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A study of twenty-three cases involving homosexual behavior.

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BOSTON UNIVERSITY
SCHOOL OF SOCIAL WORK

A STUDY OF TWENTY-THREE CASES INVOLVING HOMOSEXUAL BEHAVIOR

A Thesis

Submitted by

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(B.S., Simmons College, 1950)

In Partial Fulfillment of Requirements for
the Degree of Master of Science in Social Service

1952

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CHAPTER I

Introduction

Society condemns homosexuality as abnormal and immoral and one who is known to have had such a relationship is liable to punishment under the law. Those who are known to have had such a homosexual experience often find their way to normal social relationships is barred because people do not want to associate with "perverts." Society tends to label anyone who is known to have had a sexual experience with a person of the same sex, a homosexual. They are often expelled from schools or lose their jobs. Even if an individual has such a relationship and is never "caught," he often has emotional conflict because of the belief that such practices are immoral and that he is perverted. Even if such a relationship occurs only once or a few times, he can be very upset emotionally. Conflicts over homosexuality often lead to mental breakdowns.

Authorities disagree as to whether homosexuals can be helped. It seems to depend upon the cause of the homosexuality. The theories as to the causes of homosexuality will be discussed later in this thesis. Briefly, some authors think homosexuality is caused by glandular disturbances and cannot be treated. Others think that environmental factors play a part, and if environmental manipulation can be accomplished before the behavior is too well learned, the individual can be directed to a heterosexual adjustment. Others feel that it depends on how far back in the development of the individual the cause of the homosexual behavior is rooted. Some feel that it depends on how old the individual

is when treatment is begun.

The purpose of this thesis is to obtain a picture of the type of people referred to a mental hygiene clinic for homosexual behavior, to determine what is being done to help them and whether they are being helped.

Twenty-three cases will be analyzed to determine how they got to the clinic, how old they were when they were referred, how the sexes compared, what was the extent and duration of the homosexual behavior and with whom they were involved, if there were any common social factors, how many had physical characteristics of the opposite sex, if there were any common character or personality traits, how they rated intellectually, and what treatment they received at the clinic.

A follow-up study was done to determine how these cases adjusted after they were seen at the clinic, and if the recommendations of the clinic were carried out. This study was done by examining the records of the probation departments and through correspondence with referring agents and other agencies, and individuals known to have been involved in the cases either before or after they were seen at the clinic. There was no direct correspondence with the subjects. Adequate information for the purpose of this thesis was obtained in nineteen of the twenty-three cases. Partial, but not complete, information was obtained in three cases. No information was obtained in one case.

The cases to be analyzed are all those referred to the New Hampshire Mental Hygiene Clinics for homosexual behavior from 1940 through 1950. Homosexual behavior is defined in this thesis as a sexual relationship between two persons of the same sex, or the suspicion of such a rela-

tionship. Terminology used in describing sexual acts includes mutual masturbation, meaning a mutual fondling of each other's genitals; fellatio, meaning oral coitus, and sodomy, meaning rectal coitus.

There were twenty-three cases referred for homosexual behavior from 1940 through 1950. These cases were abstracted according to the schedule and analyzed to determine the answers to the questions previously stated. The results of the analysis were discussed in Chapter IV. Cases were presented that illustrated significant points in the discussion. If more than one case illustrated the particular point, the case with the most material was presented. There was considerable overlapping, so sometimes the case with the most material was being used to illustrate another point. In such instances the case with the largest amount of information that was not being used in another part of the thesis was selected for presentation. Conclusions were presented in Chapter V.

Limitations to this study have been few and are not believed to invalidate the general conclusions. In eight cases the background material obtainable was skimpy, and in four, very little information was obtained in the follow-up. On the whole the available information was adequate for the needs of this study.

CHAPTER II

Setting

A. History of the Mental Hygiene Movement

The material presented in this thesis was obtained at the New Hampshire Mental Hygiene Clinics. It is only relatively recently that clinics to maintain mental health have been established.

For centuries mental illness was surrounded by superstition and treated with brutality. In the 18th century Benjamin Rush pioneered for the scientific treatment of mental disease. In the 19th century Dorothea Dix campaigned for humane treatment for the mentally deranged. However it was the opening decade of the present century that saw the rise of reform movements. The National Committee for Mental Hygiene, the first successful committee of its kind in this country, was officially founded in 1909. This organization was the result primarily of the efforts of one man, Clifford Beers, who after spending three years in mental institutions, wrote a book, A Mind that Found Itself, exposing the conditions in these institutions. The book went further than the description of the conditions, as it presented a plan for their amelioration and prevention. The book was immediately a great success, and many eminent persons came forward to support the new committee which was formally inaugurated shortly after the publication of the book. The National Committee for Mental Hygiene gradually made progress in the control, care, and treatment of the mentally ill all over the country. The care and treatment, however, progressed much faster than the control because people were still skeptical that mental diseases could be prevented.

World War I gave considerable impetus to the mental hygiene movement when the government discovered that much of the populus was unfit mentally for military service. Another reason was the high rate of mental disorder among soldiers. The government therefore created a division of neurology and psychiatry within the Surgeon General's Office. The war and the post war period saw a great development in mental hygiene because of the serious problem of "war neurosis." Public attention was being constantly attracted to the efforts to decrease mental illness and improve the present methods of treatment. Within a very few years mental hygiene became an important factor in such fields as education, public health, general medicine, industry, criminology, penology, and social work.

In 1928 the American Foundation for Mental Hygiene, which grew out of the National Committee for Mental Hygiene, was internationalized, and by 1936 thirty countries were represented. An International Committee for Mental Hygiene was founded in 1930, and in 1948 the World Federation for Mental Hygiene which works closely with the United Nations.

In 1946 the government passed the National Mental Health Act for the purpose of:

the improvement of the mental health of the people of the United States through the conducting of researches, investigations, experiments, and demonstrations relating to the cause, diagnosis, and treatment of psychiatric disorders; assisting and fostering such research activities by public and private agencies, and promoting the coordination of all such researches and activities and the useful application of their results; training personnel in matters relating to mental health; and developing, and assisting States in the use of, the most effective methods of prevention, diagnosis, and treatment of psychiatric disorders. (Section 2, Public Law 487)

This led in 1949 to the establishment of the National Institute for Mental Health as part of the Public Health Service. There had been from 1930 a

Mental Hygiene Division, but the need for an intensified program became more and more apparent, especially when it was discovered during World War II that two million men of military age suffered from mental disorders.

A council of six men outstanding in the mental health field was authorized by the National Mental Health Act to assist in developing the program. In 1950 an amendment added six lay people to the council. The program was divided into three areas: research, training of mental health personnel, and the development of state and community mental health services, and three committees were formed, one to aid each area. The research committee has representatives from the various mental health sciences. The members are concerned with recommending grants for research and outlining policy on research. The training committee is made up of educators in the various fields of mental health. Their functions are to recruit and train mental health personnel and aid the Council in recommending grants to training centers. The Community Service Committee assists the Council in helping the States develop mental health programs. Responsibility for the development of mental health services is vested, in most states, in the State Health Department, but in some states it is a special agency, or the Department of Public Welfare, or the State Hospital Board. There is a close relationship between the federal and state levels, and the national authorities are always ready to consult with the State authorities. All States are eligible to receive funds depending upon their financial need, population, extent of mental health problem, and ability to match every two dollars of federal funds with one dollar. States can use these funds as they see fit within the field of mental health, except that they cannot be used for institutional care.

Services reach the individual through the State grant-in-aid program, administered by the Community Service Branch of the Institute. Plans of states vary, but certain basic services are provided by most of them: such as, clinical services, professional services outside of clinics, training programs for state and local mental health personnel who deal with the public, and activity to educate the public with the aim of preventing mental illness by making the public aware of symptoms of mental disturbances and facilities available for treatment. Thus, the services are channeled down to the individual from the National Institute, through the state agency, to the community where they reach the individual. While people living in eastern and urban areas still have most of the mental health services, there is now at least a minimal type of service for people in many rural, southern, and western areas which had no mental health facilities except institutions for mentally ill and defective.¹

B. History of the N. H. Mental Hygiene and Child Guidance Clinics

In 1930 Dr. Charles H. Dolloff, Superintendent of the New Hampshire State Hospital, went to Manchester, New Hampshire, under the auspices of the District Nursing Association, a private nursing agency, and saw the first patient who came for help with nervousness to be seen outside the State Hospital, thus establishing an Outpatient Department or a Mental Hygiene Unit. The District Nursing Association board, having become aware of the need for mental hygiene services and having some extra

¹ National Institute of Mental Health, Mental Health Series, No. 4, pp. 1-21

funds, decided to open a clinic, if Dr. Dolloff would be director. The clinic consisted of a director, two assistants, a psychologist, a social worker, and a secretary. The entire staff except the secretary was part of the State Hospital staff, while the services of the secretary and the quarters were supplied by the District Nursing Association of Manchester. The social worker was the only full time person except for the secretary. So far as could be determined no definite policies were decided aside from the fact that the clinic was to be free and open to anyone in the state of New Hampshire. It was impossible to have staff conferences because of the irregular hours of the clinic staff.

One hundred and ninety-seven patients were seen between November 11, 1930 when the clinic opened and May 15, 1932. Intensive treatment was done in only a few cases. During this time the psychiatrist had 547 contacts, the psychologist 149, and the social worker 2341 of which 596 were telephone calls.

Gradually clinics opened in other cities of the state under the direction of the State Hospital and staffed by State Hospital personnel. In 1947 the New Hampshire Mental Hygiene and Child Guidance Clinics were established as a separate unit, no longer under the State Hospital. The New Hampshire Mental Hygiene and Child Guidance Clinics operate under the authority of the New Hampshire State Commission of Mental Health. Headquarters of these clinics are in Concord, New Hampshire. Traveling clinics are held each week in Nashua and Manchester and each month in Keene, Laconia, Portsmouth and Portsmouth Rehabilitation Center. Clinics are arranged by appointment in Littleton, Berlin, Newport and Claremont. The staff has grown to a full time staff of two psychiatrists, three social

workers, and two psychologists. A psychiatrist, a clinical psychologist, and a speech therapist give part time service, and a neurologist and a doctor act as consultants. All personnel have degrees in their respective fields.

From 1948 until 1950, 490 clinics were held and 6,206 visits were made to the clinics by patients. During the time the psychiatrists had 1133 diagnostic interviews, the psychologists gave 1416 examinations, and the social workers took 554 histories. During the same period the psychiatrists had 1270 treatment interviews, the psychologists 483, and the social workers 427.

The primary function of the clinic is the diagnosis and treatment of persons, especially children, showing indications of maladjustments in their social relationships or abnormalities in their mental or emotional life. The clinic believes that early diagnosis and treatment of persons suffering with emotional and personality disorders is the best way of preventing future mental illness, juvenile delinquency, and general social disorder. The basic function of the clinic is to discover the reasons why children become maladjusted and emotionally upset and to explain these reasons to teachers, parents, and the general public in order that they may avoid in training and educating children the things that cause maladjustments, and may learn of the kind of experiences that will help an individual child, considering his environment, his abilities and handicaps, to lay the foundation for future mental health and happiness.²

² New Hampshire Commission of Mental Health, The New Hampshire Mental Hygiene and Child Guidance Clinics, Biennial Report 1948-1950, pp. 1-4

CHAPTER III

Review of the Literature

There is no general agreement as to what constitutes a homosexual. Some authors consider that a person is a homosexual if he is sexually attracted toward individuals of the same sex, even though no physical relationship has taken place. Other authors consider an individual homosexual only if he has had a sexual relationship with an individual of the same sex. Still others consider an individual homosexual only if he is unable to have intercourse with persons of the opposite sex. All are agreed that there is no such thing as a totally male or a totally female individual. All males have some degree of femininity and all females have some degree of masculinity. The disagreement comes as to what degree determines a homosexual.

The disagreement as to what is a homosexual is slight compared to the disagreement as to what causes homosexuality. Some authors think that homosexuality is caused by physiological disturbances. John Oliver¹ believes that homosexuals are born homosexual and that there is nothing that can be done except to help them accept their abnormal sexuality. Louis Berman² also believes that "femininity and masculinity have a definite chemical basis in the reactions of the internal secretions of which they are the expression." He, however, does not attribute homosexuality purely to physiological causes but also acknowledges environmental influences. He stresses glandular disturbances, however. He says that

1 Oliver, John Randolph, Psychiatry and Mental Health, p. 236

2 Berman, Louis, The Glands Regulate Personality, p. 133

"Straightforward homosexuality and the eunuchoid (feminoid) constitution have always been intimate."³ Some authors believe, however, that a feminine looking man finds it difficult to make heterosexual relationships and finds his way into homosexual circles very easily because homosexual men are attracted to him. Thus, his homosexuality becomes a conditioned response. Rosanoff says, however, that

It is significant that only a relatively small percentage of homosexuals possess secondary physical characteristics which are markedly feminine or masculine as the case may be... As a rule, however, no such physical characteristics are to be seen in homosexuals, while, on the other hand, they are sometimes seen in persons who are not homosexual. One cannot depend on physical characteristics for the detection of homosexuals. Anatomic anomalies of the genitals are if anything less common than among heterosexuals.⁴

Berman thinks that masculine looking homosexuals also have glandular difficulty and calls them thymo-centric because "the persistence of the thymus after adolescence makes for an arrest of masculinization or feminization,"⁵ as the case may be.

As the result of his recent survey Kinsey has come up with another idea as to what causes homosexuality. He found that forty-five per cent of the early maturing adolescent boys of the college level had homosexual experience while only twenty-five per cent of the late maturing males ever had such experience. He therefore came to the conclusion that

Age of onset of adolescence (which probably means the metabolic drive of the individual) may prove to be more significant than the much discussed Oedipal relation of Freudian philosophy."⁶

Thorner agrees that some people are homosexual because of

3 Ibid., p.226

4 Rosanoff, A.J., Manual of Psychiatry and Mental Health, p.157

5 Op. cit., p.221

6 Kinsey, Alfred C., Wardell B. Pomeroy, and Clyde E. Martin, Sexual Behavior in the Human Male, p.315

endocrine functioning, but also sees other reasons for homosexuality. He says

There are undoubtedly many people who because of their basic personality (including such factors as endocrine functioning) or because of sufficient conditioning experience are attracted only to others of their own manifest sex. Others may indulge in overt homosexuality practices as a retreat from heterosexuality, from curiosity, or because of a peculiarly perverse viciousness which is often part of a revolt against the whole established order.⁷

Carroll practically discounts the physiological viewpoint and stresses psychological causes. He says that there may be

some hidden disfunction of the glandular system which causes the abnormality in personality development. However, it appears much more likely that the behavior is psychologically caused... There are a number of factors in the life of an individual which might cause him to prefer individuals of the same sex to individuals of the opposite sex. One of these would be persistent failure during adolescence to establish satisfactory social and emotional heterosexual relationships. Occasionally homosexual interests result, for the girl from a fear producing experience with a man, or for a boy, from his sense of failure in his first heterosexual experience. Such interests may, of course, be learned from satisfactory relationships with adult homosexuals.⁸

The psychoanalysts put forth still another theory as to the cause of homosexuality. Fenichel discounts the idea of physical abnormality by saying that every person has homosexual drives in his unconscious and that certain psychological conditions put them into motion. Every person is born with the capacity to be sexually attracted to persons of either sex. Psychoanalyses of homosexuals has shown, according to Fenichel, that the determining factors in their choice of sexual object were (1) very deep early disappointment which turned them against women

7 Thorner, Melvin, Psychiatry in General Practice, p.84

8 Carroll, Herbert, Mental Hygiene, p.112

and (2) severe castration anxiety which was repressed in the unconscious and which made the difference in genitalia unacceptable.

Following the loss of an object or following a disappointment in an object, all persons tend to regress from the level of object love to the preliminary phase of identification; in other words, they become psychologically the object they can't possess... In homosexual individuals this identification takes place in regard to the object choice: following his disappointment in mother, he identifies himself with her in one particular respect: like her he loves only men... In short, the unconscious formula of the homosexual man is as follows: Since I cannot have my mother (because I do not want to have a being without a penis) I will be mother myself.⁹

Fenichel says that it

is possible to show in all cases of homosexuality which in general appear to be special outcomes of the Oedipal Complex ---- the original heterosexual orientation which was rejected as a result of castration anxiety.¹⁰

Flugel discusses the role of the Oedipal Complex in bringing about homosexuality by explaining that the repression of the incestuous feelings toward the parent of the opposite sex leads

first, to an extension of the love taboo to all persons of that sex, and then, as a further step, the way to heterosexual affection being now barred --- to the displacement of sexual drives into the homosexual direction.

... On a priori grounds we might expect to find that in other cases of homosexuality the direction of affection is determined in a more direct manner, viz. by the fixation of an original infantile attachment to the parent of the same sex as that of the child.

... So far as the evidence goes, however, it would seem that the fixation of love on the parent of the same sex plays a lesser part in the development of this kind of homosexuality than might have been expected: the homosexuality in question being more frequently and to a greater extent due to a displacement of a primitive love of self (Narcissism, in psycho-analytic terminology) projected on to others, so

9 Fenichel, Otta, Outline of Clinical Psychoanalysis, p.250

10 Ibid., p.257

that in loving those of his own sex the individual is directing his affection to those who, by his unconscious mind, are selected as the most suitable representatives of his own beloved Ego.

It is an important characteristic of the phenomenon of fixation on the parent, that this parent who is loved in the unconscious is not so much the parent as he or she actually exists when the child has attained to adolescence or maturity, but rather the parent as he or she appeared to the child when young, ... This idealization of the loved parent is especially liable to exercise a potent influence in all cases where the parent in question dies young and is therefore never subject to the criticism at the hands of his children to which he would later on, have inevitable to some extent become exposed.¹¹

From the early fixation on the parent of the opposite sex there are various paths of development. There is the person who is more narcissistic than feminine.

He identifies with the mother and behaves as he wishes his mother to behave toward him; hence, he turns toward love objects who are most like himself, chiefly young men and boys.....especially boys at puberty. This fact suggests a fixation at that level.¹²

If an anal fixation determined the individual's development after an identification with the mother, he extends this identification to the gratification itself and the wish to have a sexual relationship with the mother becomes the wish to enjoy sexual relationships in the same way she does or to submit in a feminine manner to a man. Other paths of development occasionally seen are a combination of the two just described, and a type which results from an intense hatred of a brother because of the competition for the mother which leads to overcompensating love of the brother which leads to avoidance of competing with him in a sexual area and desiring as sexual objects persons similar to the brother.

¹¹ Flugel, J.C., The Psych-Analytic Study of the Family, pp.54,55

¹² Fenichel, Otto, Outline of Clinical Psychoanalysis, pp.251,252

Even John Oliver¹³ who believes a man is born homosexual acknowledges there are different types of homosexuals. He categorizes them as the very masculine man who plays the dominant role in the sexual relationship. Then there is the mildly effeminate "homo-erotic" who does not always play the active role. Then there is the effeminate man who always plays the passive role as he wants to be loved as if he were a woman.

Something should be said at this point about female homosexuals. Fenichel says there are two etiological factors in female homosexuality. There are (1) an early mother fixation and (2) repulsion of heterosexuality originating in the castration complex.¹⁴ The early mother fixation accounts for the fact that the "actual activity of homosexual women consists mainly in the mutual playing of mother and child."¹⁵ All girls are supposedly more or less traumatized when they discover that they have less physical equipment than boys. The girls to whom it is especially important that they be like boys for certain psychological reasons are severely traumatized and later in life these girls are frigid and unable to consummate a heterosexual relationship because the sight of the penis mobilizes thoughts and emotions which originated in the castration complex about the difference in physical appearance. Thus they may only be able to achieve sexual pleasure if there is no penis.

13 Op. cit.

14 Fenichel, Otto, The Psychoanalytic Theory of Neurosis, p.339

15 Ibid., p.340

Ernest Horns discusses "Sex Life of Twenty-Two Hundred Women" by K. B. Davis who claims that one woman in five has physical contact with another woman. She compared a group of homosexual women with a group of normal women and came to the conclusion that

The fact that more of the homosexual group resent being women, more have marked preference for one parent, more have experienced pre-pubertal sex explorations or aggressions and more are inclined to masturbate, emphasizes an environmental basis for the problem. Interestingly enough, the homosexual group had more complete sex experience than the non-homosexual group. This group also evidenced the male body form more frequently and other physical deviations in slightly greater frequency than did the non-homosexual group.¹⁶

Because a person engages in sexual relations with persons of the same sex, does not necessarily mean he doesn't have sexual relations with persons of the opposite sex. If an individual is not particular about the sex of his partner, and if he can have sexual relations with equal pleasure with both sexes, then he is what is known as a bisexual. Oliver estimates that approximately two out of every hundred individuals are bisexuals.¹⁷

Gordon Hamilton in discussing adolescence says that

Bisexuality is constitutionally present throughout life, and a homosexual phase during early adolescence is a part of normal development, but a full-blown homosexuality (constitutional factors not being present) arises from the inability to solve the love and hate relationship of the oedipal period.... It is important to distinguish what is normal in quality and quantity for the adolescent period.¹⁸

A certain amount of homosexuality is normal in pre-puberty and adolescence, but the worker has to be on the look-out for excessively feminine behavior in boys or masculine drive in girls. If there

16 Horns, Ernest, Handbook of Child Guidance, pp.483,484

17 Op.cit., p.237

18 Hamilton, Gordon, Psychotherapy in Child Guidance, p.250

are signs of confused identification, the young person may have a good deal of anxiety about these feelings unless he is helped to solve them.¹⁹

Social workers are cautious about embarking on intensive therapy because of the instability of this period. Psychoanalysts themselves have been conservative about suggesting analyses for adolescents, because anxiety and panic states are so easily aroused and the weak ego may not be able to bear the demands of insight. The question is not whether to offer help to disturbed boys and girls, but on what levels.²⁰

Oliver describes the attitude of the courts when they are dealing with an adolescent offender.

Our courts, or most of them, have come to the conclusion that it is unjust to punish a man who has had homoerotic relationships with several adolescent boys and to let the boys go free. For no one can force another to sexual intercourse unless he drags his victim or makes him unconscious. Neither will a decent hetero-erotic boy allow the advances of a homo-erotic man. If he allows them, if he submits---especially if he is only too willing to take in return presents or actual money---if the homo-erotic act is a crime, then the boy deserves punishment as the man.²¹

In his recent survey of the sexual behavior of males, Kinsey arrived at the following statistics as to the incidence of homosexual behavior in the total white male population of the United States.

Thirty-seven per cent of the total male population has at least some overt homosexual experience to the point of orgasm between adolescence and old age. This accounts for nearly two males out of every five that one may meet...

Sixty-three per cent of all males never have overt homosexual experience to the point of orgasm after the onset of adolescence...

Four per cent of the white males are exclusively homosexual throughout their lives after the onset of adolescence.²²

19 Ibid., p.34

20 Ibid., p.251

21 Op.cit., p.244

22 Op.cit., pp.650,651

CHAPTER IV

Analysis of Cases

From 1940 through 1950 twenty-three cases were referred to the New Hampshire Mental Hygiene Clinic for homosexual behavior. The distribution of the cases is shown in Table 1.

TABLE 1.

Year	Number
1940	2
1941	0
1942	1
1943	0
1944	1
1945	0
1946	2
1947	1
1948	2
1949	9
1950	<u>5</u>
Total	<u>23</u>

It can be seen from Table 1. that there were more cases referred in 1949 and 1950 than in the nine preceding years. This should not be taken to mean that homosexual behavior increased during those years because there are other factors to be taken into consideration, such as the increase in the clinic staff and prestige of the clinic, and the increasing emphasis being put on the psychological reasons for homosexual behavior.

Of the twenty-three cases, twenty were male and three were female. This would go along with what Terman says about female homosexuals. "Although intrasex 'crushes' are more common among females than males, it is probable that the number of true female inverts is relatively small."

There is no evidence in any of the three female cases of any physical relationship. In two cases the girls were strongly emotionally involved with their women friends, far more emotionally involved than normal crushes. The case about which more is known is presented below.

This is the case of a seventeen year old girl who was referred to the Clinic in April of 1940 by the superintendent of schools because she was involved with a twenty-seven year old woman teacher in what was thought to be a homosexual relationship. They were together all the time and the woman teacher would take her riding at night and they would not return until after midnight. They had been seen parked on lonely roads. The aunt of the girl became suspicious and questioned the relationship. The teacher was dismissed.

A. is the oldest of four siblings ranging from seventeen to eleven. The next to the youngest child is the only boy. Both parents have spent time in the State Mental Hospital. The father was committed to the State Hospital when A was six because of a "nervous breakdown" resulting from gas poisoning he received in World War I. The mother then went to work and the children were placed with the Department of Public Welfare. The mother divorced the father and later remarried. In between times she spent two years in the State Hospital with a diagnosis of manic-depressive psychosis. The children were separated. A. was placed in an orphanage, then in a convent, and then in another orphanage. She was finally allowed by the State to live with various aunts. At the time of referral she was living with an aunt who was giving her a very strict upbringing and allowing her no social life. She had not seen her father for many years, but was in touch with her mother. At the time she was a senior in high school.

A. was described as an effeminate looking girl. It was thought that she was clinging, suggestible, and immature emotionally.

A. had an interview with the psychiatrist who gave her sex information and talked with her about homosexuality, telling her it was an immature, futile practice and advised her to go out with boys and girls and to play basketball which she liked.

She was given a Stanford-Binet Intelligence Test and received an I.Q. of 109 which puts her in the average range of intelligence.

The recommendations of the Clinic were that she continue high school, get vocational advice about hair dressing about which she had a knack, live away from home in a family and return to the Clinic at intervals for a talk with the psychiatrist.

There was no follow-up on this case and the girl never did return to

the clinic. The Department of Public Welfare record was missing and therefore it could not be discovered if she did receive vocational guidance, or change her living situation. It was discovered from relatives of the girl, however, that she is now married, is living in another state, and has two adopted daughters.

In this case there was suspicion that a physical relationship existed between the girl and the teacher, but there was no actual proof. The history gives a picture of a lonely, immature girl who had been moved from one place to another many times during her life. It would seem that she never remained in one place long enough to feel that she belonged, and that someone cared for her. Because of these circumstances it is not surprising that she responded to the affection of the teacher and became emotionally involved with her. The fact that she was able to marry suggests that she was not so much involved with the teacher because of her sex as she was because of her own need for affection. The follow-up was not done because of the small and very busy clinic staff.

The third female case was that of a thirteen year old girl who was suspected of approaching little girls in a homosexual manner. She was not emotionally involved.

G. was referred to the Clinic July, 1947 by the Department of Public Welfare because it was suspected that she was seducing little girls at the Children's Home where she lived.

G. is the fourth of six siblings, ranging from seventeen to four. The fifth sibling is the only boy. The father was forty years old and a general laborer. He left school at sixteen when he was in the seventh grade. He has a reputation for being shiftless and a drinker. The mother was thirty-four. She left school at sixteen when she was in the fifth grade. They lived in an unsanitary, four room, papered shack. It was rumored that the two oldest girls were entertaining service men over night at their home, but no evidence of any wrong doing could be obtained until the younger of the two girls became pregnant and it was discovered she had a venereal disease. The mother and father were arrested and placed on six months suspended sentences and the oldest girl was committed to the Industrial School for the remainder of her minority. G. and a sister were put in the Children's Home. The sister

made a good adjustment but G. was sent to a foster home because of her suspected homosexual behavior. Three weeks later the foster mother requested her removal because she discovered G. handling her three year old son's genitals. At this point she was referred to the Clinic.

G. was described as an attractive brown-haired, brown eyed girl, retarded intellectually and emotionally unstable, full of anxieties and feelings of inadequacy and guilt.

It was recommended that she stay in her present foster home and return to see the psychologist at Hanover who had tested her previously and who felt he had established a good relationship with her, and that she be seen at the traveling clinic the next time it met.

G. was placed at the Industrial School for the remainder of her minority. She was sent out on two or three work placements which were unsuccessful. One place requested removal because of undesirable associations with men. She ran away from the last work placement, and is now at the Industrial School again. The matron believes she still has homosexual tendencies and has enough evidence to warrant this suspicion.

G.'s preoccupation with sex can be understood in the light of her background. Her promiscuous sisters were allowed to entertain men over night in the home. The facilities of home did not allow for privacy so it can be suspected that G. witnessed sexual activity which stimulated her and aroused her sexual curiosity. The fact that she is continuing her sexual behavior might indicate that she has not found a person with socially desirable standards with whom she could identify enough to overcome her early identification with her family. It is impossible to know if she would have turned out differently if the recommendations of the clinic had been followed.

Table 2. shows the distribution of cases according to age. Cases referred to the clinic for homosexual behavior range from nine to twenty-seven years. Subjects up to the age of thirteen are considered children, from thirteen to eighteen, adolescents, and above eighteen, adults.

TABLE 2.

Age Distribution of Subjects	
Classification	Number
Children (-13)	3
Adolescents (13-18)	14
Adults (18-)	6
Total	23

One might read into Table 2. that, in general, cases of children are infrequent and not considered severe enough to refer to a mental hygiene clinic, and cases beyond their twenties too severe. The mode, or most frequent age, is sixteen. The mid-point, or the age at which there are an equal number of younger and older cases, is sixteen, and the median, or average, is 17.2. Thus the person most frequently referred to a mental hygiene clinic for homosexual behavior is a boy in his mid to late adolescence. Considering the findings of Kinsey that, thirty-seven per cent of all males have overt homosexual experience but sixty-seven per cent of these discontinue their homosexual behavior after adolescence, it would seem natural that the majority of the cases referred were adolescent boys. It would also seem, in the light of Kinsey's findings, that the majority of the adolescent boys referred for homosexual behavior would discontinue this behavior after adolescence without treatment. However, the same statistics indicate that thirty-seven per cent, a good proportion, would continue homosexual activity into adulthood if not treated.

Table 3. shows the sources from which the twenty-three cases were referred to the Clinic.

TABLE 3.

Source of Referral	
Source	Number
Probation Department	18
Court Judge	1
Schools	2
Department of Public Welfare	1
Catholic Charities	<u>1</u>
Total	23

It can be seen from this table that the overwhelming majority of cases involving homosexual behavior did not reach the Clinic until after the individuals had been arrested. In nineteen out of twenty-three cases, this anti-social behavior was either not observed or nothing was done about it until it came to the notice of the police. Seventeen of the twenty-three cases were minors, and yet only three of these cases were not referred by legal authorities. The other case not arrested was twenty-two. Not one person was referred to the clinic by a relative. Not one person came of his own accord seeking help.

Table 4. is a specific break down of the cases according to the age and sex of the subject. Table 5. is a summary of Table 4. Because three subjects were involved with partners in two different age categories, Table 5. totals twenty-six instead of twenty-three. A young child is anyone under thirteen, an adolescent anyone between thirteen and eighteen, and an adult anyone eighteen or over.

TABLE 4.

Partners in Homosexual Activity I		
Subject	Partner	Number
Adolescent girl	Young girls	1
Adolescent girl	Adult woman	2
Young boy	Adult man and young boy	1
Young boy	Adult man	1
Adolescent boy	Young boy	3
Adolescent boy	Young boy and adolescent boys	1
Adolescent boy	Adolescent boys	1
Adolescent boy	Adolescent boys and adult men	1
Adolescent boy	Adult men	6
Adult man	Adolescent boys	2
Adult man	Adult men	4
Total		<u>23</u>

TABLE 5.

Partners in Homosexual Activity II			
Partner	Child (-13)	Adolescent (13-18)	Adult (18-)
Child (-13)	1	0	2
Adolescent (13-18)	5	3	9
Adult (18-)	0	2	4

These tables show that subjects were for the most part minors who were involved with adults. Of the twenty-three cases, eleven were minors who had been involved with adults. Two were adolescent girls, seven were adolescent boys, and two were young boys.

All the twenty males admitted to some sexual activity with an other male. The extent of the activity to which they admitted is shown in Table 6.

TABLE 6.

Extent of Homosexual Activity in Male Offenders			
	Child (-13)	Adolescent (13-18)	Adult (18-)
Admits to mutual masturba- tion only	---	2	1
Admits to fellatio	---	4	2
Admits to sodomy	---	2	-
Admits to fellatio and sodomy	---	3	1
Sex delinquency extent unknown	2	1	2
Totals	2	12	6

All that can be concluded from Table 6. is that a large majority, nine out of twelve, of adolescent boys were very active sexually.

The length of time they were engaging in homosexual behavior is known in the case of eight out of the twelve adolescent boys, and is shown in Table 7.

TABLE 7.

Duration of Activity (Male Adolescents, 13-18 years)		
Age	Length of Activity	
1.	14	1 year
2.	14	1 year
3.	15	3 months
4.	15	1 year
5.	15	3 years
6.	16	2 $\frac{1}{2}$ years
7.	16	4 $\frac{1}{2}$ years
8.	17	6 years

In only one of the eight cases of adolescent boys in which the duration of homosexual behavior was known was the duration less than one year. The average length of time was twenty-nine months. Assuming that

these eight cases are representative of the total twelve it can be concluded that the typical case was that of an adolescent boy who was referred to the Clinic for homosexual behavior by the probation department because he had been involved in a very active sexual relationship with an adult for more than two years. The following case fulfills all these specifications.

This is the case of a sixteen year old boy who was referred to the Clinic in November of 1946 by the probation department because of homosexual behavior. He had had a good deal of homosexual experience both with older men and boys his own age. He started with mutual masturbation in 1944, extended to fellatio in 1945 and sodomy in 1946.

F. is the second of four siblings. He has a sister two years older than himself and a twin brother and sister twelve years younger. His father and mother were both forty-one. His father was a mill worker and his mother, a housewife. His mother told him about sex. His father described him as being stubborn and quick-tempered, but sorry afterward, not strong to fight. Clinic records described him as a thin, depressed looking boy, somewhat effeminate in walk, gestures, and voice, but not markedly so.

F. was given the Stanford-Binet Intelligence Test and he received an I.Q. of 111. He was also seen by the psychiatrist with whom he talked over his homosexual activities and his desire to masturbate.

The Clinic staff thought that he was a boy who needed psychiatric help and that if he could not be handled on probation, institutionalization would be necessary.

F. was given a suspended sentence to the Industrial School and was placed on probation for three years.

F. expressed a desire to reform. He talked over his sexual problem with the probation officer, to whom he reported every week, and his priest. He became interested in a girl, had dates, attended church and social activities, and obtained a part time job in the shoe company, and joined the National Guard. It is believed that he gave up his homosexual behavior, and he has not been arrested since.

This case is typical of many of the cases referred to the clinic for homosexual behavior. F. had a good deal of homosexual experience, but after his arrest he was able to discontinue his homosexual activity. A

good deal of credit for his reformation belongs to the probation officer who listened to his problems and guided him into socially acceptable activities.

Nothing is known concerning the duration of the homosexual behavior in one case concerning an adult. In two cases concerning adults the ages at which the behavior began is known, and in three cases, it can be approximated. One twenty-five year old subject began when he was fourteen, a twenty year old subject began when he was thirteen, a twenty-seven year old began "when he was a boy" and a subject, age twenty-six, began when he was in the army. As he was a combat veteran and the war ended in 1945, five years before his referral, he began this behavior before he was twenty-one. The sixth case, age twenty-two was thought to have had only a few homosexual experiences. Of the five cases in which there was some idea as to when the homosexual behavior started, three began at least by adolescence and one began before he was twenty-one. Thus we can not always regard the adolescent boy who is referred to a clinic for homosexual behavior as in just a passing phase of development that should not cause too much concern. The adolescent offender of today may be the adult offender of tomorrow if he does not get help. The case presented below is an example of an adult subject who began his homosexual behavior in adolescence.

V. was referred to the Clinic in September, 1950, by the probation department because he was a sexual problem. He was arrested by the police after a man accused him of trying to attack him in a theater. V. was twenty at the time. When questioned he admitted to being homosexual. He said his homosexual activities had been going on since he was thirteen and started when a man seduced him in a theater. He admitted frequently indulging in mutual masturbation and fellatio since then. He tried having heterosexual relationships but found them unsatisfactory. In his homosexual relationships he preferred men his own

age or older. He had a "steady boyfriend" but would "step out" with other boys.

V. was the fifth of seven children. He had three brothers and three sisters ranging from twenty-seven to twelve. His father, age fifty-three, was a watchmaker and his mother, fifty-one, a millworker. V. left high school after his freshman year at the age of fifteen and went to work as a shoemaker. His father and mother separated when V. was eleven. His father went to live in another state and while V. was in the navy he visited him and said that he felt his father was homosexual, too, although he really didn't know. He had an older brother whom he said was also homosexual. This brother was arrested for an unnatural act when he was twenty-eight. He had another brother who has been arrested for theft.

V.'s parents quarreled continually. He did not feel close to either parent. His father was a cripple, having lost a leg in World War I. He described him as being a very stern, strict person and seemed hostile toward him. He thought he was like his mother who was a pleasant, easy going type of person, a "charming woman." He was fond of his grandfather and one sister with whom he has always done things.

V. was seen at the Clinic by the psychiatrist, the psychologist, and the clinical psychologist. The psychiatrist found him to be an effeminate looking individual who related easily, somewhat exhibitionistic, and ingratiating. He talked without embarrassment about his homosexual behavior. He frankly acknowledged that he did not mind being a homosexual, but would cooperate with the Clinic to be cured. He acknowledged also being a heavy drinker, but denied ever having the D's. The results of the psychological indicated that he was functioning at the high average level. He received a full scale I.Q. of 110 with limited scatter among the subtests. He impressed the examiner as a homosexual who was attempting to make a reasonable adjustment to people who were not homosexual. Both the Szondi and the Rorschach tests indicated anti-social, aggressive, and homosexual tendencies. The clinical psychologist's impression was that he was a psychopathic personality with strong schizoid features and pathologic sexuality. The Clinic's impression of V. was that he was a severely disturbed individual whose general attitude and behavior was suggestive of his being a sexual psychopath with possible psychotic episodes. It was assumed that his sexual delinquency and aggressive behavior would continue and a period of observation at the State Hospital was recommended. It was felt that his homosexuality might be because of his having had an overstrict father and having suffered disappointment in his mother with whom he identified.

V. was found guilty and sentenced to sixty days in prison, a sixty dollar fine and a five hundred dollar bond to be on good behavior for one year. Fine and bond were then suspended. At the county jail V. was examined by three doctors who declared him a sexual psychopath. In December of 1950 he was then sent to the State Hospital for a period of

observation. While in the hospital he had talks with the physician and chaplain. He promised to continue his religious interests and put himself under psychiatric care when released. He was therefore put on undeterminate parole from the State Hospital and is going regularly on an outpatient basis to the hospital where he is receiving psychiatric treatment and supervision.

This is the case of an adult homosexual who was satisfied to remain a homosexual. He had been learning to live with himself and gaining satisfaction from his homosexual behavior since he was thirteen. By the time he was referred to the Clinic he had adjusted himself to his role in society. He frankly stated he did not mind being homosexual. He did say he would cooperate to be cured. Considering the fact that he has tried heterosexual intercourse and doesn't like it, there seems like little motivation for his changing. Why should he give up something he knows he likes for something he knows he doesn't like? He promised the State Hospital he would put himself under psychiatric care. Whether he was sincere in wanting to change, or whether he just wanted to get out of the hospital, the writer doesn't know. Anyway he is reporting regularly for treatment, so perhaps something can be accomplished. He has not been re-arrested which either means he has not been engaging in homosexual behavior, or he is confining his activity to his "boy friends," and has given up trying to seduce people.

*See [unclear] 227
re-considered*

Of the five cases of adolescents seducing children, one, the case of the thirteen year old girl, presented on page twenty, was referred because she was suspected of homosexual approaches. Another case involved only mutual masturbation, and it was believed to have been the first time it occurred. Two other cases involved fellatio but the practices were not believed to have gone on for any length of time. The fifth subject was

actually more interested in boys his own age. One of these cases is presented below.

This the case of a fifteen year old boy who was referred to the clinic in December of 1949, by the probation department for sex play involving fellatio and mutual masturbation with little boys. The activity was not believed to have gone on for any length of time. The little boys were given bicycle rides as rewards. While awaiting disposition he continued his homosexual acts at the Industrial School.

Q. had one older sibling, a sister in high school. His mother died a few months after he was born. His father later remarried but his second wife divorced him. At the time of referral he was living with his father in one room. His sister lived with a respectable family in town. The father showed no interest in her. The father drank considerably. Q. had been suspended from school for bad behavior.

Q. did not have a psychological, but he was believed intelligent by the psychiatrist who thought he was an attractive, lonely, confused, neglected boy who was a victim of his environment.

It was recommended that he be placed with his stepmother, and her husband, or a good foster home, or the Children's Village.

Q. was placed on probation for two years. He was taken from the father and went to live with the stepmother. Q. was expelled from school because of his homosexual behavior. He did odd jobs. Just before the expiration of his probation he was arrested for driving under the influence of liquor and probation was extended a year. Q. joined the navy. He is still on probation but the probation departments do not notify the services if a juvenile enlists. A juvenile has no criminal record. Q. recently called the probation officer and told him he was getting along fine.

The two young boys that were referred for homosexual behavior were both intellectually retarded, and were believed to have been seduced. One of these cases is presented below.

This is the case of an eleven year old boy who was referred to the Clinic in March of 1942, by the probation department because of sex delinquency with older men.

C. was the third of five siblings, ranging from fourteen to six. He was the only boy. His father was a taxi driver and his mother, a housewife.

He was described as a chubby, red-haired boy, small for his age, with a speech impediment.

C. was given a psychological test and it was found that he had an I.Q. of 58 on the Stanford-Binet which puts him into the classification of mentally defective.

It was therefore recommended that he be placed in the Laconia State School for the feebleminded and follow-up study reveals that this was done.

In the quantity and quality of the homosexual behavior these cases are not as severe as the cases of adolescents and adults or adults involved with other adults.

There were three cases of adolescents involved with other adolescents. Of the three cases one, a fourteen year old boy, came to the notice of the police only when he turned his attention to an eight year old boy. He had been having relations with boys his own age for a year without detection. Another, a sixteen year old boy, had been having relations with both boys his own age and men. The third, a sixteen year old boy, had sexual experience for three months with an adolescent friend, but he was arrested when he started propositioning adult men. As he was not known to have actually had a homosexual relationship with an adult, he was classified in Tables 4. and 5. as an adolescent involved only with an other adolescent. All three cases involved either fellatio or sodomy.

The low number of cases of adolescents involved with other adolescents could reflect (1) such a combination is not considered pathological or (2) it is easier to get away with or (3) it is not as frequent a combination. The fact that the three cases were not only involved with others their own age, but others outside of their group would suggest that the offense was considered serious enough to refer to a clinic when someone other than an other adolescent was involved.

The fact that two of the cases were not detected until they at-

tempted to obtain relations with someone not an adolescent would suggest that it is easier for two adolescents to get away with homosexual relationships without detection. If this is so, and logically it would seem to be so, then the fact that only three cases involve adolescents who had sexual relations with other adolescents does not necessarily mean that this combination is less frequent than that between age groups, but only that the people involved are referred to a clinic less frequently. The case of the adolescent classified as having been involved only with other adolescents is presented below.

This is the case of a sixteen year old boy who was referred to the Clinic June, 1949, by the probation department for an unnatural act. He was fifteen at the time of arrest. He admitted to fellatio and mutual masturbation about a dozen times with a fifteen year old boy friend. Activity had been going on for three months. He was arrested for approaching and writing notes to older men suggesting homosexual activity.

L. was the older of two children. His mother died at his birth. The father married in 1938 and L. had a half sister born in 1938. The stepmother was pregnant by his father at the time of the marriage. The father was a truck driver; the stepmother, a shoemaker. The family lived in a congested area which had the reputation of being poor morally. The living quarters were clean but rather cramped as they had only four rooms.

The father was a soft spoken, easy going man who never disciplined the children, but left it up to his wife. The stepmother was twelve years younger than the father. She disciplined the children, but discipline was inconsistent and consisted mostly of warnings. Both father and stepmother drank.

L. was a good looking boy but was described by the Clinic and the probation department as being markedly effeminate. He played with younger children and the boys his own age called him "pansy" and "babyish." He crocheted in his spare time. In school he was a model pupil and just before his arrest he graduated from grammar school as valedictorian. L. was very religious and aspired to the priesthood. He had been stealing but was careful not to steal an item over two dollars as that would be a mortal sin. Items stolen were candy and male apparel. He told the priest in confession about his stealing and the priest advised he get a job and earn some money. He therefore took a daily newspaper route and at night sold papers on the street. In addition to this he worked part time for a cleaners. These activities had been going on for a year and

he earned about twenty-five dollars a week. It was while selling papers on the street that he attempted to pick up men.

L. was seen at the Clinic on one occasion. He had been on probation for almost a year when he was referred. At this time he was given a Wechsler-Bellevue on which he received a full scale I.Q. of 127 with little variability. There were potentials of very superior functioning blocked by emotional disturbance. It was asked that he return for a Rorschach and a psychiatric interview. He never returned.

In August, 1948, he was placed on probation for three years. He made a good relationship with the probation officer with whom he talked over his problems. He could not get along with his stepmother who was a drunkard and rejected him. He wished to leave home and it was at this point that the probation officer referred him to the Clinic. The probation officer encouraged his leaving home. For the past two years he has been living alone. He works nights and goes to high school where he maintained a B average and he will graduate in June. He joined the Naval Reserve when he turned eighteen and will enter the Navy on graduating. He attends church regularly and visits his parents. He told the probation officer that he has had no further homosexual behavior but relieves himself occasionally through masturbation. Probation expired in August, 1951. There have been no further offenses, a matter of three and a half years.

This is the case of a boy whose homosexual activities were discovered right at the beginning. He had only masturbated about a dozen times with a boy friend. It is possible he was on the way to becoming seriously involved, however, as he was trying to pick up men and might have attracted the attention of a full-blown homosexual like V. on page twenty-seven. If this had happened the ending of this case might not have been so happy. The happy outcome seems to have been due, at least in part, to the probation officer. L. was a boy with many problems that the probation officer helped him work out. He was also an effeminate boy who needed a masculine figure with whom to identify. His soft-spoken, easy going father did not seem to be the type. Perhaps his relationship with the probation officer was just what he needed.

Table 8. is a table classifying the physical appearance of the

male subjects with regards to the degree of effeminacy they display.

TABLE 8.

Physical Appearance of Male Subjects	
Degree	Number
Effeminate	3
Slightly effeminate	4
Not effeminate	4
Not mentioned	9
Total	20

Table 8. shows that in nine cases the boys were not described as effeminate or not effeminate. If the subject were effeminate, there would most likely be a mention of the fact. Whereas if the subject were not effeminate, this fact would not be as likely to be mentioned. Thus it can be presumed that the majority, if not all, of the nine cases not described as either effeminate or non-effeminate were not effeminate. Seven out of the twenty cases or slightly less than one-third were described as effeminate or slightly effeminate. Of these only three looked definitely effeminate. Thus it can be concluded that the majority of the male cases did not appear effeminate. Nothing could be concluded from the three female cases. The case of L., previously presented, is an example of a case in which the subject was classified as effeminate.

No significant similarities of character could be discovered in this study. This does not mean that there were no similarities, but only that they could not be discovered from the short descriptions available for study. The adjective most frequently used was "passive." This adjective was used in only four of the twenty-three cases or less than one-sixth. Thus nothing could be concluded.

A theme that runs through the cases is that of broken homes.

Ten of the subjects, before they were thirteen, lost a parent or parents through death or separation. In six of the cases the subjects were under six. The case of one of the subjects who comes from a broken home is presented below.

This is the case of a fourteen year old boy who was referred to the Clinic in April of 1949, by the probation department because he was involved with an older man in a homosexual relationship. He met the man a year previous to his referral and left home to go and live with him. His relationship involved fellatio and sodomy about three or four times a week. In return the man bought him clothing and gave him about \$125.00.

J. had one sibling, a seven year old sister. Another sister died three years previous to referral and his father died of ulcer hemorrhages when J. was six. His father was a male nurse.

The Department of Public Welfare reported that the home was pleasant and cheerful and the mother had a good relationship with the children.

J. was described as a good looking, slightly undersized boy.

J. was given a Wechsler-Bellevue and received a verbal scale I.Q. of 103, a performance scale of 112, and a full scale of 115, putting him in the average range of intelligence with performance in the high average to superior. The social worker took a history from the mother. The mother told the social worker that J. did not have an opportunity to go places as she did not have any extra money since her husband's death. She was, therefore, only too willing that he should go to such places as baseball games with this man. The man had made a good impression on her. He had shown her a Federal Bureau of Investigation certificate which impressed her. He often came for supper and stayed for the evening. He said he had a bad back and wanted J. to help him bake it. She, therefore, allowed J. to stay with him nights. J. returned home in the day time. Then one day her little girl had an accident, and she needed J.'s help. He wasn't home. After this incident she told him he was to stay at home in case he was needed in an emergency. This man became very upset and started to call him every half hour. She became frightened and called the police. The police questioned J. for sometime and found out about the homosexual acts.

An appointment was given with the psychiatrist but was not acknowledged. No recommendations were given.

J. was placed on probation for one year. He graduated from grammar school while on probation.

There is a good possibility that J. would not have developed a relationship with the adult homosexual if his own father had been living. In the first place, the man might not have approached him if there had been a father in the home. In the second place, if he did approach him, the father might not have been so naive about his attentions as the mother was. In the third place, it is possible the man filled a need in the life of the boy and his mother that would not have existed if the father were alive. The boy needed a father substitute, and the mother might have needed masculine attention. There does not seem to have been any difficulty in the home situation, so it would seem the boy's greatest need was a suitable father figure.

Besides broken homes there is evidence of emotional instability in the immediate members of the families of some of the subjects. The evidence of instability are (1) heavy drinking, (2) criminal records and (3) time spent in mental hospitals. Six of the subjects came from families in which a member or members of the immediate family was a heavy drinker. Four of the subjects came from families in which one or more members of the family had police records. In two cases both parents spent time in mental hospitals. One case overlaps in the first two categories. A case in each of the three categories will be presented. An example of a case in which drinking was a factor is presented below.

This is the case of a fifteen year old boy who was referred to the Clinic in December of 1949 by the probation department because of sex play involving fellatio and mutual masturbation with little boys. The boys were given bicycle rides as a reward.

P. had one older sister and a twin brother. His sister was married and living out of state. Both parents were employed. The father was interested in the boy but couldn't control him. The mother was frequently seen in beer parlors. She paid little attention to the boy. P. roamed

the city, he played truant from school, was a disciplinary problem, and had been suspended.

P. was a large, stocky, pleasant looking, friendly boy. He was emotionally immature and easily led.

P. was given a Wechsler-Bellevue and received a full scale I.Q. of 102 with little variability. He also had a psychiatric interview.

It was the impression of the Clinic that he did not realize the seriousness of his behavior. It was recommended that he have close supervision, and it was thought he should have psychiatric study, but as there were no facilities available a foster home or a Children's Home was recommended.

Follow-up revealed that P. was placed on probation for two years and remained at home. He was not allowed back into school because of his offense so he went to work in a shoe factory. Later he followed his twin brother into the navy where he is at present.

It appears that a lot of this boy's difficulty centers around his mother. Perhaps if she stayed away from barrooms and made a proper home for him he would not be in so much difficulty. It would seem that the father is a weak, ineffectual individual.

A case in which members of the subject's family had police records is presented below.

This is the case of a sixteen year old boy who was referred to the Clinic by the probation department at the same time as J., whose case was previously presented, as he was involved with the same man. K. was involved with this man from when he was ten and a half to when he was fifteen. He lived with him for two years with his mother's consent. Homosexual acts including fellatio and sodomy occurred four or five times a week. The man bought him presents, gave him about five hundred dollars and threatened to kill him if he left. However, at fifteen, after he graduated from grammar school, he returned home. When J's mother called the police, K. was drawn into the affair.

When the probation department investigated they discovered that K. was the youngest of six siblings, all boys. K.'s mother had been married at least twice, possibly three times and the oldest child was conceived out of wedlock. K.'s father was her last husband and he died when K. was five. He had a police record and three of the sons have long records of serious offenses, the oldest is now serving life. Three of the brothers beside K. are living at home which is a ramshacked affair.

K. was described as a nice looking, well dressed, neat boy.

K. was given a Wechsler-Bellevue and received a verbal scale I.Q. of 106, a performance of 118 and a full scale of 115 placing him in the high average to superior group. No one appeared to give a history. An appointment was given with the psychiatrist but K. did not appear. No recommendations were given.

K. was placed on probation for one year. He graduated from trade school and went to work. At the time probation expired he had been laid off because of business slack. He has not been arrested since.

This boy was brought up in an environment in which anti-social acts were the rule rather than the exception. Apparently no one in the family cared when he moved away from home and went to live with the homosexual man. It would seem that this boy was very deprived. He was very poor, and he didn't have anyone who cared about him. The fact that he stayed with the man until after he graduated from grammar school suggests he was using the man for financial support until he got through school. Apparently he had the ambition to lead a socially acceptable life, as he went through trade school and has not been arrested since. It would seem that he used a socially unacceptable way to obtain a socially acceptable goal. He was probably able to accept this means to an end because he did not have moral values, due to lack of moral standards in the home.

An example of a case in which the parents had spent time in mental hospitals is presented below.

This is the case of a seventeen year old boy who was referred to the Clinic in October of 1940 by the probation department because of sexual delinquency. He had been caught seducing a twelve year old boy into mutual masturbation. As far as is known this is the first time B. ever behaved this way although it is reported he threatened to sexually attack his younger sister.

B. was the oldest of four siblings ranging from seventeen to eight, and the only boy. His mother died in the State Hospital for Mental Diseases of chronic encephalitis when B. was nine. The father remarried the following year and died two years later, when B. was twelve, of general

paresis at the State Hospital. The stepmother continued to care for the children, and was believed to have given them good care. B., however, was too much for her to handle as he was disagreeable, enuretic and stayed away from home. He was referred to the Clinic by the Department of Public Welfare and the result was that he was sent to the Angel Guardian Home, a private Home for Catholic children. He stayed in this Home until the spring of 1940 when he ran home to the stepmother where he was living at the time of the referral. He was described as being a well developed boy who was hostile, flippant and boastful.

At the Clinic he was given a psychometric. He received a verbal I.Q. of 81 on the Wechsler-Bellevue which is within the classification of dull normal. His performance scale was superior to his verbal as determined by the Kent-Kohs Color Cubes Test. Because his parents were known to have been syphilitic, B. was given a Wasserman which was positive. Syphilis was not believed to have affected his I.Q., however. B. was also seen by the psychiatrist.

It was felt by the Clinic staff that B. was an individual who was not especially responsible for his actions and it was doubted that apprehension would help him adjust unless he had continued close supervision. If it was true that he was threatening his younger sisters as there was no father to supervise, putting him in the Industrial School was recommended.

Follow-up revealed that B. was committed to the Industrial School for the remainder of his minority. After a year he was sent on a work placement and three months later he was paroled. He reported monthly and reports show that he worked steadily. When he was twenty-one he was discharged.

B.'s parents were committed to the State Hospital for Mental Diseases because of organic brain damage. It would seem that living with parents who had a venereal disease, which resulted in degeneration of the brain and ended in hospitalization and death in a mental hospital, would have affected B. emotionally. As his physical condition was not believed to have affected his I.Q., it would seem that at the time of referral his behavior was a result of emotional rather than organic factors.

There are also evidences of instability in the subjects themselves. Of the six adults, four of them are heavy drinkers. A fifth was not a heavy drinker, but his homosexual experience took place after he had

been drinking. The case presented below illustrates the importance of alcohol.

This is the case of a twenty-five year old man who was referred to the Clinic in August of 1949, by the court because of sexual advances toward young boys. He was found mutually masturbating in a parked car with a sixteen year old boy. O. admitted to homosexuality and said it started when he was fourteen and an older man practiced fellatio on him. Acts then continued up to present. He committed sodomy once but denies ever having committed fellatio on anyone, preferring to be the receiver of the act. He had never had sexual relations with women. He used both men and boys as partners.

O. was the youngest of eight siblings. The mother died when he was three and his father remarried when he was fourteen. In the meantime he lived with many different relatives. The father was sixty-three at time of referral and was a factory foreman. O. left school after the seventh grade. He was a laborer and was deferred from World War II because of stomach ulcers. He was a heavy drinker.

O. was described as a passive individual with a number of physical and personality difficulties. He was lonely, had marked feelings of inferiority, but was not psychotic. He had some effeminate mannerisms.

He was classified on the Wechsler-Bellevue as having borderline intelligence with the performance scale being in the dull normal range. He was also seen for a psychiatric interview.

It was recommended that he enter the State Hospital for study and treatment as it was believed he needed trained help or he would repeat his sex pattern.

O. served thirty days in the House of Correction and was paroled. He continued his behavior and in August of 1950, he was committed to the State Hospital for observation. O. was in the hospital until October, 1951. While in the hospital he had group and individual psychotherapy. It was felt he improved in understanding, insight, and maturity and that if he abstains from alcohol and avoids young boys as he realizes he must do, he can stay out of difficulty. He was thus discharged with a diagnosis of Without Mental Disorder, Psychopathic Personality, Psychopathic Sexuality.

The hospital staff considered that this man could abstain from homosexual behavior if he avoided alcohol and young boys. Alcohol frees a person from his inhibitions. Apparently O. had some guilt feelings concerning his behavior as the hospital felt that alcohol was an important

factor contributing to his behavior. He needed the alcohol to free himself from his guilt feelings.

This case points up the problem of adult homosexuals who initiate young boys into homosexual practices. In some boys, like O., the homosexual act seems to answer some need of their own. They continue the homosexual behavior and when they reach adulthood they initiate other boys. This case also shows the uselessness of imprisonment for homosexuals like O. He was removed from the community for a short time, but he was still on parole when he was again seducing young boys. It is too early to determine the results of his year in the hospital.

O. had stomach ulcers which could have very possibly resulted from emotional conflict. Another case also had a psychosomatic complaint. This subject was the only adult referred for homosexual behavior who was married.

This is the case of a twenty-six year old man who was referred to the Clinic in August of 1950, by the probation department because of mutual masturbation with his fifteen year old brother-in-law. Behavior occurred on the average of once a week for a year. S. had had similar experience while he was in the army.

S. was the youngest of six siblings. He had three brothers and two sisters. The family was thought of as "queer" by the neighbors because they didn't mingle. The parents were strict and demanding. The father died a little over a year previous to the referral. Two of the siblings were alcoholic. S. left home because he was not happy. S. was a veteran and he saw action in Italy. S. had been happily married for two years. His wife was demanding sexually but he believed he satisfied her, and sexual relations were normal and satisfactory. It bothered him that his wife was a non-Catholic as he was a very religious Catholic. His wife seemed to be warm and accepting and very much in love with her husband. It was her second marriage. S. suffered from neurodermatitis. It first occurred when he was in Italy, following nervous shock. He had to quit vocational school and had trouble holding a job because of it. He received fifty per cent disability pension.

S. was a passive looking, poorly groomed man who looked older than his age.

S. was given the Wechsler-Bellevue and received an I.Q. of 103 with little variability. He had a Szondi which showed ambivalence in sexual identification, and a Rorschach which showed basic instability and vague anxiety. He also had a psychiatric interview.

The Clinic saw S. as a severely disturbed individual whose conflicts were, to an extent, somatized. He appeared to be arrested at a bi-sexual level. It was recommended that he receive medical treatment and psychotherapy at a veterans hospital and then long ambulatory treatment.

S. was placed on probation for three years. S. is getting along with his wife and in-laws. He had a job but had to give it up because of the rash. He then spent time in a veterans hospital. He was impatient and left the hospital. He still gets the dermatitis and is not working. He has not seen his brother-in-law since they were arrested.

This man is what is known as a bisexual. He was happily married and had normal sexual relations with his wife, yet he sought and enjoyed homosexual relations. The reoccurrence of neurodermatitis is an evidence of his basic emotional instability. It first occurred after he was removed from the battle field because of "nervous shock." The neurodermatitis might possibly have been a result of an emotional conflict. He did not want to go back to the battle field, on the one hand, but on the other hand he wanted to do his duty like every one else. Later in life he went to vocational school and obtained jobs, which indicates a desire to work and be independent, but he could not keep the jobs because of the dermatitis which indicates a desire to be dependent. He made efforts to rid himself of the dermatitis yet didn't follow through. Apparently he had not reached the stage of independent maturity.

There was also evidence of emotional instability other than the homosexual behavior in the cases concerning minors. Three minors had been school problems. Three had been arrested for charges other than homosexuality, one for theft, one for driving under the influence of liquor, and one as a stubborn child. Two cases overlapped as the subjects were school

problems and had been arrested. Three minors had nervous habits, one stuttered, one had a tic, and one was enuretic.

The case of a minor who was emotionally upset is presented below.

This is the case of a fifteen year old boy who was referred to the Clinic in October of 1950, by the probation department. He was brought into court on a stubborn child charge. It then came out that he had been involved with three different men in a homosexual relationship since the age of twelve. All of these men are now serving time. When W. was twelve his mother became suspicious because a man was buying him presents. She questioned him about the relationship and then notified the police. The summer previous to referral, the mother went on a trip and W. became involved with two other men. W. claimed he submitted to get money. Extent of activity is unknown.

W. was the oldest of four siblings, two boys then two girls ranging from W., fifteen, to six. His father married his mother to spite someone else. Then he went away and left her. While he was gone she became pregnant by another man. She and her husband reconciled. The mother said that at first the father rejected W., but now he treats him like the other children. Only recently he started to give him spending money. The father was forty and a warehouse man. The mother, thirty-five, and a housewife. The social worker felt the relationship between the mother and W. was that of a constant battle with one occasionally getting advantage of the other, and both enjoying it. The worker felt the mother had ambivalent feelings toward the subject, rejecting him on the one hand, but feeling guilty enough to do what she could for him, on the other. The mother always disciplined W. and many times quite harshly. At other times, she was inclined to give in to him. W. was a general problem in school and the neighborhood. He had also been involved in some stealing. His progress in school had been fair and he was in high school. W. was described as an average looking boy with a normal physical build.

The social worker took a history from the mother. The psychiatrist saw the boy and the mother, the psychologist gave him the Wechsler-Bellevue test and he received an I.Q. of 99 with little scatter. This places him within the average range. The Clinical psychologist gave him the Rorschach and the Szondi projective tests. These tests indicated a tendency to accumulate aggressive tension, inability to cope with strong emotionality, and a trend toward exhibitionistic discharge of emotions. The Clinic felt the mother had ambivalent feelings about the boy, limited warmth and affection, and that the boy was emotionally upset and needed an acceptable outlet for his aggressive impulses and emotional tension. It was felt his present environment was inadequate because of the emotional instability of the mother and lack of recreation facili-

ties and contemporaries. Placement in a specific Children's Home and follow up by the Clinic were recommended.

W. was sent to the Industrial School. For the first six months he was involved in many sex offenses. He began to do better and was given a trial placement at home. W. violated his parole from the Industrial School by committing unnatural acts with adults and attempting intercourse with his ten year old sister and has again been referred to the Clinic.

This boy was acting out his emotional problems, not only through his homosexual behavior, but also through disobedience, stealing, and making a general nuisance of himself in the neighborhood. *analysis* (It appears that the difficulty was rooted in the home situation. He continued to act out for the first six months he was in the Industrial School, but then his behavior improved to such a degree that he was allowed to go home on trial placement. He immediately reverted back to his old behavior. The boy did not have a good relationship with either his father or mother. The father rejected him for years because of the circumstances of his birth, and the mother had ambivalent feelings toward him which were probably rooted in guilt feelings concerning his birth.

Of the twenty-three cases, *analysis* there are only eight in which there is not a broken home situation or evidences of instability or both. Of these eight cases, two are cases in which the reason for the homosexual behavior is believed to have been low I.Q. One is the case of an eleven year old boy with an I.Q. of 58, which is considered feebleminded. The other is the case of the nine year old boy whose I.Q. was 75 or borderline. Both little boys are believed to have been seduced.

Five of the remaining six cases have something in common. All five subjects are the youngest siblings in their respective families. In all, eleven out of the twenty-three subjects were the youngest siblings in

their respective families. Of the eleven, eight came from families of six or more siblings. Thus of the twenty-three cases, eleven or almost half were the youngest siblings in their respective families. It does not seem that such a high percentage would be due to chance. There may be inherent psychological factors unique to the position of youngest sibling in a family, especially in a large family. A case in which the subject is the youngest sibling in the family is presented below.

This is the case of a sixteen year old boy who was referred to the Clinic in May of 1946, by the probation department. He had been arrested twice in thirteen months. The first time was for accepting stolen property, breaking and entering and stealing. The second time, for an unnatural act. He was seen at the Clinic after both offenses.

E. was the youngest of eight siblings, three girls and five boys. The next youngest sibling was eight years older than E. E.'s father was a farmer and his mother a housewife. His mother was an easy-going woman who called him "her baby." The father was a passive man who was afraid to discipline E because he was the mother's pet. The father was an alcoholic and at the time E was seen at the Clinic, the father was on probation. When drunk, he was strict with E.

E. had been very sickly from when he was born to when he was six years old. All his older brothers and sisters spoiled him and his mother was very protective of him. E. attended several schools, transferring from one to the other because of bad behavior. Every school report described him as the hardest boy to handle that the school ever had. His marks were all either very low or failures.

E. was described in the Clinic report as effeminate looking and having an effeminate walk.

When at the Clinic the first time E. saw the psychologist who found that he had an I.Q. of 89 with scattering up to the superior adult I level. He was given a physical and was found to be eighteen pounds over weight. He had bad teeth, enlarged tonsils and his vision was impaired in both eyes.

It was felt by the Clinic that quite a lot could be done with the boy. It was felt that he needed home discipline plus help from the Clinic rather than detention in the Industrial School. Glasses, orthopedic and dental care were also recommended.

E. was put on probation for two years. The probation officer talked with the parents who agreed to be firmer about discipline; the father said

that he would take more responsibility. Five months later E. was arrested for an unnatural act. It seems that he was not only engaging in overt homosexual activity with an older man in which he played the female role, but he also had a business in which he rounded up other boys for this man. The man paid him for his efforts.

He was again seen by the psychologist and the psychiatrist. This time he received an I.Q. of 90 with a performance scale of 110. The Clinic felt that E. was neurotic, had not developed normally sexually, and should be kept out of his home and remain at the Industrial School where he was being held for disposition and should be seen at the Clinic. The Clinic further felt that he should be taught a trade and have male guidance and kind but firm discipline. This time E. was placed in the Industrial School and he did come to the Clinic for one interview.

E. did not get along at the Industrial School. He used filthy language, was a habitual liar and got involved in fights. He paled with another boy arrested for homosexual behavior, but was not involved in any trouble. He was supervised all the time. He complained to the superintendent that the boys were flirting with him. In the opinion of the superintendent of boys, "It is impossible to help this boy as he refuses to help himself."

In May of 1948, E. was sent home on trial. He obtained a job in a bakery and held it successfully until just recently when he entered the service. He was discharged from trial placement in December of 1950. During this time he had a girl and a normal social life. He has not been in any trouble since he left the Industrial School.

An important element in this case is the boy's place in the family constellation. He is the youngest child. The mother babied him. She even verbalized how she felt about him, as she called him "baby." She protected him, and would not allow the father to discipline him. The only time the father obtained enough courage to do so was when he was under the influence of liquor. The fact that E. was a sickly child probably contributed to the situation, as the mother could justify her over-protection on the grounds of E.'s physical condition. The older brothers and sister contributed to the situation because they also pampered their baby brother. It seems that E. was being emasculated by his mother and siblings. His father was a weak, passive man so identification with him could not save

E. from emasculation. E. had some effeminate mannerisms, but it seems he must have wanted to become a man or he would not have tried so hard to prove he was a man through his aggressive behavior.

The subject in one case was not only the youngest of six siblings, but also the only boy. He was described as "passive," which is not surprising, occupying such a position in such an environment. There are two other cases of boys with only female siblings. One case had three sisters and another, four. Two other cases were also in double-barrelled psychological positions. They were not only the youngest siblings, but also the youngest boys in families of all boys. The mother in one of these two cases admitted that she wanted a girl.

Of the twenty-three cases, twenty had psychological examinations. Table 9. shows how they rated.

TABLE 9.

Intelligence Rating Table	
Classification	Number
Mental defective	1
Borderline	4
Dull normal	2
Average	9
High average to superior	3
Superior	1
Very superior	0
Total	20

It can be seen from the above table that thirteen of the twenty cases tested had average or better intelligence. The mid-point is in the average range which is true for the population as a whole. Of the three cases not tested, one graduated from Teachers College, one, it was determined from the Rorschach, had better than average intelligence, possibly

as high as superior, and one was believed by the examining psychiatrist to be intelligent. Thus it can be said that sixteen, or slightly more than two-thirds of the twenty-three cases had average or better intelligence.

Table 9. shows the level at which the subjects were functioning but does not show potentials. Four of the twenty cases were tested only on the Stanford-Binet test and scatter is not known. Eight of the sixteen cases, or fifty per cent, in which scatter is known had performance scores much higher than verbal scores. This is an evidence that a good many of them were not functioning up to their capacity because of emotional disturbance. Thus it can be said that the large majority of the cases referred to the Clinic for homosexual behavior were functioning at least at the level of average intelligence and a good many were not functioning up to their intellectual capacity possibly because they were emotionally disturbed.

For the most part people referred to the Clinic for homosexual behavior were seen only for diagnostic interviews. Of the twenty-three cases, twenty were given psychometrics, five were given projective tests, nineteen were seen by the psychiatrist and in four cases social histories were taken from relatives. In 1950 the percentage of cases seen by a complete clinic team vastly increased. This is because of the increase in clinic personnel.

TABLE 10.

Comparison of Diagnostic Interviews in 1940-1949 and 1950					
Year	Number of Cases	Interview with Psychologist	Interview with Clinical Psychologist	Interview with Psychiatrist	History taken by Social Worker
1940-					
1949	18	15	1	14	1
1950	5	5	4	5	3
Total	23	20	5	19	4

Up until 1950, almost all of the cases were seen only by the psychologist and the psychiatrist. In 1950 the big improvement was in the number seen by the clinical psychologist for projective tests and the social worker for social histories. The first social history on these cases was taken in 1949. This does not mean that there was no knowledge of the background of the cases, as it was the practice of the probation department to forward a history on the people they referred. Histories were also sent by the Department of Public Welfare, Catholic Charities and one of the two schools that made referrals. It was difficult to get a history on the probation cases because the probation officer brought the boys from the Industrial School where they were being held pending disposition of their cases, and many relatives would not come to the Clinic unless they were brought.

As far as treatment is concerned only three of the twenty-three cases were seen for the purpose of treatment. One case was seen three times by the psychiatrist; another case was seen twice, and a third case was seen thirteen times. In the first two cases the Clinic was willing to help further, but the client did not accept the services extended. In

the third case the psychiatrist terminated the contacts only after he considered the treatment sufficient. This case is presented below.

This is the case of a nine year old boy who was referred to the Clinic by the Catholic Charities in November of 1949, because of sex play with a boy twelve and a man. Extent of activity was unknown. The man was imprisoned.

R. was the second of four siblings, ranging from fifteen to four. The oldest was a boy and the two youngest were girls. The father left school at sixteen when he was in the seventh grade. He was a mechanic by trade and the longest he ever held a job was four years. He was thirty-two years old and the mother was thirty-five. She completed the fifth grade at sixteen and worked in the mill. She was married previously and the oldest child was by her first husband. She had an ulcer. The family lived in a "notorious" block. The father was domineering and the mother did not seem rejecting of the children. The family received financial aid.

R. was a small boy with a tic. He was passive but friendly.

R. received an I.Q. of 75 on the Stanford-Binet Intelligence Test which classified him as borderline. He had thirteen play therapy sessions with the psychiatrist. The goal of therapy was to help him work out any feelings he might have toward men through a warm, accepting relationship with the therapist, and to prepare him for placement.

It was recommended that he be placed in a foster home preferable.

R. was placed in a Catholic Orphanage in March of 1950. His behavior was good and he had frequent visits from his parents and visited home during vacation. He was discharged in June of 1951 and has been getting along well since then.

It is understandable that only three cases received treatment in the light of the fact that only since 1950 has the Clinic been able to give most cases complete diagnostic service, never mind treatment.

In twenty cases recommendations were made. The three cases in which recommendations were not made were cases who did not appear for the psychiatric interview. The one case in which recommendations were made without the psychiatric interview was the case of the feebleminded little boy. The psychologist tested him and then recommended that he be placed in the State School for the Feebleminded. The recommendations that were

given are shown in the following table. In some cases more than one recommendation was given. The recommendations are classified individually.

TABLE 11.

Recommendations of Clinic	
Recommendation	Number
Further psychiatric study	6
Treatment:	
At the Clinic	5
State Hospital	2
Medical	2
Re-examination in the future by Clinic	2
Placement:	
Foster home	3
Foster home or children's home	3
Children's home	2
Industrial School	2
State School for Feebleminded	1
Close supervision	3
Vocational help	3
Physical examination	2
Re-admittance to school	1
No recommendations	3

The follow-up study revealed the following results regarding the twenty cases in which recommendations were given.

TABLE 12.

Follow-up of Recommendations	
Results	Number
Recommendations followed	7
Recommendations followed in part	3
Recommendations not followed	<u>10</u>
Total	20

In one of the cases in which the recommendations were not followed, the matter was taken out of the hands of the probation department because the subject appealed to a higher court and the case was not

pressed. In two other cases the recommendations were followed eventually but are scored as not followed because they were originally ignored. In two cases the Clinic recommended the State Mental Hospital and predicted the homosexual behavior would continue otherwise. The recommendations were not followed at the time they were given so are classified as not followed. The subjects were later sent to the State Hospital, however.

Of the seven remaining cases in which the recommendations were not followed, four were recommendations of placement. In two cases a Children's Home was recommended. In one case no placement was made, and in the other case the boy was sent to the Industrial School. In the other two cases foster homes were recommended. In one case the boy was sent to an orphanage and in the other case, the Industrial School.

In the other three cases in which the recommendations were not followed, the recommendations were that the person be seen again at the Clinic. In two of these cases it was thought important that the boy be seen again and given sex instructions by a male staff member. In two cases the subjects were to be followed at regular intervals. The clinic did not contact these people again and hence did not follow its own recommendations.

Of the three cases in which the recommendations were followed only in part, the part not followed in all three cases was the recommendation to come back to the clinic. Two were adults who were told they should continue coming to the clinic for treatment. The other case was a boy on probation. Four of the six cases that were told they should return to the clinic for further study were on probation and the recommendations were given to the probation department. While the clinic did not follow

up its own recommendations, the probation department did not request further interviews either.

The follow-up study reveals that only five out of the twenty-three cases were in trouble after they had been seen at the Clinic. One subject broke his probation in three or four months and went over into Massachusetts where he was arrested. Why he was arrested the writer could not discover. The Clinic did not believe he needed to be hospitalized. This is the only case in which the Clinic's recommendation was proven incorrect. Another subject broke his parole and landed in the State Hospital which is what the clinic recommended in the first place. Another subject broke his probation by driving under the influence of liquor. Recommendations of the clinic were followed, and on the whole he improved. The fourth subject was put in the Industrial School against the advise of the Clinic. He broke his parole by committing further sex offenses. The fifth, who is at the Industrial School, has had unsatisfactory work placements and is believed to be still sexually delinquent.

On the whole, however, the subjects turned out very well. It seems to have made no difference whether the recommendation that the subjects return to the Clinic were followed or not, they still did well. In many cases it has not been very long since the persons were seen at the clinic but they have made good beginnings toward living a socially acceptable life. Of the fifteen adolescents, five went on to graduate from high school. Of these, one is now married and a mother, and three are known to be working regularly. Two boys are attending high school and one of them will graduate in June. One graduated from trade school. Two were expelled from high school because of their arrest. These two had been trou-

blesome to the school before their arrest. They are now in the navy and seem to be adjusting. One boy who was sent to the Industrial School is now also in the service and another is working steadily. Another boy who quit high school previous to his arrest works regularly. Of the two remaining adolescents, one broke his parole with further sex offenses and has been referred back to the Clinic. The other is still in the Industrial School and continuing sexual delinquency. On the whole, for people with a good deal of unhappiness and instability in their background, they are adjusting themselves very well to society. All the eleven cases placed on probation are doing well and two of the four cases sent to the Industrial School. The subject in the case presented below is an example of a boy who adjusted himself to society.

D. was referred to the Clinic in August of 1944, by the probation department for homosexual activity. He was fourteen at the time. Activity included sex play and overt homosexual activity and sodomy. Partners were for the most part boys his own age. He claimed he was not the aggressor. The sexual experience had been going on for about a year and came to the notice of the police when the father of an eight year old boy complained.

D. came from a broken home. His own mother died when he was eight years old and his father subsequently married. His father was a carpenter. D. didn't get along with his stepmother and felt that she turned his father against him. On the other hand he blamed his father for his mother's death, because the father ran around and neglected her. He felt his father would "just as soon see him dead." D. was the sixth of seven children. The two oldest siblings were boys, then three girls, then D., then another girl. The two brothers were in the service at the time of referral.

D. was a tall, husky, friendly, cooperative boy. He had a facial asymmetry which was left over from infantile paralysis which he had at the age of three or four. He had a mild stutter and suffered from a language handicap as he spoke French and until just prior to his arrest attended a French parochial school. He was about to enter an English speaking junior high school.

D. was seen in 1944 by the psychiatrist and the psychologist. The psychologist found that he had an I.Q. of 112 on the Chicago Non-Verbal

Test. On the Stanford-Binet vocabulary test he received the equivalent of a mental age of eight. The psychiatrist felt that he was an unhappy boy who got in with unfortunate companions. Recommendations were that if he were placed on probation he should come to the Clinic for psychiatric studies, and later on it would be well to do aptitude tests. It was felt that if some work or hobby could be found to interest him, there was a possibility that his anti-social behavior would not return. Close supervision and guidance were recommended until a future study could be made of the case.

D. was placed on probation for two years. He made a good relationship with the probation officer and talked over his problems concerning his father and his stepmother with the officer. His marks went from seventies before his arrest to straight A's in the eighth grade which was when he was on his second year of probation. The first year he was on probation he was still struggling to overcome his language handicap. His stepmother agreed to his entering high school if he would work and pay her \$10.00 a week which he did.

In 1950 D. was again referred to the Clinic. This time he was referred by the speech therapist at the Rehabilitation Center because he felt that he wanted to talk over his problems with the psychiatrist. His main complaint was his stammering. His stepmother had died and he was doing all the housework and was in constant friction with his father. He talked this situation over with the psychiatrist. He saw the social worker for an intake, and the psychiatrist twice. He did not show up for the third appointment. His future was discussed and he said that he wasn't interested in mechanical things or sports and he wanted to go to the University of New Hampshire.

A report from the high school principal said "He appears to all his teachers as a mentally mature boy who makes a maximum scholastic effort. His general social behavior indicates a normal function in and around his friends." He made a good relationship with one of his teachers and talked over his interests and problems with her. He organized the Junior Red Cross entertainment group and took part in the school operetta and other extra curricular activities. He was going with a girl. He used facial exercises to make his face less deformed and referred himself for speech therapy. The high school teacher found him "a conscientious worker, a sensitive thinker, a person concerned deeply with the feelings and troubles of others." The speech therapist saw him twice a week for a year and thought he improved steadily. The therapist said, "For his years he thinks in a very mature way. From his own sufferings he has learned to avoid causing others to suffer. He has a strong urge to be of help to people who are in difficulty or distress. He accepts injustice and unkindness without resentment. His intelligence, forward look, honesty and loyalty are far above average. His industry is amazing. The best is not too good for him in my humble view."

D. graduated from high school in 1950. In October of 1950 he was con-

tacted by the Clinic. It was found that he was employed and getting along well and felt he was helped by the Clinic. It was left that he should contact the Clinic if he felt he needed further help. D. has never been arrested since his first arrest almost eight years ago.

It seems that an important factor contributing to the social adjustment of this boy was the good relationship he was able to establish with the probation officer, speech therapist, and teacher.

Of the six adults, one graduated from college, is known to have had no further offenses, and apparently is living a socially acceptable life. Three received psychiatric help. Two seemed to have profited from it. One gave it up, and still has symptoms of emotional instability, such as inability to hold a job and neurodermatitis. One was arrested, and nothing is known of the sixth.

Of the two young boys, one is in the State School for the Feeble-minded and the other is apparently getting along fine.

CHAPTER V

Conclusions

It can be concluded from the evidence presented in the preceding chapter that the bulk of cases referred to a mental hygiene clinic for homosexual behavior are adolescent boys. The overwhelming majority of the boys were very active sexually and most of them were involved with an adult for a period of more than two years. The majority of male cases did not look effeminate and no significant similarities of personality or character could be discovered. The most severe cases, as judged by quantity and quality of the homosexual behavior, were the adolescents involved with adults and the adults.

Over eighty per cent of the cases were referred by the legal authorities, indicating that in an overwhelming majority of the cases either the behavior was not observed or nothing was done about it until it came to the notice of the police. Not one person was referred to the Clinic by a relative, very few by other agencies or schools, and none by the church. Not one person came of his own accord seeking help. Possibly some publicity about homosexual relationships and the function of a mental hygiene clinic would result in more adolescents being referred by parents, schools or teachers and less by the police. Publicity might also attract a few people who were emotionally upset about their behavior but did not want to go to a mental hospital. It would seem, however, as no one came of his own accord, that those who engage in homosexual activity do not look for help, that they have to be pressured into it.

Considering the fact that most of the adult homosexuals began their homosexual behavior when they were young, it does seem necessary that

young offenders be discovered and treated when they are still treatable with a good prognosis. The results of this study show the prognosis is good in the case of the adolescent offenders. The great majority of adolescents did well on probation. When they were required to discontinue their homosexual behavior, it is believed in most cases they did so. Certainly it can not be said that treatment at the Clinic was responsible for the good outcome in the majority of cases as the clinic only treated three cases. In half of the cases the recommendations were followed entirely or in part, so the clinic played a part in the outcome of these cases. In many of the cases the probation officer seemed to have had a very positive effect.

The majority of cases came from broken homes or homes in which there was emotional instability, or else they were living in environments in which they were having trouble with their sexual identification because of their position in the family constellation; i.e. the youngest sibling or the only boy. It would seem from the examination of the backgrounds and the psychological tests, that the homosexual behavior is just a symptom of general emotional instability.

The probation officer played an important role in their rehabilitation because he was a stable figure with whom they could talk over their problems and identify, and he was the super ego they had to incorporate. Thus it is important that the probation officer not see these youngsters narrowly as sex cases, but broadly as emotionally disturbed individuals, that he be firm with them, but that he give them understanding. They must derive satisfaction from this relationship to make up for the pleasure given up. The homosexual behavior is pleasurable and in view of their un-

happy backgrounds is not going to be given up unless other satisfactions are substituted. Thus some cases may continue this behavior into adulthood where the prognosis is not so favorable. Others may substitute heterosexual behavior, but they will remain emotionally disturbed individuals.

The best treatment seems to be discovering the individual indulging in extensive homosexual behavior when he is still young, and then giving him a figure with whom he can identify. The figure should accept and understand him as a person but not accept his behavior, and guide him into areas in which he can obtain socially acceptable satisfactions.

It seems that in most adolescent cases it is enough that the clinic make recommendations and that a qualified probation officer carry the case. If the case is not a probation case, then it seems essential that the case be referred to a qualified person or else carried by a member of the clinic staff. It would seem that a qualified person would be someone who has had professional training in mental health, such as a social worker. The problem seems to be getting the person engaging in homosexual behavior into a clinic in the first place, and then keeping him in treatment if he is not under legal requirement. Thus the arrest is often a blessing in disguise.

Approved:

Richard K. Conant
Richard K. Conant
Dean

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APPENDIX

Schedule

Date:

Age:

Sex:

Referring Agent:

Extent of Activity:

Duration of Activity:

Partner:

Background:

Age

Occupation

Father

Mother

Siblings

Schedule (Cont.)

Other significant points in background:

Appearance:

Personality and Character:

Clinic interviews:

Psychometric tests	()
Projective tests	()
Psychiatric interviews	()
History	()
Treatment interviews	()

Recommendations:

Significant points discovered in follow-up:

TABLE 13.

The Measurement of Intelligence*			
Classification	Wechsler-Bellevue	New Stanford-Binet	
		Ages 8-12	Ages 14-18
Mental Defective	67 below	70-below	68-below
Borderline	79-68	79-71	79-69
Dull Normal	90-79	91-80	91-81
Average	110-91	115-92	115-92
High Average-Superior	119-111	116-125	116-26
Superior	120-127	126-137	127-136
Very Superior	128-over	138-over	137-over

*Source:

Wechsler, David, The Measurement of Adult Intelligence, The Williams & Wilkins Company, 1944.

Copy of Letter to School

February 21, 1952

Dr. _____, President
_____ Teachers College
_____, New Hampshire

Dear Dr. _____:

I am doing a follow-up study on certain cases seen at the New Hampshire Mental Hygiene Clinics and would be grateful for any help you can give me. I am interested in finding out what happened to _____ whom you referred to the Clinic in August, 1949. At that time he was involved in some sex difficulty with a classmate and there was a question as to whether he would be able to continue school.

Thank you for your cooperation in this matter.

Sincerely,

(Miss) Dorothy A. Fahey
Resident Social Worker

Anna L. Philbrook, M.D., Director
New Hampshire Mental Hygiene and
Child Guidance Clinics

DAF:alf

Copy of Letter Sent to Probation Department

February 21, 1952

Mr. _____
Municipal Court
Probation Department
_____, New Hampshire

Dear Mr. _____:

I am doing a follow-up study on cases involving homosexual activity which were referred to the New Hampshire Mental Hygiene Clinics and would be grateful for any help you can give me. I am interested in finding out what happened to _____ whom you referred to the Clinic in August, 1948. I would like to know the disposition of the case, and, if he was placed on probation how he adjusted while on probation and afterward if you know, and also if he has been arrested since.

Thank you for your cooperation in this matter.

Sincerely,

(Miss) Dorothy A. Fahey
Resident Social Worker

Anna L. Philbrook, M.D., Director
New Hampshire Mental Hygiene and
Child Guidance Clinics

DAF:alf

Copy of Letter Sent to Agency

March 31, 1952

Dr. _____
Veterans Administration Clinic
497 Silver Street
_____, New Hampshire

Dear Dr. _____:

I am doing a follow-up study on cases referred to the New Hampshire Mental Hygiene Clinics. _____ of _____, New Hampshire, was referred here in August, 1950, by the _____ Probation Department. I understand from the Probation Department that he has since been seen for treatment by your Clinic. I wonder if you could tell me how he is progressing in treatment. I am interested in learning if he is able to keep a job, if his dermatitis has improved, and if there has been any further homosexual behavior.

Thank you for your cooperation in this matter.

Sincerely,

(Miss) Dorothy A. Fahey
Resident Social Worker

Anna L. Philbrook, M.D., Director
New Hampshire Mental Hygiene and
Child Guidance Clinics

DAF:alf