SOME PROBLEMS IN THE TREATMENT OF HOMOSEXUALITY

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INTRODUCTION

ALL ATTEMPTS to determine whether any of the methods of treatment applied to cases of homosexuality† do have a therapeutic effect, suffer from the fact that the diagnosis of pathological erotic adjustment relies almost exclusively on verbal exploration. This fact is particularly disturbing in the therapeutic situation where the patients are inclined to deny certain facts in order to appear as cured and therefore to avoid any further treatment, which is often regarded as undesirable by them. On the whole, there does not appear to be any method of treatment the efficacy of which could be said to be very apparent and the proportion of cases of homosexuality where—with or without treatment—heterosexual adaptation is reached appears to be very small.

In order to make a systematic comparison of the number of "cures" following upon a particular method of treatment, and that arising in an untreated group of homosexuals, we would of necessity have to use a rather unreliable and purely clinical criterion; it would follow that the number of persons in the various groups would have to be rather large. Such a comparison would not appear very useful at the present time. It may, however, be useful even at the present early stage to look at a few important problems in this connection. In the first place there is the question of the success of psychotherapeutic treatment and the kind of heterosexual adaptation which may be achieved. In the second place the question arises as to whether, supposing a certain degree of success were to be discovered in psychotherapeutic procedures, this would be reducible to a particular common cause. In the third place an attempt may be made to discover prognostic signs which may throw some light on the probability of achieving

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† As usual, we shall denote as homosexual only those persons whose sexual desires are related exclusively or almost exclusively to persons of the same sex.

heterosexual adaptation. We shall begin with a short review of those methods of treatment which have been recommended in cases of homosexuality. These may be divided into three groups: the use of hormones, the use of various psychiatric methods and the use of psychotherapy.

THERAPY BY MEANS OF HORMONE TREATMENT

Work of this type was begun by Steinach and Lichtenstern.[1] Their claims for successful treatment were contradicted by several other authors who reported failure,[2] although Pfeiffer[3] has also reported an isolated success. In all these cases treatment consisted of the replacement of diseased glands by healthy ones.

Later types of treatment involving the injection of male hormones failed to show favourable results; indeed they often produced a deterioration of the patient's situation because these hormones as administered to homosexual men influenced the *strength* of the drive but not its *direction.* Only Lurie[4] and Myerson and Neustadt[5] believe in the efficacy of hormone therapy.

PSYCHIATRIC METHODS OF TREATMENT

An attempt to use electroshock has been reported by Thompson,[6] but no success was recorded with any of his 6 patients. Owensby[7] claims to have treated 6 homosexuals successfully by means of shock treatment, and Meduna[8] claims to have achieved very good results with some homosexuals through the use of his method of carbon dioxide inhalation.

PSYCHOTHERAPY*

Among older authors, such as Schrenck-Notzing, Forel, Krafft-Ebing (1924), Fuchs, Frey,[9] and many others, hypnosis and suggestion are considered the most appropriate treatments for homosexuality. Fuchs,[10] Frey, and others have published a series of cases which they consider cured. On the other hand, Diethelm[11,p.458] claims never to have seen a single case of homosexuality which was cured by hypnosis, and Allen[12] who prefers psychoanalytic methods, claims that neither hypnosis nor suggestion are of any use in well defined cases of psychosexual aberration.

Moll[13,14,15] reports on a series of therapeutic successes in a large number of quite different sexual aberrations by means of " Assoziations-therapie." This " consists in the appropriate directing of the patient's imagination, and in the methodical advancement of the *normal,* and the methodical suppression of *perverted* associations". For this purpose he advocates persuasion, the use of erotic literature, and similar types of pictorial material.

* This term is used here as covering every therapeutic treatment which does not depend on chemical or physical methods, regardless of whether verbal or non-verbal methods are being used.

Kronfeld[2] reports failure of these methods in contradiction to Moll. Bechterev[16] recommends " distraction therapy,"* in which he uses hypnosis and suggestion as well as persuasion.

A number of psychoanalytic writers claim to have treated cases of homosexuality with good success, although Freud (1920) himself did not make any great claims for his methods. Among authors who have claimed successes are Sadger,[17] Stekel,[18,19] Serog,[20] Ellis,[21,22] and Allen.[12,23] Hadden[24] reports success with a patient who took part in a group therapeutic type of treatment. Kronfeld[2] comments on the other hand: " I know over a dozen homosexuals who have been treated for years by well-known experts in the field of psychoanalysis and who have shown no change whatsoever "; he claims never to have seen any successes with this type of treatment.

The descriptions given by psychotherapists of their successes are not usually very precise. In the majority of cases they simply consist of the statement that the patient has overcome his homosexual desires, is capable of heterosexual intercourse, has married, and other statements of a similar kind. In other cases the behaviour of the patient before treatment is described in so little detail that it is not always clear whether he was in fact homosexual or not. Reports covering months, or even years of careful interview material are only given in the most exceptional cases.

Considering the optimistic reports of psychotherapists working with a great number of quite different methods, it is noteworthy that many authors, and among them the greatest experts in the field, manifest the greatest doubts as to the curability of homosexuality altogether. Hirschfeld[25] claims that he has not seen any cure in any one of the 15,000 cases seen by him. Later[26] he corrects this remark to read that " only in the most exceptional cases " was a change-over to heterosexual behaviour noted. According to Havelock Ellis[27] it is possible for a homosexual man to have heterosexual intercourse but not to fall in love with a woman. Curran[28,29] compared 25 homosexuals who received psychotherapeutic treatment with a similar number of homosexuals who received no treatment; he found that the treatment cases showed neither a better control nor a lessened intensity of their homosexual tendencies than did the cases receiving no treatment. It is noteworthy that the follow-up period in this case averaged between 4 and 5 years. Harris (1948) is of the opinion that only in cases of bisexuality is therapy of any use.

A careful reading of the literature quoted gives one the impression that the cause of these apparent contradictions lies not so much in the *facts* as rather in the *evaluation* of these facts. This is most apparent when we consider the criteria of therapeutic success as used by psychotherapists.

* Quite obviously it is essential to make efforts to weaken the disordered drive. In doing so one of the most useful means appears to be weakening of the concentration or else a distraction of the attention of the disordered person from the object of his perverted drive.

The major criterion of success appears to be a change in the sexual behaviour of the patient; a homosexual is regarded as cured when he gives up homosexual practices and succeeds in initiating heterosexual conduct. Complete heterosexuality is regarded by many of the psychoanalytic authors (Stekel, Ellis) as an artefact inherent in our type of civilization; as such they do not even consider it desirable to lead homosexual patients to an exclusively heterosexual type of adjustment. Thus the optimal effects claimed and described by psychotherapists are inevitably rather modest. In those cases in which better results are reported there are always circumstances which throw doubts on the diagnosis either before or after treatment.

BEHAVIOURAL ELEMENTS IN THE PSYCHOTHERAPY OF HOMOSEXUALS

In comparing the reports of adherents of the various psychotherapeutic schools and their claims of successful treatment of cases of homosexuality, one notices considerable differences between naïvely optimistic publications of authors offering just one publication, the propaganda-type articles of authors returning again and again to the fray and the monographs of the more objective type of therapists. There is, however, no evidence in these writings that there are qualitative or quantitative differences in the heterosexual adaptation of patients submitted to the various psychotherapeutic procedures. There are two possible explanations for this. It is possible that psychotherapy in general is quite ineffective; this is the first alternative. The second is that all psychotherapists make use of the same casual agents in the treatment of homosexuality; from this view the differences between their procedures would then have no relevance to the actual treatment. While the first of these two hypotheses is quite plausible, we will have a look at the plausibility of the second hypothesis. At first sight this might appear superfluous, but it might be useful if we could find certain general features underlying all the different types of psychotherapy. In this way it might be possible to make use of whatever fundamental causal factors might be at work, disregarding accidental features.

Therapists who use hypnosis and suggestion try in every possible way to reinforce the patient's desire to keep away as far as possible from homosexual activity and to enter into heterosexual contacts. At the same time, they try directely to heighten the desirability of heteroerotic objects for the patient and to diminish that of homoerotic objects. In the type of therapy used by Moll, persuasion is used to cause the patient to abstain from homosexual images and behaviour patterns, and at the same time heterosexual images and behaviour patterns are encouraged. As Moll[15] himself says, " this method has many similarities with pedagogy."

While the suggestion is quite plausible that hypnosis and " Assoziationstherapie " obviously share many common features, and therefore presumably

make use of similar mechanisms, this does not at first sight appear to be true of the explorative psychotherapeutic types of treatment—at least as long as certain easily overlooked features are not taken into account which occur in the course of these treatments. Most psychoanalysts, including those mentioned above, demand of the patient that during his treatment he should use restraint in his homosexual behaviour and that he should seek the company of members of the other sex. In addition, even psychoanalysts of the classical school seldom succeed in remaining so neutral that the patient fails to get the impression that the therapist is very much concerned to change his behaviour in a heterosexual direction, and in consequence of the transference which the patient develops for the therapist, we may here be dealing with causal that mechanism which we discovered in the types of therapy not making use of explorative treatment. Already in 1911 Moll[13] suggested some such hypothesis when he referred to " suggestion " as the underlying causal element in psychoanalytic treatment of homosexuality.

In view of these considerations, it is not impossible that psychotherapy, in so far as it has any therapeutic effect in cases of homosexuality, owes its success to this particular causal feature which we have isolated in spite of the different modifications encountered in the different types of treatment. To repeat, this causal element is to be found in the *encouragement of behaviour patterns which emphasize restraint or complete abstinence from homosexual behaviour, and which involve heterosexual behaviour.* In addition, it is likely that there is some efficacy in the attempts to devaluate homoerotic desires and associations and to encourage and reward heteroerotic desires and associations.

THERAPEUTIC EXPERIMENTS

If we are correct in assuming that the effect of psychotherapy is not related to systematic verbal exploration, dynamic exploration, abreaction, etc. then we may be justified on a neuristic basis in introducing a behavioural type of therapy which, as far as one can tell, contains the above mentioned causal curative element.[30] We shall compare the effects of this treatment with those reported by other psychotherapists. If conduct shows that no very marked qualitative or quantitative differences between these treatments exist, this may be interpreted either as evidence for the uselessness of psychotherapy altogether, or for the efficacy of the causal element mentioned.

The experimental procedure relies in the main on those methods which have been used particularly in the aversion treatment of alcoholics. It has been used entirely with male patients because very few homosexual women were sent for treatment, none of whom expressed any desire for a cure. Of those male patients sent to us, none were refused treatment.

Treatment consisted in the administration to the patient of an emetic mixture* by subcutaneous injection. When the emetic mixture became effective and as long as the effects lasted, slides of dressed and undressed men were shown to the patient. This constitutes the first or aversion part of the treatment. During the second phase of the treatment the patient was shown films of nude or semi-nude women; these were shown approximately 7 hr after the patient had been administered 10 mg of *testosteronum propionicum*. Our choice of this method of conditioned reflex therapy rests on the assumption that it could be shown that in this way a greater diminution of the valency of the socially unacceptable object and the heightening of the valency of the socially acceptable object could be produced than by any other psychotherapeutic measure.

This procedure was only used on patients whose erotic desires were exclusively or almost exclusively directed towards homosexual experiences and who either were completely incapable of heterosexual behaviour or in whom in any case the frequency of heterosexual behaviour was less than that of homosexual behaviour. Heterosexual adaptation was diagnosed where in such a patient erotic behaviour had changed to such an extent that heterosexual intercourse was far more frequent than homosexual intercourse (information was derived from the patient's own report in so far as this was not contradicted by other information). In consideration of the lack of reliability of the diagnosis of erotic tendencies, we only included those patients in the experiment who had undergone cure in the years 1950–1953, so that a follow-up of at least 3 years would be available for all patients. This follow-up was undertaken in June, 1956; another follow-up was undertaken up to a further two years in May and June of 1958.†

Of the 67 patients treated altogether, a sub-group of 20 had dealings with the police, the magistrates or other official agencies because of their homosexual behaviour. In some of these cases complaints had been withdrawn or punishment delayed in order to make it possible for the patient to undergo medical treatment. In other cases the patient asked to be treated because he hoped in this way to avoid punishment. Only 3 people in this group achieved any kind of heterosexual adaptation and in no case did this continue for more than a few weeks. The same is true of 9 patients who underwent treatment because of unrequited homosexual love. (Three of these reported suicidal tendencies.) Seven homosexual patients were sent or brought by their relatives. One of these is possibly the best adapted patient in the whole group (A); at the time when he first came to our attention he was only 14 years old. In spite of this it is improbable that it is a question

* During the first 5 applications a mixture of emetine and apomorphine was administered; after that caffein with apomorphine. Treatment was administered every day but the number of treatments never exceeded 24.

† Subjects who underwent less than 5 treatments were excluded from the follow-up.

of one of those not infrequent homosexual episodes which occur at this age. Another patient who also belongs to this group was 17 years old at the time of treatment. He could not be followed up properly so that although he claims to be perfectly heterosexual, his true state cannot be evaluated.

A fourth group is formed by those patients who claimed to desire treatment in order to escape from the undesirable social position of homosexuals and to be able to marry and start a family. Five of these reached heterosexual adaptation of short duration, ranging from several weeks to several months. The final state of three further patients is not sufficiently known to be evaluated; they claim to be well adapted heterosexually. Nine further persons in this group (A, B, D, E, G—M) who reached good adaptation immediately following treatment had not returned at the time of the last follow-up to homosexual practices. The state of one further patient (C) who achieved heterosexual intercourse for the first time at the end of the second course of treatment, and who reached complete heterosexual adaptation 6 months later, could not be ascertained after June, 1956. Patient (F) remained well adapted for 18 months, but deteriorated from then on until by the end of 1956 his behaviour was almost completely homosexual. Table 1 shows for the four groups of patients, the proportion of successful heterosexual adaptation as ascertained in our follow-up procedures.

TABLE 1

	Sent by police, magistrates etc.*	Unrequited homo-sexual love	Sent by relatives	No obvious external pressure	Total	Pro-portion
No improvement	17	7	5	12	24	51·1%
Short-term heterosexual adaptation	3	2	0	5	7	14·9%
Adaptation lasting for several years	0	0	1	11	12	25·5%
Outcome not sufficiently documented	0	0	1	3	4	8·5%
Total:	20	9	7	31	47	100%

* Not included in calculations in last column.

Table 2 contains a brief summary of the erotic desires and behaviour pattern of those 12 persons who reached relatively long continued heterosexual adaptation. The first row gives the identification of the patient by letter. In the second row is given the age of the patient at the beginning of

treatment, and in the third row, month and year of treatment. In the other rows, Nos. 4–8 relate to the state of the patient before treatment, and Rows 9–15 to his behaviour afterwards. Row 4 shows whether the patient ever felt any excitement following bodily contact with a woman (+) or not (−), or whether such contact was never achieved (0). Row 5 shows whether before treatment any heterosexual desires had ever occurred (+) or not (−). Row 6 shows how frequently the patient tried to have intercourse with a woman with (+) or without success (−). When more than 20 attempts at intercourse were made (++) is noted; (0) designates no attempt at all. In the seventh row a (+) shows that the patient was married; (−) that he was single. Row 8 shows whether he reported regular homosexual affairs (++), frequent homosexual intercourse without personal feeling (+), sporadic homosexual intercourse (no.), or whether such intercourse had hitherto not taken place at all (0). Row 9 shows whether patients unmarried before treatment, married afterwards (+) or not (−); the issue of children from such marriages is recorded in Row 10 (pregnancy of the wife is also indicated by a (+) sign). The happiness of the marriage is rated by the patient in Row 11 as happy (+), unhappy (−), or impossible to decide (+−). Row 12 gives details of frequency of heterosexual intercourse; (++) indicates twice weekly, (+) denotes at least once a fortnight, and (+−) denotes at least once in two months. Row 13 shows whether since treatment other women have also called forth sexual desires (+); whether these have been directed entirely to the wife (+−) or whether desire for intercourse has not been clearly homosexual, although never becoming quite heterosexual (−). Row 14 shows whether homoerotic desires have appeared frequently (+), occasionally (+−) or never (0). Row 15 shows how often after treatment homosexual intercourse has taken place.

The following summary could be made of the heterosexual adaptation of these 12 patients in June, 1956. In 3 patients (*a*, *b* and *l*) there is an occasional desire for heterosexual intercourse with women other than the wife. Only one of these (*l*) claims to have no more homoerotic desires. Four other patients report that their wives have some degree of erotic attraction for them, even outside the intercourse situation, but that other women do not have any sexual attraction for them at all. Five patients have no further heterosexual desires. In all of these heterosexually adapted homosexuals the intensity of homoerotic desires admittedly overbalances that of heteroerotic desires, although some patients claim that homoerotic desires only occur infrequently.

At the time of the second follow-up there was a complete recidivism for 1 patient (*f*) and another one could not be traced (*c*). Of the remaining patients, years of follow-up since treatment were as follows: one (*m*) 4 years, two (*j* and *k*) 5 years, four (*a*, *d*, *e* and *h*) 6 years, three (*b*, *g* and *l*) 7 years.

TABLE 2

1	*a*	*b*	*c*	*d*	*e*	*f*	*g*	*h*	*j*	*k*	*l*	*m*
2	14	24	22	33	21	28	28	27	29	31	24	22
3	I–III, 52	VIII–X, 51	VIII–XI, 51 I–V 53	V–VII, XII, 52	VI–VII–IX–X, 52	II–IV, 52	XI, 50 II, 51	II–VII, XII, 52	V–VII, 53	IV–VI, 52	IX, 50 II, 51 V–VII, 51 I–II, 54	VIII–X, 51 III–V 54
4	+	+	−	+	+	+	+	+	−	+	+	−
5	−	−	−	+−	−	−	+−	−	−	−	+−	−
6	0	+ 1x	0	+ 1x	++	++	++	0	− 5x	++	− 1x	− 5x
7	−	−	−	−	−	+	−	−	+	+	−	−
8	+	++	++	+	++	++	++	++	1x	++	0	1x
9	+	+	+	+	+	/	+	+	/	/	+	+
10	+−	+	+	+	+	−	+	+	+	−	+	+−
11	+	+	+−	+	+	+−	−	+	+	−	+	+
12	++	++	++	++	++	+	+−	++	+	+−	++	+
13	+	+	+−	+−	−	−	+−	−	−	+−	+	−
14	+−	+	+	+	+−	+	+−	+	+	+−	−	+
15	0	0	very frequently until 1953	once a week	0	once every 10 days	3x	1x	0	3x	0	0

Patient *l* who, except for one homosexual episode in 1954 had claimed throughout to be entirely heterosexually adjusted, demanded at the beginning of 1958 to receive further treatment because of renewed homosexual tendencies. He was admitted to hospital and treated for 3 months by means of hypnosis; at the end of this period he claimed to have no further homoerotic desires. He never had any actual homosexual intercourse at any time. His testimony, as well as that of his wife, confirms that they have intercourse at least once a fortnight, and usually once a week. Both consider their marriage as happy in spite of impossible living conditions. They have 2 children.

Patient *j* had a relapse about the same time because he fell in love with a colleague and became impotent with his wife to whom he had been married for 6 years. After treatment by hypnosis he claimed not to be tied to his colleague any more, with whom he had indulged in mutual masturbation, and to be capable of heterosexual intercourse again. According to both him and his wife, it appears that they have intercourse at least once a fortnight and that both are content in their marriage. The wife is ignorant of the maladjustment of her husband.

Patient *a* has had promiscuous relations with women since he left treatment, but claims to have homosexual as well as heterosexual desires. In 1954 he took up a lasting sexual relationship with a girl of the same age whom he married 18 months later because she was pregnant. Both claimed to be happily married and well adjusted. In 1958 this patient had to undergo his military service and appeared as a soldier for investigation in the same year. He now claims, in contradiction to his previous statements, always to have been orientated in a purely homosexual way and never to have enjoyed heterosexual intercourse. He also states that his wife complained that he did not care for her, that he did not make love to her, etc. The wife herself, although she had told her husband that she would not be available for questioning, did turn up in spite of difficulties, and was interrogated on these points. Since the birth of her child she suffers from an endocrine disorder, has added 5 stones to her weight, has ceased to menstruate and has lost her sexual desire to the extent that she does not enjoy intercourse any more. She claims that her husband gets very annoyed at her refusal to have intercourse very frequently and that he demands such intercourse particularly urgently now that he is on furlough. She further claims that they are very happily married and that they hardly ever quarrel. She does not take her husband's statements regarding his homosexual desires very seriously, although he has told her about them occasionally. The patient himself claims never to have had any homosexual intercourse since the termination of therapy.

Patient *b* divorced his wife, to whom he had been married for 3 years, because his wife, who had previously been a prostitute, relapsed in this

respect. Very shortly after this he married again. Both he and his wife agree that they have intercourse about once a week, although occasionally as long as 3 weeks may elapse from one occasion to another. During the last year, the patient has fallen in love with a perfectly normal man; he has succeeded three times in getting this man drunk and in embracing and kissing him in this state. From this time onwards there has been a good deal of quarrelling between husband and wife, although until then the marriage was satisfactory. The patient does not leave his wife mainly because of the children. She is still in love with him although she is fully aware of the state of things.

Patient *d* claims to have been happily married over a period of 6 years, but insists that his wife should not come into contact with us (while he was being treated and before she married him she had paid him regular visits at the hospital). His reasons are that she always got very excited when he spoke of his homosexual tendencies and conflicts so that he ceased to discuss them with her; he thought that she would interpret the discussion with a physician at the clinic as a sign that his problem had become more serious. Intercourse takes place about twice weekly and they have 2 children. The patient has homosexual intercourse about once every 10 days.

Patient *e* was under treatment until 1957 and was happily married, with 2 children, according to his own statements. Neither his wife nor his family were aware of his sexual problems and he was constantly worried that our investigations would let the cat out of the bag; consequently we were never able to discuss this case with his wife.

Patient *g*, who has been married for 7 years, has intercourse with his wife every fortnight or three weeks; they have one child. Although they quarrel quite frequently, they nevertheless are very close to each other. Since 1956 there has been homosexual intercourse on three occasions. It was impossible to interview the wife of the patient because of the great distances involved.

Patient *h* has been married for 5 years and the marriage is a very happy one, according to both partners. They have 2 children, and intercourse occurs two or three times weekly. This patient has only had homosexual intercourse once. He tells his wife everything about his inner conflicts and his abnormal sexual desires and she helps him to overcome these.

Patient *k* has been married for 9 years. He claims to be quite happy in his marriage, although he and his wife have small quarrels quite frequently. They have intercourse about once a fortnight. His homosexual activity has increased since 1956 and he has homosexual intercourse at about the same frequency. The wife is emotionally very much tied to her husband; she claims that the marriage is a very happy one and praises his good qualities. According to her, intercourse does not take place more frequently than once a month.

Patient *m* has been married for 3 years and the marriage was very happy for the first two years. Even now, there is no quarrelling between husband and wife although the patient has been in love with another male for the last ten months, and has lost interest in his wife. Homosexual intercourse occurs once every 10 days, and intercourse with his wife about once or twice a week. The wife knows about her husband's troubles but it was impossible to interview her personally because of the great distances involved. There is one child of this marriage.

Of the 10 patients followed up, 8 are at present so well adapted heterosexually that they have heterosexual intercourse exclusively or preponderantly; up to a point they are satisfied with this. Except for patient *l*, however, they all claim that their motivation is still almost exclusively homosexual. Six of them had no homosexual intercourse until 1956, the others had such intercourse only sporadically. In 1958, only three claimed not to have had any homosexual intercourse since treatment. In nearly all patients there is a slow increase of homosexual activity. Only one patient (*a*) claimed to have been really in love with his wife, and he took back this statement in 1958. Only he and patient *l* claimed predominantly heterosexual motivation, but this statement was disclaimed later by *a*, and in the case of *l* there has since been a relapse on 2 occasions.

The heterosexual adaptation of the whole group appears to consist mainly in the fact that the patients have learnt to have intercourse without previous stimulation by the (for them) specific erotic object; this may be the reason why for some of them homosexual intercourse has become more infrequent. One should not overlook, however, the fact that even before treatment 2 patients had become adapted to heterosexual intercourse, one of them the now entirely relapsed patient *l*. (These 2 patients had undergone treatment because of relapses lasting for at least 6 months.)

A comparison of the cases of heterosexual adaptation described here with those described in connection with other types of psychotherapy, is very difficult. Attention has already been drawn to the weaknesses of the existing diagnostic techniques and the consequent inaccuracies in the description of behaviour before as well as after therapy. Another cause of difficulty is the lack of control in the choice of patient. It is probable that most of the patients would not have come for treatment if their efforts at heterosexual adjustment had been successful. Particularly difficult is a comparison of the degrees of disagreeability of treatment consequent upon the different therapeutic procedures, a comparison which is particularly important for the judgment of the motivation of patients. In most of the cases described in the literature, these disadvantages are perhaps mainly of a financial kind. This would not apply to the treatment discussed here because patients were accepted without paying in the hospital, but on the other hand this type of treatment is probably much more disagreeable than any kind of psychotherapy.

We can be fairly certain, however, that those therapists whose descriptions of the success of treatment are encountered in the literature have not dealt with homosexuals sent by the police or other official bodies, and consequently it seemed appropriate to leave out of account in any comparison this group of 20 people. (Accordingly this group has not been included in computing the outcome of treatment recorded in Table 1.) In addition, it should be remembered that because of the unreliability of diagnosis, the length of observation of the patient after the end of treatment is of considerable importance for the accuracy of the determination of his state and the motivation which has led him to treatment; such follow-up observations are much more difficult in the case of patients of this type.

Taking into account all the possible sources of error mentioned, we find on a rough actuarial comparison between cases described here and those described by orthodox psychotherapists in connection with typical psychotherapeutic treatment, that *there are no obvious differences either in the quality or the degree of therapeutic success* of these treatments in so far as such success can be ascertained through the rough and ready clinical methods used. This finding supports the hypothesis that in so far as psychotherapy is effective in cases of homosexuality, this effectiveness depends on the common causal agent already discussed previously.

SUMMARY AND CONCLUSIONS

Hitherto, there has been no proof of the efficacy of any form of treatment as applied to homosexuals. Nevertheless, there appears to be an important distinction between the traditional biochemical and physical methods on the one hand, and the various psychotherapeutic procedures on the other. Successes claimed by writers using biochemical and physical types of treatments have never been verified by later authors, so that the uselessness of these methods appears fairly obvious. Claims of improvements and cures obtained by psychotherapeutic procedures, however, have been verified in a number of cases. The question of the correctness of these claims must therefore still be regarded as open. A comparison of the efficacy of the different psychotherapeutic procedures would be a very ambitious undertaking, and before planning such an experiment an effort was made to estimate the optimal success of such procedures, excepting, of course, occasional special cases. It became apparent that this optimum effect in its poverty was identical or nearly identical with those post-treatment states which had led some of the best known experts in this field to claim that psychotherapy in the case of homosexuality was useless. It follows from this that a control of the efficacy of the various relevant methods of treatment was very much less important than a revision of the therapeutic orientation.

It appeared probable that *all the therapeutic measures considered to be efficacious in the case of homosexuality depended on a common principle.* This

principle consists of the *discouragement of homosexual activities* and the *encouragement of heterosexual activities*. (It is also possible that we should add to this the method of devaluating homoerotic desires and to encourage heterosexual desires, in so far as desires can be separated from actual behaviour.) This assumption was strengthened by the fact that there appeared neither very strong qualitative nor quantitative differences between the outcomes of treatments relying on non-verbal, non-explorative psychotherapeutic procedures, and those of a psychoanalytic type. This served as justification to carry out a treatment of homosexuality and to attempt to discover its efficacy, which in simplified form represented the main principle of therapeutic effectiveness previously isolated. It has been shown that the efficacy of this simplified treatment does not appear to be very different from that of other types of treatment of a psychotherapeutic nature.

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