

(1955). *Psychoanalytic Quarterly*, **24**:506-515

Etiology and Therapy of Overt Homosexuality

Lawrence C. Kolb, M.D. and Adelaide M. Johnson, M.D. 

Although the origin of latent homosexuality has been discussed frequently in psychoanalytic literature, there has been no definition of those factors that lead to the eruption of overt homosexuality. Many patients have strong latent homosexual impulses, but do not act out these impulses, just as many neurotics show tendencies to destroy, set fires, or steal, yet never carry out these actions. This paper attempts to define the impetus that leads to acting out of homosexuality.

BACKGROUND OF STUDY

Research by Szurek and Johnson¹ showed that such antisocial behavior in children as repeated stealing and arson is stimulated by similar antisocial impulses in their parents. Collaborative therapy of children and parents makes it clear that parents unwittingly seduce their children into expression of the parents' own forbidden impulses, thus giving the parent unconscious vicarious gratification. A specific defect in the child's superego duplicates a similar distortion in the personality of the parent. Such children and their parents show various degrees of neurotic as well as antisocial behavior, but emphasis in Johnson and Szurek's research was on the specific source of the permission to act out and the reasons for the permission.

Read at the meeting of the American Psychoanalytic Association, New York, December 4, 1953.

From the Section of Psychiatry, Mayo Clinic and Mayo Foundation; the Foundation is a part of the Graduate School of the University of Minnesota.

¹ **Johnson, Adelaide M. and Szurek, S. A.: *The Genesis of Antisocial Acting Out in Children and Adults*. This *QUARTERLY*, **XXI**, 1952, pp. 323-343.**

The process of unconscious communication of the parental wishes and sanctions to the child is the key that must be sought in the analysis of all such cases. Although verbal expression is often an important force in communication between parent and child, it is by no means the only force. The parent's conscious and unconscious images of the child, the parent's hopes, interests, fears, and frustrations are felt by the child through parental gestures, intonations, bodily movements, provocative smiles, and maneuvers. Time and again, instead of a firm, direct statement, 'double talk' is employed by the parent. It is no wonder that the parental reproof, 'If you had to take money, why didn't you take it from my purse?' constitutes an effective invitation to steal. A parent's intense interest in a child's account of its misadventures can be communicated to the child in such a manner that no subsequent punishment will serve to prevent repetition of the acting out.²

PRESENT STUDY

Why does the impulse to homosexuality become overt? Clinical data indicate that overt homosexuality in some adult male patients initially resulted from the unconscious permissiveness of one parent, with the other parent more or less condoning. It is suggested that overt homosexuality, as well as other aberrant behavior, may be induced or persist through the technique employed by a therapist. Recognition of this fact is important in therapeutic management of homosexuality.

Three of the four homosexual patients to be considered genuinely desired to overcome their homosexuality. The fourth patient came to treatment for other reasons; his conscious homosexual impulses found overt expression only after therapy was begun. All these patients presented behavioral and affective disturbances in addition to their sexual problems. In none was homosexuality the only form of sexual gratification.

² **Litin, Edward M.; Giffin, Mary E.; Johnson, Adelaide M.: *Parental Influence in Unusual Sexual Behavior in Children. To be published in This QUARTERLY in 1956.***

CASE I

The first case demonstrates that the mother had long been unconsciously seductive with her son and that this parent's specific permissive impulse, communicated to the patient as an adolescent, induced his overt homosexual behavior. His father was obsessed with business and had little association with his wife and children. The patient thought of him as a stern man who failed to understand him, did not sympathize with his loneliness, and disparaged his ambitions. His mother, who was still alive, dominated her children, especially the patient, with her ambivalent solicitude. She continually worried over her son, emphasizing his frailty, his need for her close care, and his finicky eating. The patient made a strong, hostile, feminine identification with her. More recently her solicitude was expressed in frequent telephone calls and presents, with the expectation that her son would reciprocate with expressions of love and frequent visits. The maternal grandmother had played a similar role. The boy was consequently exposed to teasing as a 'sissy'.

He was thirty-four years old, unmarried, when he came for treatment because of insomnia, indecision, periodic gastric distress, a tendency to withdraw from others, and an increasing impulse toward homosexual gratification. The homosexuality had been manifest in his late adolescent and early adult life. During the past three years he had been interested in women and in men, but was active sexually only with men.

The patient's first homosexual experience occurred as follows. The mother became interested in a church organist who soon was a frequent guest in the home. The patient recognized his mother's interest and his father's dislike of this visitor. The mother encouraged the patient to take trips with the organist. Clearly she identified her son with herself, encouraging his relationship with her potential lover. During one such trip the organist seduced the patient to practice fellatio—his first homosexual experience. The same thing happened on subsequent

trips forced on the adolescent by his mother. Some time later a loud and angry argument occurred between the parents and the organist never visited the house again. This ended the homosexual relationship. In therapy, the patient expressed his hatred of his mother for encouraging this association with the seducer.

In the nine months of psychoanalytic treatment before therapy was discontinued when his occupation took him to another city, the patient was active in working out the psychogenesis of his homosexuality. The therapist interpreted in the customary way, but otherwise listened passively to the account of the patient's homosexual activities. It was apparent that homosexual activity during therapy consistently followed an actual or supposed rebuff by a woman. This was demonstrated to the patient, but his homosexual discharge of anxiety was not forbidden. The therapist's attitude, tacitly expressed by his passivity, may have been interpreted as permission for homosexual acting out; it repeated the permission previously given by the hated mother.

Our next case demonstrates that the overt homosexual activity may occur in an individual with strong latent homosexuality when the therapist inadvertently behaves permissively.

CASE II

This patient, twenty-four years of age, came to treatment complaining of recurrent anxiety and depression associated in his mind with his inability to leave home and make a success of his life. He gave piano lessons and lived with his parents. His older brother was a masculine and successful man who had a comfortable relationship with the parents and had been able to separate himself from them. The patient stated early in treatment that he had been fearful for three years that he might become overtly homosexual.

The patient's father had been married twice; the first wife died. A half sister was seven years older than the patient. The

patient's mother was always ambivalent toward him. She had always been annoyed by having to give of herself to him and often reminded him that he was too demanding. She had, however, great anxiety about any adventurousness or spontaneity on his part. When the patient was four, his father spent two years in a sanatorium for tuberculosis. The patient recalled that being alone with his mother at that time was idyllic. There was much physical contact then between the patient and his mother and he said that after the father's return he never again felt so happy.

The father liked, even at the age of seventy-five, to exhibit his physical strength before the patient and his friends. The patient had participated between ages six and eleven in many outdoor activities with his father, but the mother always showed concern lest he be sick and was continually trying to restrain his interest in sports and other activities with boys. In later years the father also spoke of the boy's lack of physical stamina.

At the age of eleven, while the patient was struggling to work out his ambivalent competitive relationship with his father, his mother and older half sister commiserated with him, protecting him in a seductive way from the father. The half sister expressed hostility toward her father and his alleged meanness, and disparaged the father in long conversations with the patient. From that time, the patient submitted to a predatory closeness with this half sister. She called him her 'first love' and maintained, even after she married, that the patient was first in her life. She had him run errands and wait on her. Early in treatment this man had no awareness of his resentment toward this sister, but spoke with satisfaction of being more important to her than her husband. When he frustrated the wishes of his mother and half sister, they exhibited hysterical symptoms and flew into rages. For a long time they were able to manipulate him by means of this behavior. Both women discouraged him from close friendship with other men and women. The patient had few dates with girls, and his only

friends were several artistic, effeminate men.

There was much evidence of strong, hostile, feminine identification and latent homosexuality, expressed in fantasies of physical contact with men. As the patient's fantasies about a certain man and the possibilities of a homosexual relationship with him developed in analysis, the therapist, a student under supervision, actively encouraged the revelation of homosexual fantasies in relation to himself. As anxiety developed in the patient because of these transference fantasies, he became resistant. In an attempt to allay this anxiety, the therapist himself provided some details for the fantasies. The patient thereupon for the first time in his life entered into homosexual acts with the man about whom he had been having fantasies. Analysis of the events leading to the homosexual acting out, with frank admission by the therapist of his error in implicitly giving permission, made possible continuation of the treatment.

Two other cases have shown us the importance of prolonged seduction by the mother and of the genital frustration caused by her emphasis on her son's identifying himself with her early in life as well as in adolescence and manhood. The father condones this seduction and emphasis. One of these cases is reported below.

CASE III

A thirty-two-year-old lawyer with a very responsible position in a large city came to treatment because he was becoming increasingly depressed, was miserable at home with his wife and children, and feared that his overt homosexuality was dangerous to his career. He was an only child, a sister having died in infancy before the patient was born.

The patient's father, a driving, creative businessman, was away from home throughout much of the first five years of the patient's life. His mother, assisted during several long periods by rigid, unsympathetic nurses, had an ambivalent relationship with the patient. Thumb-sucking was drastically prohibited,

and his mother made him sit for hours while she attempted to force him to eat. Any minor naughtiness resulted in a spanking, followed immediately by the mother's cuddling her son on her lap and kissing him to stop his tears and bring about an immediate reconciliation with her. She suffered from migraine and required the patient even as a small boy to massage her head and stroke her back while they lay in bed. This early hostile and seductive dependence upon her resulted in a hostile identification.

The parents' sexual relationship was unsatisfactory, a fact not learned from the patient. When at three the patient began clutching his genitals, his mother had him circumcised. At five, when the father began to spend more time at home, the patient felt he could never win his affection. The mother protected him from the father, although basically the father was friendlier than the mother. As the years passed, the patient felt in the wrong with his father, who was a man with little formal education and disparaged women and anything artistic. The mother enslaved herself to the father, explaining to the patient that the father was an important captain of industry. The patient, continually seduced by the mother, feared his father but also longed to win and placate the father as his mother did, and as she encouraged him to do.

The patient in adolescence became rather obese, considered himself a 'sissy', and was terrified of appearing feminine. He knew he was a 'mother's boy'. His father disparaged 'sissies' and often warned his son against homosexuality. The patient and his mother commiserated over the father's despotism, and yet they attempted to regard the father as the brilliant, charming person known to the public. From the time when her son was eight and into his adolescence, the mother often asked him to assure her that her breasts were not so large as to spoil her beauty; his judgment, she said, was 'as dependable as any girl's'.

During his first year in a university the patient had many dates with girls and 'fell in love' with the belle of the campus, whom he asked to marry him. His mother raised many objections. He

confided to his mother that he was too much interested in having boys like him, and that he rather worshiped some of them. His mother advised him to see more of men and less of girls, and laughingly said, 'It is less dangerous to love men than women'. Soon the patient had his first homosexual relationship. When the mother, a few years later, objected to the patient's engagement, he eloped with his fiancée.

In analysis the patient was repeatedly furious as he realized how his mother had kept him for herself and had sanctioned his close relationship with men. By this time his anger prompted the conscious wish to ruin the family reputation and himself. His homosexual affairs became extensive and dangerous to him and his family. Until this time the patient had acted out, without any awareness of anger toward the woman therapist. Anger meant punishment by the mother and perhaps a seductive reconciliation.

It seemed wisest for the therapist not to encourage the patient's self-destruction, as his mother had done, but rather to prevent further acting out. To this end the patient was told that he was relieving tension through his homosexual behavior, that the therapist could not be a party to his self-destruction as his mother had been in the past, and that treatment must cease if there was further homosexual behavior. The patient became furious at the therapist, and threatened suicide and termination of treatment. The therapist remained firm, and remarked that she could not be threatened into continuing a relationship that clearly could lead only to his ruin. For several months the patient raged and threatened and charged that the therapist, like his mother, was keeping him for herself. He became aware, however, that the therapist was not seductive, as his mother had been after an outburst of rage, nor was the therapist giving sanction, as his mother had done, to his homosexuality. He became fully convinced that the therapist could let him go and that there would be no seductions to propitiate his rage.

After this stormy period, the analysis proceeded like other

³ Since this paper was presented the patient acted out homosexually. The patient's treatment was terminated and he was advised to seek treatment with another therapist which he did.

analyses of neuroses. For approximately thirty months the patient found it almost impossible to conceive that there could be any tenderness in women. Rage occurred often during therapeutic sessions, but he suffered almost none of the violent depression that had occurred before his acting out was forbidden.³

COMMENT

In all but the second of our cases, overt homosexuality was caused by the mother's overseductive relationship with her son, her frustration of his heterosexual drive, and her sanction of his homosexuality. The major determinant of the homosexuality was the hostile, passive, feminine identification with the mother, which occurred early in life. The mother showed little real tenderness and prevented masculine identification with the father, who did not fully protect the son from the mother, partly because he was often absent from home.

The second case illustrates that the therapist may give permission for homosexual acting out and thus cause it to occur. These cases, and our experience with adolescents, show that therapists must in some instances consider their attitudes in order to prevent the eruption of homosexual behavior in their patients. Psychiatrists and analysts to whom a patient in late adolescence says, for example, 'I certainly never accepted any homosexual invitation', sometimes reply, 'Why not?'. This answer is confusing and may be implicitly permissive. Answering an adolescent in this way is dangerous.

In our third case, the therapist intervened to stop the patient's homosexual activity. Such intervention should not occur until the data disclosed in treatment clearly indicate that the parents' seductiveness and permissiveness encouraged overt homosexuality. A strong positive transference has usually been established by the time such data have become apparent. The

reason for intervention is explained to the patient; it therefore does not seem to him a mere authoritarian demand. When the therapist makes it clear to the patient that if homosexual behavior continues therapy must be stopped, the therapist must be prepared to discontinue treatment until the patient is willing to give up the behavior and face the consequent frustration, anxiety, and rage that then ensues.

Freud⁴ sometimes insisted that certain patients give up destructive sexual gratifications and that others face their phobias for the sake of treatment. In our technique, the therapist by his intervention causes the patient to face the anxiety aroused by his hostility to the hated parent. The interpretation resolves the transference to the analyst as the seductive and hated mother. It is our impression that for this intervention to succeed, there must exist no other channels for antisocial acting out, such as pathological lying or stealing. Such channels must come under control if the prohibition of homosexual activity is to succeed. The technique is under study by continuing treatment of the previous patients and its eventual value will be determined in the future.

CONCLUSION

In four male patients overt homosexuality first occurred as the result of unconscious permissiveness by a seductive parent or parent-substitute. Therapists must be on guard lest they repeat that permissiveness. The therapist may facilitate analysis of the patient's basic conflicts by a well-timed prohibition of self-destructive homosexual activity.

⁴ Freud: *Turnings in the Ways of Psychoanalytic Therapy*. Coll. Papers, II. London: Hogarth Press and the Institute of Psychoanalysis, 1924, pp. 392-402.

Article Citation [\[Who Cited This?\]](#)

Kolb, L.C. and Johnson, A.M. (1955). Etiology and Therapy of Overt Homosexuality. *Psychoanal. Q.*, 24:506-515