus that homosexuals could be treated for the most part like phobics. However, this presented considerable

difficulty, including the probability of premature termination of treatment and the production of excessive anxiety. The major challenge in treating homosexuality from the point of view of the patient's resistance has, of course, been the misconception that the disorder is innate or inborn.

It is now widely agreed that to achieve therapeutic success it is necessary to interpret to the patient his fear of castration; his fear of oral dependence; his distrust of the opposite sex; and his fear of his own destructiveness and sadism. However, in this writer's experience, the interpretation that most effectively achieves a relaxation of the patient's resistance is that of the attempt to acquire masculinity through identification with the partner and his penis in the homosexual act. After this interpretation is worked through, the patient may be able to function heterosexually, going through a strong narcissistic-phallic phase, women serving only the "grandeur" of his penis.

Detailed reports of successful resolution of cases of overt homosexuality have been published by Flournoy, Lagache, Poe, Socarides, Vinchon and Nacht, and Wulff. In addition, important insights are offered by Bergler, Bychowski, Anna Freud, Freud, Glover, Lorand, Nunberg, Ovesey, Rosenfeld, Socarides, and Sachs.

Data on positive therapeutic outcome have been collected in surveys by

the American Psychoanalytic Association, and by the Bieber study conducted by the Society of Medical Psychoanalysts, the former presented in statistical format.

The central issues which must be uncovered and worked through by both patient and therapist are the following:

1. While the analysis of oedipal fears of incest and aggression is of paramount importance in the course of treatment, it is vital to the understanding and successful resolution of homosexuality that the nuclear preoedipal anxieties be revealed. These consist of primitive fears of incorporation, threatened loss of personal identity, engulfment by the mother, and personal dissolution which would accompany any attempt to separate from her.

2. The homosexual makes an identification with his partner in the sexual act. Homosexual contact promotes a transient, pseudo-strengthening of his own masculinity and identity, which must be constantly repeated or a psychic decompensation occurs. The homosexual seeks masculinity, not femininity, and knowledge of this unconscious motivation becomes a potent source of strength, reassurance, and determination for change in the direction of heterosexual functioning.

3. The conditions under which the imperative need for homosexual relief occurs include mounting anxiety, depression, and paranoid-type fears.

4. The ubiquitous presence of a distorted body ego is manifest.

5. The penis of the partner is revealed to be a substitute for the feeding breast of the sought-after "good" mother (breast-penis equation). The homosexual thereby escapes the frustrating cruel mother and makes up for the oral deprivation suffered at her hands.

6. There is a characteristic demeaning and degrading of the father, often quite openly. The patient identifies with the aggressor (mother). This hatred of the father produces guilt, and in therapy is an impediment to his feeling entitled to be a man.

7. At unconscious levels, there exists an intense yearning for the father's love and protection. This deprivation is a further frustration of the need for masculine identification. The homosexual act dramatizes the yearning as well as the frustration-derived aggression toward all men as a consequence.

8. Heterosexual interest and strivings are continually subject to suppression and repression in the course of therapy. This is due to unconscious guilt feelings toward the mother because of intense incestuous and aggressive impulses.

9. The careful maintenance of the positive therapeutic alliance is a considerable source of strength to the patient in his attempts to control and finally triumph over his fears of murderous retaliation on the part of the mother, as he gradually moves toward his long sought-for masculine identity.

Group Therapy

Because the exploration of conscious and unconscious fantasies, feelings, and actions are limited in group therapy, it is wise to combine it with individual therapy. Successful results utilizing group therapy have been reported by Gershman, Hadden, and T. Bieber.

Gershman has provided a clear description of the group process. He has conducted a combined program of simultaneous group and individual therapy for the past twelve years. He shows that healthy and unhealthy interplay between a patient and seven or eight of his peers brings issues sharply into focus. The therapist along with others in the group assists in promoting awareness of healthy interactions, neurotic defenses, and conflicted feelings toward oneself and others. The groups are composed entirely of homosexuals, generally five men and four or five women.

It was found that such homogeneous groups go far toward minimizing competitiveness, feelings of inferiority, and secretiveness. Because of their common sexual orientation, mutual interest and concern are evident; sometimes, their feelings are acted out homosexually outside the sessions. The attitude of the group to such liaisons is generally empathic, but skeptical as to the motivation and durability of such a relationship. During the ordinarily brief duration of the liaison, the partners involved are generally reticent about discussing it. But upon its termination, much material emerges

in retrospect regarding the underlying anxieties that drove one to the other.

Thus, an atmosphere of mutual acceptance and dedication to a common goal of trying to understand the source, nature, dynamics, and tenacity of the homosexual symptom is established. Although homosexuality is the common basis of the group, the emotional difficulties from which each member suffers in his own life are unique to that individual. Anxiety, either conscious or unconscious, provides valuable therapeutic material. The advantage of group examination of the material stems from the fact that resistance is lowered through the contributions of additional personal insights offered by all members of the group and heightened by the special psychodynamic knowledge of the therapist.

The predominant attitude toward fellow-group members is generally sympathetic, encouraging, and growth-promoting. Inasmuch as the group meets only for one-and-a-half to two hours weekly, it would seem that not enough time is available for each participant to investigate his life situation in depth. That, however, is not true. Customarily, one or two members dominate any given session, as a result of the intensity of the conflicts that have erupted within them. As that material unfolds, each member identifies with it and often brings in correlative material that stems from his own life, to help to explain and expand the significance of the material brought out by the presenting member. As a consequence, each learns the nature, application,

and efficacy of expressing and communicating his thoughts and feelings as freely as possible. Similarly, dream material, emotional responses, changes in mood, sudden blocks to verbalization, and other phenomena, are understood in terms of intrapsychic processes by each member through memory or through identification with other members.

The consequences of such experiences are often dramatic. This is in part due to the intense interaction, clarification, and understanding of various events that come under group scrutiny. Members gradually learn the dynamics of their unconscious and the correlation of their present manner of living to the conditioning factors of their early life. More than that, they learn to recognize the psychodynamic forces that gave rise to homosexuality.

The position of the group as to the question of changing from homosexuality to heterosexuality becomes in time a belief that such change is possible, depending upon the strength of motivation and the willingness to withstand the anxiety entailed in such progress. From many years of experience with group therapy with homosexuals, Gershman reports that he has yet to see a patient whose degree of anxiety at least has ultimately not diminished. About 20 percent, he estimates, have been able to change to active heterosexual functioning as a result of combined individual and group therapy.

Discussion

The general pessimism as to the outcome of treatment of homosexuality is diminishing. The unpublished informal report of the Central Fact Gathering Committee of the American Psychoanalytic Association was one of the first surveys to be made available on this issue. Out of 46 cases, 8 in the completed group (which totaled 22) were described as cured, 13 as improved, and 1 as unimproved. This constituted one-third of all cases reported. Of this group, those that did not complete treatment (24), 16 were described as improved, 3 as untreatable, 5 as transferred. In all reported cures, follow-up communications verified assumption of full heterosexual role and function.

Out of the 106 homosexuals studied by Bieber et al., 29 (27 percent) became exclusively heterosexual.

This writer noted in 1968 that over 50 percent of the obligatory homosexuals whom he has seen (over a seventeen-year period), strongly motivated for change and undergoing depth therapy, have not only shown full heterosexual functioning but have been able to develop love feelings for their heterosexual partners.

In addition to the uncovering techniques of depth psychotherapy and psychoanalysis, treatment requires educational and retraining measures, interventions and modifications in the handling of transference, resistance,

and regression.

In 1953, the Portman Clinic survey in England reached the following conclusions:42 “Psychotherapy appears to be unsuccessful in only a small number of patients of any age in whom a long habit is combined with . . . lack of desire to change.” The Portman Clinic, under the direction of E. Glover, divided the degrees of improvement into three categories: (a) Cure, i.e., abolition of conscious homosexual impulse, and development of full extension of heterosexual impulse, (b) Much improved, i.e., the abolition of conscious homosexual impulse, without development of full extension of heterosexual impulse, (c) Improved, i.e., increased ego integration and capacity to control the homosexual impulse.

In conducting *focal treatment* (brief therapy aimed at the relief of the homosexual symptom), Glover states that the degree of social anxiety that prevails, particularly among patients seen in private, is based on a projected form of unconscious guilt. He is of the opinion that the punitive attitude of the law and society enables the patient to project concealed superego reactions onto society or the law.

A therapist must decide whether to treat homosexuality through the regular course of depth therapy, or whether he and the patient will be satisfied with focal relief. In any case, according to Glover, the therapist must

deal with both conscious and unconscious guilt, severe anxiety upon the patient's attempting heterosexual relations, and, of course, oedipal conflict and castration anxiety.

It is necessary to demonstrate to the patient the defensive aspects of homosexual relationships. Only by uncovering the positive aspects of his original relationships to women (mother, sister), and by revealing their associated anxieties or guilts (real or fantasied) derived from the hostile aspects of these early experiences, can heterosexuality be attained.

The question of prohibiting homosexual activity in therapy should be decided on the basis of its unconscious meaning to the patient. Outbursts of hostility and anxiety may threaten continuation of therapy if the therapist prohibits activities that the patient considers necessary for survival.

In my experience, it is vital that the depth of regression be controlled, in order to offset its utilization as resistance in the transference relationship. It must be stressed to the patient that the resolution of his problems will have to take place outside the psychiatrist's office in attempting heterosexual functioning.

The following are important criteria for the selection of patients:

1. A feeling of guilt on the part of the patient for the unconscious wishes underlying homosexuality. The absence of conscious

guilt does not mean that the patient does not suffer guilt, but instead this may be experienced by him as a need for punishment and for engaging in self-damaging behavior. The presence of unconscious guilt arising from infantile fears and wishes lifts the problem out of its externalized context into an internal conflict. Once seen as an internal psychic conflict, the patient is at last on the path toward resolution of his homosexuality, and no longer can view himself solely as a victim of society's attitudes and judgments, should he have been so inclined.

2. Treatment must be voluntarily undertaken by the patient. Ideally, homosexual patients should not seek treatment under duress from parents or other authority figures because of the hostility they already feel toward their parents.

The patient's turning to heterosexual relationships often coincides with a strong positive transference. In the positive transference, the patient is able to identify himself with the "good" father (the therapist) and thus achieve in the transference what he has been unsuccessfully trying to achieve in homosexual relationships, namely, to become strengthened through the masculinity of the therapist. He can thereby begin to free himself from his enslavement to the mother.

When homosexual contacts become less frequent and lose their imperativeness, the patient is no longer so anxiety-ridden. Awareness of all feelings becomes much greater and he is more potentially capable of object

love. He becomes aware, too, that in reality his main competition in life is with men; that love and comfort are to be found with women in a complementary relationship.

While neither the hard work and resoluteness required of the therapist nor the courage and endurance required of the patient can be minimized in treating this serious disorder, in time both find the challenge and fulfillment to be equal in measure.

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Notes

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