

**Homosexuality:  
A Consideration of Factors Relevant to the Success/Failure  
in the Psychoanalytic Treatment of Overt Obligatory Male Homosexuality<sup>1</sup>**

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Abstract

The rise of the gay movement has caused psychoanalysis to take a hard look at our views of homosexuality, the theory of psychosexual development as first proposed by Freud, the concept of normative heterosexual functioning, and the efficacy/failure of psychoanalytic therapy. In the spirit of free scientific inquiry, and against the backdrop of advances in our knowledge of the pathology of internal object relations, ego developmental psychology (including self psychology), ongoing psychoanalytic infant observational studies, new concepts of narcissism, and knowledge of primary psychic development, this paper comments upon these controversial questions. Its major thrust and focus, however, is to examine its most pressing problem, namely, the efficacy of psychoanalytic therapy and the psychoanalytic techniques that make for success or failure.

The topics covered include (1) the homosexual patient who comes for psychoanalysis; (2) homosexuality as a developmental disorder; (3) the issue of gender-defined sexual identity; (4) some pitfalls in technique; (5) overall strategies decisive for success/failure; (6) a survey of treatment results.

**A Contemporary Controversy: A Different Understanding**

Before Freud, the subject of sex and sexuality long tended to be clouded by passion, confusion, and mystery. Poets, historians, writers, philosophers, sociologists, anthropologists, and political/social critics of bygone eras have provided little to the understanding of the motivational forces of human sexual practices, with few exceptions. In our current psychiatric climate many behavioral scientists in an attempt to remedy social injustices, have correctly demanded equal civil rights for the homosexual--a demand arising from legitimate humanitarian motivations deeply embedded in our humanistic science. But many have taken severe exception to categorizing overt obligatory homosexuality as a perversion/deviation and insist that homosexuality is neither sexual perversion nor deviation, only an alternative or different lifestyle without psychogenic origins, clinical signs and symptoms, psychodynamics, course, and certainly no therapy. It is clear that such a position has achieved unprecedented popularity and even scientific support and epitomizes the current nihilistic attitude to therapy in many quarters, promotes the unfortunate assumption of its inevitable failure and severely compromises the outcome of therapy as well as the future of psychoanalytic clinical

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<sup>1</sup> Portions of this chapter are adapted from my diverse writings on male homosexuality over a forty year period (1968, 1974, 1978, 1979, 1988; Socarides et al. 1973, Socarides and Volkan 1990, 1991).

research and progress in this area. Compounding the disregard of established psychoanalytic knowledge of human sexuality, it is the fervent desire of many to remove the category “sexual perversion” from psychiatry, as in their opinion, perversion is simply a “moralistic/pejorative” word. Earlier, Arlow (1960) addressed this issue: “While it is true that the term ‘perversion’ in long usage carries the connotation of adverse judgment, the essential meaning is a turning away from the ordinary course. As such, the term “perverse” is an accurate one, “the origin of meaning of unusual sexual behavior [which is] the subject matter of our scientific concern. The phenomenology of perversions should be approached from a natural science point of view, divorced from any judgmental implications” (p.249). It is this spirit, free of moral judgment, that we approach the subject of treatment of homosexuals who desire psychoanalytic help.

It is commonly asserted today by gay activists and other behavioral scientists that homosexuality is normal<sup>2</sup> and that there is no difference between normality and abnormality in sexual behavior and practices. Kubie’s (1978, p. 143) comments on these points are succinct and invaluable.

Since the predominant forces in homosexual patients are unconscious, they will not respond to experiences of pleasure or pain, to rewards, punishments, or argument-- “Neither the logic of events nor to any appeals to mind or heart. The behavior that results from a dominance of the unconscious system has the instability, the automaticity, and the endless repetitiveness that are the stamps of the neurotic process” (Kubie 1978, p. 143).

My clinical findings indicate that most homosexual patients endure suffering, massive unconscious guilt feelings masked by defensives, profound psychopathology in many instances, and severe overall impairment in functioning, except in those cases which are fixated at the higher levels of development, i.e., those which arise from a structural (oedipal) conflict which are only lightly touched upon in this paper. These findings of psychopathology are not readily available to those investigators who do not deal in depth with homosexual patients, their dream material, transference manifestations, and the function of their homosexual enactment's. The neutralization of unconscious conflict of preoedipal origin allows for the growth of certain ego adaptive elements in the personality, and the obligatory preoedipal homosexual may therefore appear not to be ill at all except for his incapacity to engage in the standard male/female sexual pattern. With regard to the question of guilt, Le Coultre (1956) clearly distinguished between real guilt feelings attached to repressed conflicts of homosexual acts which are *eliminated* from consciousness by the perversion and societal guilt feelings on the surface that are often interpreted as real guilt feelings. The latter have the quality of being easily removed by fairly simple measures. The unconscious guilt feelings are kept in repression by the construction and enactment of the perverse act--an end-defensive product, and

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<sup>2</sup>That such an impediment to scientific comprehension of homosexuality is not a strictly modern phenomenon is indicated by Freud’s comment made as early as 1910, “It must be stated with regret that those who speak for the homosexual in the field of science have been incapable of learning anything from the established findings of psychoanalysis” (Freud, 1910, p. 99. Added footnote, 1919).

these transformations make homosexual acts “ego-syntonic,” wiping out all traces of conscious guilt derived from unconscious conflict. (Le Coultre 1956, p. 53-54).

The ego-syntonicity of homosexual acts has confused many investigators. In ego-syntonicity we are dealing with two components--conscious acceptance and unconscious acceptance. The degree of conscious acceptance of a homosexual enactment varies with the person's reactions to societal pressure and consciously desired goals and aspirations. (See Socarides 1988 for a complete discussion of this issue.<sup>3</sup>)

### **Homosexuality as a Developmental Disorder**

Overt obligatory homosexuals suffer from a partial developmental arrest due to a fixation in the preoedipal phase of development. The nuclear conflict of preoedipal Type I homosexuals consists of a desire for and a dread of merging with the mother in order to reinstate the primitive mother/child unity with its associated separation anxiety. In preoedipal Type II homosexuals, the class of conflict is similar, but with an earlier level of fixation; in the differentiating sub phases of the separation-individuation process, with severe disturbances in self cohesion marked by fragmentation anxiety (Socarides, 1988). Their conflict is an object relations one, antedating structural conflict of the oedipal phase, involving anxiety and guilt associated with self-object differentiation. This type of conflict (an object relations one) (Dorpat, 1976, Gedo and Goldberg, 1973, Fairbairn, 1954, Jacobson, 1964, Modell, 1968, Edgecumbe & Burgner 1975) leaves unmistakable signs on the developing personality and its future maturation. All obligatory homosexual patients fixated at a preoedipal level, show disturbances in their ego functions, e.g., reality testing, thinking, impulse control, self concept, ego boundaries, a relative freedom from internal conflict, an intolerance to external frustration which arouses anxiety in which action is substituted for normal anxiety and depression, a tendency to respond to anxiety and depression with object directed or self directed aggression, as well as an impairment in object relations (Socarides, 1978). McDougall (1972) succinctly states that for the homosexual “[his] erotic expression...is an essential feature of [his] psychic stability and much of [his] life revolves around it” (p. 371). There is anxiety in his sexually approaching a person of the opposite sex, pronounced gender-defined sexual identity confusion (either hidden or overt) and a predominance of archaic primitive mental mechanisms, e.g., splitting, projection, and projective identification as well as paranoid thinking. Clinically there are signs of a continuance of symptoms of an undue fixation to the mother and the ego's infiltration by the maternal figure, thereby weakening the patient's ego structure. The homosexuality itself neutralizes conflictual intrapsychic forces, so that these individuals may appear upon superficial examination to be without psychopathology, although narcissistic conflicts may predominate, confusing those who simply perform a superficial clinical examination.

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<sup>3</sup> A number of ego syntonic symptoms today may be successfully analyzed, e.g., neurotic character traits, addictions, psychopathy, borderline conditions, psychotic characterology, and perversions.

## The Issue of Gender Identity

In a paper entitled “The Development of Sexual Identity in Homosexual Men” Isay, (1986) completely misunderstands the concept of acquisition of gender-defined sexual identity. This misunderstanding has been compounded by many to deny even the role or existence of a disturbance in the gender identity of homosexuals, and asserting that gender identity problems are only to be found in transvestites and transsexuals, contrary to the clinical opinion of psychoanalysts working with all three types of patients (Loeb 1995, Socarides 1995, among others). Isay (1986) as well as others, assumes that the development of a personal sexual identity is a *given*, something that normally occurs, is not a product of development, and that we must not interfere with the patient’s acceptance of his inborn “homosexual identity.” On the contrary, he insists that we must protect, enhance, and encourage this “homosexual identity” found in homosexual patients. I believe that this position has no theoretical validity, is anti-therapeutic, and completely misunderstands the concept of gender-defined sexual identity.

What we call identity is the result of the synthesis and integration of different isolated self-representations (Jacobson, 1964; Spiegel, 1959). Mahler (1957), Greenacre (1958), Jacobson (1964), Edgecumbe and Burgner (1975), Fast (1984), and Lichtenstein (1977) have all elucidated how the different forms of identification play a central role in the transition as maturation makes it possible to progress from total identification with the mother to selective identifications either as male or female.

Four factors play a role in the development of appropriate gender-defined self identity: (1) an awareness of the anatomical and physiological structures (Greenacre, 1958), primarily the face and genitals; (2) the assignment of specific gender done by parents and other important social figures in accordance with the overt sexual structures; and (3) a biological force which seems to be present at birth (Stoller 1964). A fourth factor--important in the production of perversion, including homosexuality--is disidentifying from mother and developing a counter identification with the father (Greenson 1968, Socarides 1978, 1988, Mahler 1975, Mahler, et al. 1975). The little boy must renounce the pleasure and security giving closeness that identification with the mother has afforded and he must make a counter identification with the father. The outcome will be decided by several elements: (1) the mother must be willing to allow the boy to identify with the father; (2) she must facilitate his genuinely admiring and enjoying the boy’s features and must look forward to his further development along this line; (3) there must be other motives leading him toward identification with the father, especially those characteristics of the heterosexual father who enjoys both his own phallicity, his son’s phallicity, and their mutual relationship to opposite sex partners. Homosexuals have been unable to complete the separation-individuation phases (Mahler, et al. 1975) and resolve the primary feminine identification with the mother (Van der Leeuw 1958). This finding is a universal one in the study of all p erversions, including homosexuality. There is an inability to develop a self-representation as distinct from the object representation with a faulty establishment of appropriate gender-defined sexual identity.

## **The Homosexual Patient Who Comes For Psychoanalysis**

Many homosexuals seek our help because of a long-hidden wish or hope that they might somehow become heterosexual after a long period of being homosexual; others out of a declared “curiosity” that something much deeper may be troubling them; while others desperately desire help to overcome what they perceive to be a serious difficulty. The most promising cases I have found, as I reported elsewhere (Socarides 1979), are those in which the patient feels worse, not only from the point of view that his homosexuality may be accompanied by neurotic symptoms, but that he can no longer tolerate his homosexual adaptation. Some of these patients are prompted to enter therapy because of disturbing symptoms which have invaded their lives: episodes of depersonalization, regressive desires to isolate themselves from others; fears of self-dissolution; splitting phenomena; sudden awareness of a breakthrough of feelings of femininity; episodes of sadistic/masochistic behavior in their sexual encounters; tendencies to severe mood swings of depression/burst of rage/anxiety. Some begin to perceive that the homosexual act itself serves to save them from a mysterious fragmentation, and that a magical restoration occurs whenever they engage in homosexual relations. In others, the homosexual needs have become increasingly insistent, imperative, and intrude into their everyday functioning, thus interfering with every aspect of the patient’s life. The college student, in contrast, his first time away from home, who has “affirmed” his homosexuality in a homosexual encounter, feels intense relief in the achievement of orgasmic pleasure and aided and abetted by local college gay activism feels entitled to his “sexuality.” At this moment he is not prone to enter therapy but may return to therapy if the issue is handled in an informative, tactful, and empathic way. Psychoanalytic work at this point, in the face of personal opposition is, of course, out of the question.

Some homosexuals are aware that they are not simply responding to an instinctual need, but are dominated by a tension that they can neither understand nor control. Many seek therapy because they feel severely distressed about being homosexual, not only because of societal guilt or shame, but because they find homosexual life increasingly meaningless and empty and alien to the biological realities of life around them. Khan (1965) has accurately described the “inconsolability of the homosexual” who uses the “technique of intimacy” as a therapeutic device in an attempt to achieve ego satisfaction, but only succeeds in the “idealization of instinctual discharge processes.” The ultimate failure of this technique leads to a sense of depletion, exhaustion, a reduction in expectations, and despair. At this point, many of the homosexuals frequently enter therapy and are in a motivational state to undergo psychoanalysis.

Soon after beginning therapy, associated neurotic symptoms may disappear and the patient feels much better, due to the protection of the analytic setting. Paradoxically, it is at this point that we may face our first crisis, an obstacle to success. If the patient is entirely relieved of his accessory symptoms before any insightful connections are made between them and his homosexuality and if he has not been provided with some insight into the unconscious meaning of the homosexual act in the context of a positive transference, a strong resistance may appear consisting of an intensification of his continuing need to be omnipotent and irresistible to other men. Some patients may begin

therapy with a proviso that no attempt be made to alter their homosexuality. In such instances, while a concerted effort may be made to deal with other problems besetting the patient, such as anxiety, depression, passivity, masochism, and narcissism, and while they may be relieved, the homosexuality will usually be found to have invaded and influenced every aspect of the patient's life. In this connection Anna Freud (1954, p.15) reported three such female cases in which the homosexual symptom was completely removed as the result of psychoanalytic treatment, despite the wish of these patients at the beginning of therapy that it not be altered. The loss of the homosexual symptom may also be unconsciously feared because homosexuality provides a narcissistic restoration of the self representation through the act and is experienced by the patient as vital to his sense of "well being" for long periods of time. Consequently, premature therapeutic incursions in this direction may be met with hostility, castration anxiety, a feeling of narcissistic insult, a threatened sense of personal dissolution, and rage against the analyst in anticipation of an impending crisis.

### **Some Pitfalls in Technique**

To overcome these obstacles and others, the technique of psychoanalysis precludes a focal attack on the symptom itself. Effective interpretation of resistance guides the analyst. Assurances must be made that we do not attempt a forcible removal of the homosexual symptom for in some instances this is tantamount to a self-castration. A general policy is not to interdict homosexual acts; alleviation comes about through a gradual resolution of the unconscious anxieties and motivations which produce it, as well as decoding the symbolic meaning to the act in a manner similar to the translation of the manifest dream into its latent dream content (Socarides 1980). We attempt to discover the root disturbances responsible for the symptom and the psychic purpose which it serves. The patient must be shown that the nuclear conflict in pre-oedipal homosexuality consists of anxiety and guilt associated with the failure of development in the phase of self-object differentiation (in preoedipal homosexuality), and anxiety and guilt derived from the subject's aggressive sexual and other wishes and his own prohibitions and ideals (in oedipal homosexuality). The preoedipal homosexual's inability to adequately separate from the preoedipal mother produces an unconscious wish/dread of merging with her, and a fear of re-engulfment. At the same time that he cannot disidentify from the mother, he is unable to make a counter-identification with the father; both must be promoted throughout the therapy. In the more serious cases, homosexuality is an ego survival measure which is often dramatically reenacted in the therapeutic sessions.

If the homosexual symptom is to disappear, it will do so through the healing of the patient's underlying gender-defined sexual identity disturbance and the overcoming of separation anxiety from the preoedipal mother. As he begins to discover some of these difficulties and conflicts, the patient will begin to experience heterosexual impulses. It is my belief that these can be gently encouraged as it is difficult to satisfactorily treat a homosexual patient when he is left without any sexual pleasure as a result of the progressive decrease of interest in the homosexual object. The homosexual symptom diminishes in intensity through the filling in of ego deficiencies, which beset him, e.g., his impairment of reality testing; thinking which is dominated by the pleasure principle;

and incomplete or partial control of his impulses to act out and the pursuit of instantaneous gratification; a self concept promoting an elevated self-esteem bordering on omnipotence; alternating with feelings of self-depreciation and the need for narcissistic supplies and narcissistic restoration; an impairment of ego boundaries which remain essentially intact but deficient; a relative freedom from internal conflict in which his reactions and thoughts are results simply of external frustration at which point internal conflicts occur; an intolerance to external frustration which arouses anxiety and in which anxiety is substituted for normal anxiety or depression; a tendency to respond with object or self directed aggression (sadism and masochism). Such ego deficiencies or deficits are the hallmark of a fixation at the rapprochement phase of the separation/individuation, namely at the practicing or differentiating sub phase of separation/individuation with consequent fears of ego fragmentation. In short with the filling in of these ego deficits the patient is less burdened and a gradual achievement of a sense of self occurs. There is no longer a necessity to engage in short circuiting attempts to find masculine identity in object relations through an incorporation and identification with another man's body and penis (A. Freud, 1949, 1951, 1954, and Socarides 1978).

Which individuals cannot be treated psychoanalytically? Under what circumstances do we fail? The exceptions to the position that homosexual patients may be treated successfully and much of their suffering alleviated are found in situations similar to those described by others, namely Kernberg (1984) in his discussion of the treatment of severe narcissistic personality disorders. To summarize: a poor outcome may be predicted in those patients who exhibit severe antisocial personality structure; are unwilling or unable to attend sessions: show severe distress in verbal communications with an inability to make connections in the analysis; produce little or no dream material throughout the analysis; and who have a severely defective superego so that they are unable to profit either from the therapeutic alliance or the positive transference; engage in chronic lying and withholding of information; or are severely drug dependent. The worst prognoses among my patients are those who are in the most severe range of narcissistic pathology (borderline cases), preoedipal type II cases (Socarides 1988), who demonstrate severe splitting of the ego with projection more prominent than repression and a tendency toward paranoid thinking of an insistent and intractable nature. They later evidence psychosis-like transference reactions with the chronic inclination to misunderstand others and continually feel that the analyst is letting them down. Under conditions of severe stress and environmental frustration of their unrealistic goals they retreat to a "malignant" part of their pathological grandiose self (Rosenfeld, 1971); or Kernberg's (1984) haven for revenge which is to be visited on imagined powerful persecutory figures. These patients will remain in regression for extended periods of time, unaffected by interpretation of early experiences or empathic responses.

It is necessary, above all, that the analyst, with tact, concern, and empathy, provide the patient from the outset with an opportunity to admit the extent of his desolation with the paternal figure in the transference. Unconscious material revealing aspects of himself that he abhors and wishes to change may not appear for a long time. Eventually, the patient realizes that he is the victim of childhood events and early intrapsychic conflicts that have produced an interference in his normal sexual development and functioning. As

a consequence, he has been forced to utilize roundabout methods for sexual arousal and sexual gratification. The pathological form of sexuality is, however, only one manifestation of complex, deeper disorder affecting all areas of development and functioning. The patient may feel the reawakening of hopes for heterosexuality, long-suppressed and express disbelief that anything can be done to remedy matters.

Kohut's (1971) admonition to those who would treat narcissistic personality disorders should be well heeded in the treatment of homosexual individuals: that the analyst be sympathetic in tone, manner, and voice. One proceeds with correct empathy for the patient's feelings, ever mindful of his need for gratification through homosexual acts in order to insure the development of both a relationship and a successful outcome. The patient's anxiety or tolerance depends on his ability to identify with the therapist, who can both accept the patient's anxieties, his vulnerability, and depressions, and pathological sexuality, as well as be a container for them.

It goes without saying that since the prognosis often depends on the patient's determination to change, and the extent to which this determination can be awakened in analysis, it is important that no authoritative assertion of incurability be made regarding homosexual practices. I make it clear as soon as feasible and in response to the patient's sincere and concerned inquiry as to the nature of his problem for which he seeks help that I view the obligatory performance of homosexual acts as a form of psychopathology, a disturbance of psychosexual functioning, a form of developmental pathology, and consequence of preoedipal conflict. The essential task is the resolution of a preoedipal conflict in order to commence a process of developmental unfolding, in R. Spitz's (1959) words, "Free of the anxieties, perils, threats of the original situation" and through the "transference relationship enable the patient to reestablish his object relations or form new object relations at a level at which the development was deficient" (1959, pp. 100-101). The removal of these conflicts and obstacles makes it possible for the patient to progress along the road to heterosexual functioning as the need for homosexual gratification becomes less obligatory. In time it becomes less fear-reducing and thus in time it competes with newly established heterosexual functioning for pleasure and self-esteem.

It would be a narcissistic manifestation on the therapist's part to fail to acknowledge the difficulty or perhaps the impossibility in some instances of the patient ever giving up a specific need. On the other hand, one must keep in mind the *relativity* of the *need* for perverse gratifications. Such needs are not absolute or independent. They are dependent for their existence, intensity, and significance upon the total functioning of the individual. Kolansky and Eisner (1974) referring to such needs in impulse disorders and addictions, point out the differences and distinctions between the phrases "cannot do" and "will not do" or "do not want to," and note the analyst must question the "cannot" before the "do not want to." The same can be said for the phrase, "need for immediate gratification." Is it a "need" like breathing is a need or is it a "wish" for gratification such as the wish for

candy? There is a back-and-forth movement as to the relative strength of the “need for gratification” at various points in treatment.<sup>4</sup>

The extreme view held that “the homosexual identity” of a patient should be preserved (notably by Isay 1985, 1986 and other practitioners) destroys therapeutic effectiveness and eliminates the possibility of the removal of symptomology. Such a position, the result of social political activism in an era of permissiveness and liberation, the wish on the part of psychiatrists and even psychoanalysts to declare that homosexuality is normal (including genuine concerned but misguided efforts to remedy the plight of the homosexual who has suffered such social disapproval for centuries for something that he has no control of), all produce undue pessimism and resistance as to the value of psychoanalytic therapy for this disorder and therefore promote its failure. To this clinician versed in the treatment of homosexuality, however, unfavorable outcome in therapy should lead psychoanalysts to more rigorous pursuit of their theoretical and clinical understanding of this condition and techniques most efficacious for its treatment and not to pronouncing it a “nondisorder.” All homosexuals in my opinion, that I have seen, wish *more*, not less help from psychoanalysts.

Some individuals compound ignorance in their assertion that analysts betray a principle of psychoanalytic therapy, namely, the concept of neutrality, when the attempt is made to change one’s “sexual identity” (Isay 1985). Those who espouse this view unfortunately misunderstand the concept of neutrality as used in psychoanalysis. This concept does not mean that the analyst is “neutral” as to whether the patient is helped in the removal of either phobia, obsession, or perversion. The analyst *does* care and the patient comes with the implicit understanding that the analyst wishes to help ease his suffering through the analysis of his preoedipal fixations, his object relations conflict, and thereby eliminating the perversion and opening the pathway to heterosexuality. Correctly used, the concept of neutrality means that the analyst must be neutral so that the patient can project affects of the past onto him, in other words, to promote the past onto him, in other words, to promote the transference.

### **A Summary of Overall Strategies Decisive for Success/Failure**

Having defined the level of ego-developmental arrest, the overall strategy is to discover the location of the fixation point, delineate ego deficiencies, and the type of object relations dominating the patient’s life and make it possible for the patient to retrace his steps to that part of development that was distorted by infantile or childhood traumas, conflicts, and deficiencies due to unmet needs and tensions. I eliminate compensatory reparative moves in the maladaptive process that have distorted it and inhibited functioning, and remove self-perpetuating defenses. With their removal I encounter head-on preoedipal conflicts especially reenactments of rapprochement-sub phase conflict, separation and fragmentation anxieties, disturbances in self-cohesion, and castration anxieties of both oedipal and preoedipal origin. I routinely find anxieties

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<sup>4</sup> It is beyond the scope of this paper to discuss the erroneous concept of “bisexuality”—that in every individual there is an innate, *inherited*, object choice of the same or the opposite sex (See Rado, 1949, Limentani, 1972).

related to separations from the mother which are then relived and abreacted during the course of therapy. In all patients a central task is the elucidation of the three great anxieties of the rapprochement sub phase (Mahler, Pine & Bergman 1975); fear of the loss of the object; fear of losing the object's love; and undue sensitivity to approval and/or disapproval by the parents.

One must keep in mind that any preoedipal developmental arrest must be treated with supportive measures until the patient can begin full analysis. A longer psychoanalytic treatment may be necessary in order to first breakthrough the developmental arrest and the pathological character structure activated in the analysis. Defenses in these patients may be immature and at prestages of development (Stolorow and Lachman 1978). It is developmental necessity at least for the time being and not a resistance. In such cases, special techniques are necessary to promote the maturation of arrested ego functions. The aim of these techniques is to promote structuralization of ego functions sufficient to aid exploration of the defensive aspects of the patient's psychopathology in terms of the instinctual conflicts which they serve to ward off. Developmental imbalances can be reconstructed from memories, dreams and in the transference, and can be placed correctly in the specific developmental stages in which they belong.

In the transference, patients are helped gain the feeling of an individual idealized self (a real self) first based on identification with the analyst. This approach of permitting such idealizing transferences with borderline or narcissistic patients is not however without its perils, for in the borderline preoedipal type II narcissistic homosexual patient (Socarides 1988) there is a tendency toward fusion with the object and a confusion between self and object (between analyst and patient). The subsequent "failure" of the object (analyst) to gratify the omnipotent and grandiose needs of the patient may then be responded to (if suitable interceptive interpretations are not made) with severe aggression, paranoid feelings and psychosis-like transference reactions.

In order to facilitate the structuralization of the psychic apparatus, the analyst must promote gradually differentiated and integrated self and object representations within the therapeutic relationship. During this period the analyst restricts his interpretations to an empathic understanding of the patient's primitive arrested self and object representations which the patient attempts to restore. This ensures the continuation of the positive transference. These ego deficiencies arise either from the predominance of *aggressive* conflicts themselves in the earliest phase of life (Kernberg 1984) or are due to the *lack of empathic responses* from early caregivers (Kohut 1971). Neutrality and consistent understanding of archaic states promotes differentiation and integration and contributes to the formation of a patient's new world of self and object representations. Once sufficient structuralization of the psychic apparatus has taken place, one may proceed with analysis of transference manifestations of libidinal and aggressive conflicts.

Elsewhere I have described four *specific* major tasks (Socarides 1988) to be achieved for the successful psychoanalytic treatment of homosexual patients: (1) Separating and disidentifying from the preoedipal mother, (2) Decoding the manifest perversion, (3) Providing insight into the function of erotic experiences in perverse acts, (4) "Spoiling

the perverse gratification,” i.e., this phrase is meant to connote therapeutic activity which although leading to discomfort and anxiety in relation to previously held ego-syntonic areas of immaturity, results in the conversion of an addiction or an impulse neurosis or perversion into a condition similar to a neurosis. “Spoiling” is accomplished through analytic comprehension of the defined psychopathology resulting from the failure to make the intrapsychic separation from the mother, educating the patient as to the nature of his specific vulnerabilities, and uncovering and decoding the hidden meaning of and content of the perverse acts and the underlying fantasy system. (I equate “spoiling” therefore to uncovering conflict and comprehending the meaning of symbols.) By delineating of these specific tasks I in no way wish to minimize the importance of the *fundamental tasks of psychoanalysis*, implicit with them or related to them, i.e., promoting differentiation and integrating self and object representations, resolving castration anxiety of both oedipal and preoedipal phases, eliminating the “narcissistic resistance” to change, diminishing unneutralized aggression, and so on. The reader is referred to these sources for a further description of how separation from the preoedipal mother and the other tasks including the unfolding of heterosexual desire take place (Socarides 1988).

### **A Survey of Treatment Results**

In a thoughtful essay on homosexuality, reviewing biological, social, and psychological factors in homosexuality, Jon Meyer (1995) comments on the status of our current therapeutic situation. He states, “It is assumed by various authors that the benefits of analysis should be made available to homosexual analysands, but there are marked differences as to whether the treatment should be seen as exclusively for the homosexual or for the homosexual and their homosexuality. There is therapeutic optimism but not the same insistence toward change that characterized past decades. Clinical reports illustrate a diversity of phenomena beyond what might be suggested by more restrictive theoretical positions” (p. 357). “Whether homosexuality will change in the course of analysis depends upon its serviceability and stability, but prognostications are fundamentally conservative” (p. 260). Meyer warns, “The efforts of some analysts to minimize conflict and compromise formation, to simplify development, to emphasize biology, and to define behaviors descriptively or epidemiologically often seem to be based on a misunderstanding of those essential differences. Although some criticisms of psychoanalysis might be lessened by devaluing motivated psychic determinism, abandoning that concept would not actually serve anyone very well. The uniqueness and power of analytic understanding and treatment are based on the fact that we construct our own living compromise formations and have the potential for reconstructing the m” (p. 360).

With Myer’s comments as background, I want to submit some therapeutic results from psychoanalytic clinicians and leave it to the reader to render his opinion as to whether the promise and dedication to treatment by psychoanalysts and patients can well be justified. A leading and respected psychoanalyst and former president of the International Psychoanalytic Association (Edward Glover, 1960) studied the case histories of several hundred cases of homosexuals seen at the Portman Clinic in London over an extended

period. The Portman Clinic Survey (1960) reached the following conclusions: "Psychotherapy appears to be *unsuccessful* [emphasis added] in only a small number of patients of any age in whom a long habit is combined with psychopathic traits, heavy drinking, or lack of desire to change" (Glover 1960. p. 236). He divided the degrees of improvement into three categories: (1) cure, that is, the abolition of conscious homosexual impulses and development of full extension of heterosexual impulse; (2) much improved, that is, the abolition of conscious homosexual impulse without development of full extension of heterosexual impulse; and (3) improved, that is, increased ego integration and capacity to control the homosexual impulse. In conducting focal treatment (brief therapy aimed at the relief of the homosexual symptom), Glover commented on the significance of social anxiety present in these patients. This social anxiety, despite apparently rational justification, however, is based largely on a projected form of unconscious guilt. The unfortunate punitive attitude of society enables the patient to project concealed superego conflicts on the society and the law. He felt that almost from the outset the therapist must decide whether to conduct the treatment through the regular and prolonged course of analysis or through focal therapy of the symptom. In following the latter course, he would soon find that having uncovered some of the guilt, he would then strike against a core of sexual anxiety and, in particular, the multifarious manifestations of the castration complex. At this point the history of the individual's familial relations, traumas, frustrations, disappointments, jealousies, and so on, would come to the surface or should be brought to the surface. It is necessary to demonstrate the defensive aspects of the homosexual situation, for only by uncovering the positive aspects of his original relation to women (mother, sister) and by demonstrating the anxieties or guilt's (real or fantasized) associated with a hostile aspect of these earlier relations can a path be cleared for the return of heterosexual libido (Glover, 1960).

An unpublished and informal report of the Central Fact-Gathering Committee of the American Psychoanalytic Association (1956) was one of the first surveys to compile results of treatment. It showed that of 56 cases of homosexuality undergoing psychoanalytic therapy by members of the Association, they describe eight in the completed group (which totaled 32) as cured; 13 as improved; and one as unimproved. This constitutes one-third of all cases reported. Of the group which did not complete treatment (total of 34), they describe 16 as improved; three as untreatable; and five as transferred. In all reported cures, follow-up communications indicated assumption of full heterosexual roles and functioning.

A research team consisting of nine practicing psychoanalysts and two psychoanalytically-trained psychologists published the findings of a nine-year study of male homosexuals (Bieber, et al. 1962). The team psychiatrist and 77 respondents to a 500-item questionnaire were members of the Society of Medical Psychoanalysts, whose roster consisted of faculty and graduates of the Psychoanalytic Division of the Department of Psychiatry of New York Medical College. The research sample consisted of 106 male homosexuals and a comparison group of 100 male heterosexuals, all in psychoanalytic treatment with members of the Society. The data obtained were analyzed statistically in consultation with statistical experts and the clinical applications were carefully analyzed and evaluated. The results of treatment were as follows: "Of the 106

homosexuals who started psychoanalytic therapy, 29 were exclusively heterosexual at the time the volume was published. This represented 27% of the total sample. Fourteen of these 29 had been exclusively homosexual when they began treatment; 15 were bisexual. In 1965 (in a follow-up study of the 29, one (Bieber) was able to reclaim the data on 15 of the 29. Of these 15 men, 12 had remained exclusively heterosexual; the other three were predominantly heterosexual, but had occasional episodes of homosexuality when under severe stress. Of the 12 who had remained consistently heterosexual, seven had been among the 14 who had been exclusively homosexual when they started treatment. Thus, seven men who started treatment as exclusively homosexual had been exclusively heterosexual for at least six or seven years, (Bieber 1987, p. 424).

My own clinical experience with homosexual patients in private practice may well be, with the exception of Bergler, one of the most extensive. During a 10-year period from 1967 to 1977, I treated psychoanalytically 55 overt homosexuals: 34 of these patients were in long-term psychoanalytic therapy of over a year's duration (average 3.5 years). The number of sessions ranged from three to five per week. In this group there were only three females. The remainder (11) were in short term analytic therapy (average six to seven months) at two to three sessions per week. Three were female. In addition, full-scale analysis was performed on 18 latent homosexuals in which the symptoms never became overt, except in the most transitory form. Thus the total number treated in long-term analysis, whether overt or latent, was 63. In addition, over 250 overt homosexuals were seen in consultation (average one to three sessions) during this 10-year period. I can report that of the 45 overt homosexuals who have undergone psychoanalytic therapy, 20 patients, nearly 50 percent, developed full heterosexual functioning and were able to develop love feeling for their heterosexual partners. This includes one female patient. These patients--of whom two-thirds were of the preoedipal type and one-third of the oedipal type--were all strongly motivated for therapy. In addition, similar positive therapeutic results have occurred during the period from 1977 to 1988 in which I have treated over 50 more overt homosexuals in psychoanalytic therapy. In answer to those who say a successful treatment has never been demonstrated in homosexual patients, I also reported a detailed seven-year follow-up of a patient who achieved full heterosexual function and the ability to love his opposite-sex partner (Socarides 1978, pp. 497-529).

It is beyond the scope of this paper to give a detailed account beyond what has already been said as to why certain homosexual patients do better than others. Briefly, it can be stated that the situation is entirely different when conflict stems primarily from the earliest period of life prior to appropriate self-object differentiation and verbalization. For example, patients do better who struggle from a structural class of conflict compared to an object relations class of conflict. Also, those fixated at the rapprochement phase respond better than those fixated at practicing or differentiation phase of the separation-individuation period of development. Dickes (1960) in the libido frame of reference has commented on this problem: "Unfortunately, the importance of the early preverbal difficulties may become apparent only after the patient is well into the analysis or sometimes late in treatment. It then becomes clear that it was the earliest difficulties which played the most significant role in the creation of [homosexual] patient's illness. These occur so early, it may be postulated that the early id-ego matrix is influenced

adversely and the resultant skewing is present, not only in the developing ego, but also in that special portion of the id which is contiguous to the ego and significant for the formation of proper object choice.... In such cases, it is not sufficient to rely on making matters conscious in the expectation that the patient's ego and especially the synthetic will initiate a correction in the ego's structure and therefore in its adaptation to reality" (p.273).

More recently, a report by MacIntosh (1994) reveals that in response of a survey of 285 psychoanalysts (graduate of the Washington, D.C. Psychoanalytic Institute) who reported having analyzed 1,215 homosexual patients, 23 percent changed to heterosexuality from homosexuality, and 84 percent of the total group "received significant therapeutic benefit" (MacIntosh, p. 1183) "...regardless of whether or not they have changed their sexual orientations" (MacIntosh, p.1204)). In addition, four recent successfully analyzed cases are presented in a forthcoming volume, The Sexual Deviations: Theory and Therapy by psychoanalysts I. Graham, H. MacIntosh, A. Montes, and J. D. Blackman (Eds. C.W.Socarides, S. Kramer, A. Freedman, K. Gould, International Universities Press, in press, 2000).

During the early development of psychoanalysis, reports of favorable outcome in the treatment of homosexuality rarely appeared and the outlook was pessimistic. Starting in 1944, Bergler published extensive studies confirming his finding that with suitable treatment, homosexuality could be reversed (1944, 1959). Bychowski (1945, 1954, 1956); Lorand (1956), and other workers including Gersham (1967); Ovesey (1969); Bieber (1967) and Socarides (1969) had also published significant material to this effect, including the results of psychoanalytic, psychotherapeutic, and group therapy.

For my part and for my colleagues, I believe that one's compassion for the plight of the homosexual, his responsiveness as a patient, and his value as a human being, in interaction with the scientific challenge and fulfillment posed by intrapsychic conflicts, leads to a mutuality of gratitude and satisfaction between patient and psychoanalyst which well justifies the commitment to attempted alleviation of this important and serious disorder.

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