the diminished sense of personal responsibility and the unfortunate reduction of sex to its physical component as a physical pleasure, have made necessary the development of marriage guidance. To bring marriage guidance in purely at the stage of problems is a mistake, and no marriage guidance service is complete without courses for pre-marriage training, courses in which you will not just give information to people but again encourage them to start thinking for themselves about this state of life they are going to embrace. If one does this I think one is helping them to build a healthy and satisfactory marriage.

It has always been said that the health of a society depends upon the strength of its family life. Though the form of family life has differed in different societies from the polygamous to the monogamous, it is a sociological fact that the health of the family, whatever its form, is essential to the health of society. I would suggest without being a pessimist that there is a lot wrong with family life in western society at the present time, and that there is a need for us to do something positive to put things right. It is for this reason that I welcome this symposium and have been glad and honoured to be able to take part in it.

HOMOSEXUALITY

T. McCracken, M.B., B.CH., D.P.M. (*Dublin*)

Homosexuality is a sexual propensity in men and women for persons of their own sex. It may or may not be expressed in homosexual acts. When expressed in acts, it may take the form of mutual masturbation, the so-called full body technique, the production of orgasm by mouth, or anal penetration by the penis. There is, in fact, as much variety as in heterosexual relationships. The latter reminder may lower our temperature a bit in approaching this subject. It is hoped that in the next half hour we may be able to bring the same attitude of scientific detachment to a consideration of homosexuality as to other medical problems. This paper is intended to be a clinical commentary on homosexuality, with emphasis on the problems and decisions it may involve in general practice. Since I am what you might call a working-class psychiatrist, my own time is equally divided between general hospitals and private practice. Therefore, the clinical material on which this

paper is based should fairly closely approximate to that in general practice. The paper will not lead you into the esoteric regions of psychopathology. The latter is important, but may be read more accurately in a textbook. Out of the vast mass of literature, if we wish to be better informed, can be mentioned the Wolfenden *Report on homosexuality and prostitution*, Gordon Westwood's excellent research book called *A minority: male homosexuality in Great Britain: Towards a Quaker view of sex*, in which there is a great deal of sense talked about sex in general and homosexuality in particular, and for good measure, Donald Corey's *The homosexual outlook: the biography of a married homosexual.* In the reference tables of these books you will probably be surprised to find that there would be enough bedside reading to last you for many years.

What kind of people are these homosexuals? If you go to a homosexual pub or club you will see the highlights—the extremes in dress and bearing, the long hair, the powdered face, the nail varnish, the swinging hips, the effeminate mannerisms, the exhibitionistic dress, the affected voice—in other words, the deliberate creation of a society within a society which even has its own vernacular. But this is, in fact, only the fringe area. The vast majority of homosexuals are men who, to outward appearance, differ not from other men. They include athletes as well as actors, carpenters as well as company directors, scoundrels as well as scholars, boilermakers as well as ballet dancers. Homosexuality is not a status symbol. Two gifts from the gods, however, are usually theirs: an unusual insight into beauty and a love of music. This applies at all social and intellectual levels, as in the case of the electrician in the shipyard working among men to whom four-letter words are commonplace, but returning home to his collection of long-playing classical records in the evening and revealing a feminine insight into other people's feelings. The homosexual is a person living in a topsy-turvy world of sex. For him the public urinal, the ballet, the men's bathing place, the showers in the dressing room after a hard-fought football match are all needling points of intense sexual attraction. He is also a person living in fear. Apart from a few who blatantly and defiantly flaunt their homosexuality, all are constantly on the defensive lest an unguarded word, an absent-minded gesture or a glance will betray them. They inevitably have the characteristics of any minority group in our society.

One point we must get quite clear, and that is the distinction between homosexual tendency and homosexual activity. It is probable that the percentage of men with homosexual tendency far exceeds that of men who engage in homosexual activity. It is, in fact, a sliding scale in which there are many gradations. This was one of Kinsey's most important contributions to the understanding

of this problem, and it is essential to keep it in mind. The Kinsey rating scale of homosexuality arbitrarily took the figures 0—6. Six represented those who were exclusively homosexual; five, those who were predominantly homosexual but incidentally heterosexual; four, those who were predominantly homosexual but more than incidentally heterosexual, and three, those who were equally homosexual and heterosexual. Two, one and nought were those who were predominantly or exclusively heterosexual. This is much more accurate clinically than the older divisions into homosexual, bisexual and heterosexual.

How widespread is this problem? For obvious reasons, we do not really know its extent with any degree of accuracy. The available reliable statistics come from criminal records and from those of mental hospitals. These record only those charged in court, or hospital inmates. The number of people charged with theft bears little relation to the number of those who steal, or the number of acts of theft committed. The Wolfenden Report mentions a systematic investigation into a so-called normal sample of 100 male undergraduates. Thirty of them were found to have had homosexual phantasies at some time in their lives, and five of them still retained these beyond their twentieth year. Most investigators would accept that probably four to five per cent of the male population are exclusively homosexual. This would mean that there are in Britain at least three-quarters of a million male homosexuals and probably as many female homosexuals. There is no reason to think that the percentages would be any different in Ireland. There is no reliable evidence that homosexuality is on the increase. It is true that the total number of homosexual offences known to the police in England was 622 in 1931, and 6,644 in 1955. However, there was a drop of 17 per cent in 1956. These figures can be relied on only as an indication of police activity rather than of actual increase or decrease in homosexual incidents. Most family doctors would say that homosexuality is rarely encountered in their practice. There are a number of reasons for this and for holding that homosexual problems in general practice are more common than the visits to the surgery of an exclusively homosexual patient would indicate.

We may then ask what causes a man or a woman to be partially or exclusively homosexual. It may as well be said right away that we do not yet know. Clues have been taken up only, at this stage of our knowledge, to end in sand. There is the so-called normal homosexual phase of pre- and early adolescence. The sixth form schoolboy writing to the *Observer* last February maintained that all the boarders in his form had homosexual tendencies and that only four of the day boys had homosexual tendencies. Why 95 per cent

should outgrow this phase we do not know. The search for endocrine, biochemical or characteristic bodybuild causes has proved negative. Contrary to general opinion, seduction in youth has been shown to be a negligible factor. Both Westwood and Wolfenden agree that investigations do not show that seduction has any appreciable effect on the development of homosexual tendencies. What man among us has not had some form of homosexual experience in his childhood or his youth? Rosenof's view seems to be substantiated by the facts when he writes: " Seduction can only be of lasting effect if its direction corresponds with the inherent tendencies of the subject ". A most interesting book, *Aspects of psychiatric research*, published recently, includes a section on sexual inversion in birds and fish. Observations show that where sexual activity of first priority is denied in these regions, activity of lower priority, that is, inversion, will be pursued. This may, perhaps, be relevant to homosexual activities in boarding schools, prisons, ships and other unisexular communities, but the preponderance of evidence still is that in the vast majority of males where such temporary conditions of heterosexual deprivation exist, the predominantly heterosexual activity will reassert itself when opportunity recurs, except in those whose basic tendency is homosexual.

One of the most interesting and I think possibly most significant observations has been made by Westwood in his histories of 120 homosexuals. He found that 21 per cent were only children, 15 per cent the only son and the youngest child, 13 per cent the only son but not the youngest child, 14 per cent the youngest child but not the only son, 7 per cent the youngest son but not the only son and not the youngest child; 20 per cent occupied other positions in the family. The inference appears to be that the only child, the youngest child and the youngest son are more likely to be homosexual than children placed in other positions in the family. This would seem to support the theory that it is the spoilt child who is more likely to grow up homosexual and that therefore a significant emotional factor is involved. You, Sir, in your book *Psychiatry today*, were very cautious when you wrote: " Some forms of sexual inversion may owe at least a part of their abnormality to glandular function, although this may be less important than was at one time believed, while the underlying disturbance may prove to be more one of emotional development ". I was astonished when I read Westwood's figures, but on going over my own clinical records of homosexual patients I was more astonished still to find them to be substantially correct. But perhaps the last word with regard to aetiology rests with the old alchemist, when he said: " Lord, although Thou art King, yet Thou rulest and governest badly, for Thou has joined

males with males knowing that males do not produce offspring". What we do know is that a man rarely, if ever, deliberately chooses exclusive homosexuality as his sexual pattern. The throw of the dice has decided it for him. Whether the dice throws up a 6 on the Kinsey scale, or a 4 or an 0, does not seem to be within the individual's power to determine.

Sodomy is still legally referred to as " the abominable and detestable crime against nature ", and until 1828 it was punishable by death. I have often wondered why this legal description of this act and why this vicious attitude towards it exists. The maximum penalty now is imprisonment for life, and this, of course, applies not only to male and male, but also to male and female. Most homosexuals appearing in court are charged under Section 13 of the Sexual Offences Act, 1956, which makes it an offence for a man to commit an act of gross indecency with another man, whether in public or in private. The important words here are ' in private '. We may be surprised to know that until 1886 the criminal law in these islands was not concerned with alleged indecencies between grown-up men committed in private. Everyone knew that these things were happening, but the law only punished acts against public decency or conduct tending to the corruption of youth. The words ' in private ' were accepted almost as an afterthought in the British parliament in the form of an amendment. Ten years later, Oscar Wilde was charged under this amended section, leading to his trial, his imprisonment and his disgrace. It is of some interest to recall that he lived in rooms about a stone's throw from the hall in which we are holding this meeting, and that he and Edward Carson, who was to be the prosecuting counsel with such devastating effect at his trial, were students and friends at this university, and often chatted together in the square outside this hall. When the late Travers Humphries, defending counsel, told Wilde that he would be cross-examined by Carson, he immediately replied: "No doubt he will perform his task with all the added bitterness of an old friend ". The main recommendation of the Wolfenden Report was to omit the words ' in private ', and that homosexual acts between consenting adults in private should cease to be a criminal offence. It is not a criminal offence in Belgium, Denmark, France, Italy, the Netherlands, Spain and Sweden.

We now turn to the clinical aspects of homosexuality, how it can present and what can be done when it does. Recognition of the condition is easy in the older, exclusively homosexual patient who knows that he cannot change his way of life. He may come because he is in trouble with the police or because his life of covering up has become intolerable, leading to alcoholism or drug addiction, and he seeks for the catharsis of confession to another human being—

his doctor. Like all of us, the homosexual has to maintain the public image, but live with the private fact. Again, he may come because he is a well-controlled homosexual, among whom are people who are the salt of the earth, but fears that his defences may break down unless he has the support of one he can trust with the knowledge of his true feelings. The young man as a patient is more difficult, and in some ways tragic. He fears he may be homosexual and he seeks the authoratitive word on, say, the prospect of marriage. In diagnosis here we need to be sure of ourselves and to keep in mind the Kinsey rating on this continuum. It is a great help to take a careful history and then to enquire carefully into the patient's sexual dreams. It has been well said that no man is a liar in his dreams. Alternatively, homosexuality may present as an anxiety state, depression, or drug addiction, where the homosexuality is latent and the presenting symptoms are due to unconscious conflict. This is a diagnosis which can be easily missed, and one must confess that there are times when one suspects the underlying condition to be homosexual in both men and women who present with these symptoms, but refrains from too much probing. It is sometimes better to let sleeping dogs lie and to help the patient live with his anxiety state rather than with a homosexual awareness. Clinical judgment here will be finely tested. Impotence in men and frigidity in women are very rarely due to organic or biochemical causes, and a possible homosexual basis should be high on the list of differential diagnoses.

A very practical aspect of homosexuality may arise in general practice when a young man or woman comes to discuss with the doctor his or her prospective marriage. There are, of course, all sorts of reasons why a man develops cold feet before his marriage, but if we are consulted about this it is worth taking trouble to know where we are, and to be able to discern how far a conscious or latent homosexuality is at the root of the patient's doubts. With the wide dissemination of knowledge of sexual subjects today, we would expect the young people to know all the answers, but they do not. A few months ago a young woman patient stated that she had been married for four years without consummation of the marriage. When asked if she had not noticed anything strange or unusual about her courtship, she replied: "No, I didn't. I thought he was being the perfect gentleman". Everyone will not agree with the dogmatic view that if homosexuality is present in any degree, marriage is inadvisable. One has seen too many tragedies in which a woman with a happy home life and family suddenly sees it all collapse like a pack of cards because she discovers, when sending her husband's suit to be cleaned, a letter in the suit from the husband's boyfriend. Let a homosexual himself speak on this.

He says: "Marriage, I think, intensifies the conflict but does not provide increased incentive to fight it. To pretend to be heterosexual and to get on with life on that basis may delay but cannot prevent a showdown in which the odds, or so I have found, are against the contender". The problem may, therefore, present in general practice as obvious homosexuality, or disguised homosexuality in the form of an anxiety state, depression, alcholism, drug addiction or marital difficulties.

What can be done with regard to treatment? Ideally, as always, treatment will be treatment of the cause, but here we as yet do not know the cause or causes. Generally speaking, we may either pass the patient on or keep him on. To pass him on as quickly as possible may be the kindest thing to do. If our attitude is one of disgust and contempt, we have no right to subject another human being to such indignity in our surgery a moment longer than is necessary. However, we may pass him on because, with sympathy and understanding, we wish to help him as best we can. We may then refer him to the psychoanalyst on the assumption that a deep analysis will resolve the underlying emotional problem. This treatment is lengthy and costly, and the most suitable subjects are those who are young, have a reasonably high IQ, a good income and plenty of time. Alternatively, we may refer him to the behaviour therapist. This interesting approach to treatment rests on the opposite assumption with regard to causation from that of the psychoanalyst. It assumes that homosexuality is a learned response, not an instinctive or innate tendency; an assumption which many would challenge. It therefore applies the Pavlovian technique that any conditioned response may be de-conditioned or re-conditioned, as in aversion therapy in alcoholism. The treatment consists of the administration to the patient of an emetic mixture, emetine and apomorphine, by subcutaneous injection. When the emetic mixture becomes effective and as long as the effect lasts, slides of dressed and undressed men are shown to the patient. This constitutes the first or aversion part of the treatment. During the second phase of treatment the patient is shown films of nude or semi-nude women. These are shown approximately seven hours after the patient has been given 10 mg. of testosterone. A refinement of this method is to use a controlled series of electric shocks instead of the emetic mixture. On reading this, one may wonder whether one is in the land of Pavlov or in the land of the free. However, it is a valiant attempt to do something. Whether that is always a wise attitude or not is another question. With regard to the results of these methods of treatment, there are claims and counter-claims from both analysts and therapists. For myself, the position is put with commendable brevity and truth by a homosexual who is also a doctor: " No one

has ever changed a real queer into a normal". For us, then, in the rough and tumble of general practice, what can be done if we decide to keep the patient on?

First, this may mean that our clinical insight and skill have improved because we are better informed and are therefore able to detect the homosexual factor when it presents under its various guises. One would venture to say that this will throw unexpected light on more of our clinical problems than we think possible. It is being able to recognize, in Jung's phrase, ' the psychic concealments ' when they occur. Secondly, we can help a man to live with himself, and this may be the full extent to which we can help him. You may call this psychotherapy or informed common sense or what you will. But here a word of caution—a short time ago, I had three consultations with a very attractive looking, single, young woman. The object of the first was to tell me that she was a lesbian, and she was; of the second, two months later, to tell me that she was pregnant, and the third a month later to tell me that she was not. So psychotherapy can evidently be a little too enthusiastic! However, to be serious, the maintenance of secrecy acts, as Jung says, as a psychic poison which alienates its possessor from the community. How true this is of the homosexual; but when a man sits in our room and reveals his secrets to us, it ceases to be a secret, and this psychic poison is cut off at its source. This may be as valuable a service as we can ever render to our patient in this particular time of need. Thirdly, we can inform the patient that his homosexuality is not a matter for guilt or shame but that Nature has presented him with this specific problem in his sexual life that demands as much self-control as is expected from the man whose pattern is heterosexual. We can also ensure that he knows the legal position, and the possibility of blackmail. Fourthly, we can help him by chemical means. The administration of oestrogens to a co-operative homosexual male patient can be of the greatest assistance. Given in the form of stilboestrol or any of the other oestrogens, it reduces his sexual drive to manageable proportions, releases his tensions and promotes a sense of well-being as a result. Finally, keeping the patient on can mean that, for us, our attitude to the homosexual is determined neither by Church nor by State, but by the scientifically informed compassion of a physician towards his patient. Only then, away in the back of our minds, will we meaningfully ponder the truth, that there, but for the throw of the dice, go I.

Chairman: Once again, commendation would be superfluous and appreciation has been admirably expressed for a beautifully delivered and clear exposition. One observation occurs to me out of the remarks made by the last speaker which may be entirely apocryphal, but I throw it out as a matter of interest. The speaker said that the law on homosexuality had originated with its tremendous implication of guilt almost from time immemorial. Certainly in Mosaic Law, homosexuality between men was regarded as an abomination, but it is not entirely clear where it has crept into Anglo-Saxon law. I have been told that it is a direct takeover from ecclesiastical law, the foundation of a good deal of society's laws in the early Middle Ages. When ecclesiastical law was taken over, homosexuality, along with other aspects of sexual behaviour, became a matter of common law. It is certainly true that in modern Anglo-Saxon law lesbianism is not a crime whereas the practice of homosexuality among males is, and the reason which I have heard advanced for this is that in ecclesiastical law male homosexuality was impugned with such violence not, as sociologists and anthropologists have suggested, because it was a sterile and wasteful procedure in a people which required fertility and reproduction as part of their survival, but because it was believed that man was made in the image of God and that therefore male homosexuality was a form of blasphemy. The delightful implication is, of course, that women are not made in the image of God and therefore what they do is their own business. Certainly, society is much more tolerant of overt sexual activity between women. Actresses always kiss each other and call each other ' darling ', and this is regarded as a perfectly natural form of one of their more engaging, or if you do not happen to like it, disengaging, vicissitudes. But actors who called each other ' darling ' in public and kissed each other would rapidly stir up the kind of resentment which always attaches to male homosexual behaviour publicly displayed. There is a word for this—the word is ' camp '. This flagrant flaunting of this mixture of histrionic, shameless, and at the same time spectacular, homosexual trends in men is a form of defiance and as such calls for courage, even though of a somewhat hysterical kind. I think that until we get male homosexuality treated in exactly the same way as female homosexuality in Anglo-Saxon law we have an archaic, brutal, indefensible blot on the system of justice of which we are otherwise rightly proud, which will continue to load and burden it. I would say that most of us would put our Kinsey rating privately at some level on that scale with some confidence. James Cain once wrote a novel in which a man discovered that he was homosexual and talking about it said: " Of course, there's five per cent of it in all of us, and I suppose there was 15 per cent of it in me; it was just enough from time to time to

complicate my life ". Certainly, it is a natural phase in adolescence and there can be very few men who have not had homosexual experience of some sort at some stage in their lives and probably very few women. Even so, it is a phase through which the normal adolescent and child grow and out of which they emerge to their great comfort and to the fulfilment of their lives, but once again the theme here is the constant one: if we cannot accept, cannot treat as human beings of infinite value, those with sexual problems that differ from our own, we have not made a start on the work that this symposium intends to lay as its foundations.

INFERTILITY

A. D. H. Browne, M.D., M.A.O., F.R.C.P.I., F.R.C.O.G. (*Master of Rotunda Hospital, Dublin*)

Those of you who have been to the Rotunda Hospital chapel may have seen the beautiful ceiling, now 200 years old, on which you can see every sign of fertility. The founder of the Rotunda recognized that fertility was his main object in life and the *raison d'être* of the hospital itself. Infertility in those days was not a serious problem and certainly not one that worried Bartholomew Mosse. The natural desire of the married couple is to look forward in the fullness of time to reproduction. The initial weeks and months of marriage may be more occupied with the mutual discovery of love, the acquisition of sexual harmony and the enriching human relationships that go with this, but soon this gives way to the hopeful anticipation of a family of youngsters. I need not tell you that where a marriage is faced by failure to achieve the desired pregnancies, tensions soon develop—tensions which affect all aspects of married life, social, personal and intimate. The act of coitus becomes more deliberate, less spontaneous, and therefore in many ways less harmonious. Unspoken fears and doubts are felt by husband and wife and various unco-ordinated efforts may be made by them to render coitus more fertile.

Now these are unco-ordinated because they are uncommunicated, and it has already been emphasized by previous speakers that immense difficulties exist inside the bond of marriage for communication between husband and wife. They find it difficult to talk about