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Aetiological Factors in Homosexuality as Seen in Royal Air Force Psychiatric Practice

By P. J. O'CONNOR

I have been interested in the conflicting attitudes of the legal and psychiatric branches of the Service towards homosexuality. The legal branch sees homosexuality as a crime which still carries severe penalties. As a Service psychiatrist I have been impressed by the seemingly genuine desire to be cured shown by many homosexuals who come to me for help and I was struck by the high incidence of neurotic symptoms in them. To find out how many of the homosexuals seen by me were ill and to learn about the aetiology of homosexuality as seen in the Armed Forces I compared 50 consecutive homosexuals with 50 neurotics picked at random from my out-patients during the same period (1958–59).

Method

All the men were aged 16–51 years and were serving in the R.A.F. at the time I examined them. Synopses of the case histories are given in Appendices I and II.

There is the same difficulty in defining the syndrome of homosexuality as there is in defining an anxiety state. Most people have some experience, however slight, at some stage of their lives of the central symptom of both syndromes, i.e. the subjective feeling of anxiety in the face of doubt on the one hand and of sexual excitation in relation to one of their own sex on the other. The difficulty lies in deciding when either of these two symptoms becomes excessive, for this point must be the Rubicon dividing the range of normality from the abnormal state. Both anxiety and affection for one's own sex are part of normal mentation; only when either symptom reaches the point where the patient's mental life, or society, is made uncomfortable has the condition become pathological.

The criterion of homosexuality that I used was that the man consulted me in connection with a homosexual problem. Sometimes it was a single episode of homosexual behaviour: sometimes it was inveterate and longstanding homosexuality: sometimes the man was in trouble with the law: sometimes he was not. I made no effort to grade the degree of homosexuality into:

1. Pseudo-homosexuals, i.e. those who are normally heterosexual and have no psychic attraction to their partner, and
2. True homosexuals, who have psychic attraction to their partner and none to the opposite sex.

My patients shaded imperceptibly from the mildest to the most severe. I could place some clearly into the "pseudo" group and some into the "true" group, but the majority occupied a mid-position. The condition of homosexuality may be mild or severe, but in my experience the mild and the severe varieties are merely the opposite ends of a continuum.

There are three main channels by which homosexuals reach a Service psychiatrist:

1. Those who seek help to cure their condition.
2. Those who are being prosecuted for homosexual behaviour.
3. Those homosexuals who find Service life intolerable and use their homosexuality to escape.

Probably all those in categories 1 and 3 reach the psychiatrist, and 80–90 per cent. of those in category 2 are seen. It has been suggested that men will claim homosexuality in order to get discharged from the Service. This may be true. I do not try to get proof of homosexuality: if a man is so unhappy as to make such an

abnormal claim, then he is most unlikely to be of use to the peacetime Service. As most of the cases I have seen conform to a pattern, I do not think that many of those claiming to be homosexual are malingering.

As this work was done while National Service was still compulsory, it would be interesting to know what percentage of the homosexuals and neurotics were National Service airmen and what percentage were on regular engagements. Of the men who were serving in the R.A.F. only because they were forced to do so by the National Service Act, many signed on for an extra year to make their enforced service more congenial and these were classed as regulars. To get over this difficulty of nomenclature I ascertained how many homosexuals and neurotics had served less than three years when I saw them. Table I shows that half of the neurotics saw a psychiatrist after they had been three years in the R.A.F., i.e. they were regulars. One quarter of the homosexuals were regulars, so that there was a bigger percentage of National Service airmen among the homosexual group. This in turn may explain why the average age of the neurotic group is two years higher than that of the homosexuals. All the homosexuals who consulted me were recommended for invaliding. Those asking for treatment were given advice and sometimes in-patient treatment before they left the service. If the man was being charged with homosexual behaviour he would not be invalided until trial and punishment were complete. Psychiatric follow-up in civil life was always offered.

TABLE I

The Proportion of National Service Airmen in Both Groups

	Percentage who had served less than 3 Years	Percentage who had served more than 3 Years
Homosexuals	74	26
Neurotics	52	48

It is hard to say what fraction of the Service homosexual population is seen by a psychiatrist, as the incidence of homosexual behaviour varies from time to time with religious, social and economic pressures. The incidence of homosexuality was high in ancient pagan Greece; similarly in wartime where soldiers are in an all-male environment—Napoleon said of his army in Egypt "mes hommes se suffisent"; Ford and Beach (1952) found that 64 per cent. of 76 primitive societies recognized and condoned some form of male homosexuality. Thus the true incidence of homosexual behaviour in our day and age is difficult to determine, but Kinsey's (1948) very careful studies showed that 4 per cent. of an American university population remained homosexual throughout their lives. Less than 0·1 per cent. of the R.A.F. personnel consulted a psychiatrist during the period under review because of homosexuality. This suggests that a large number, probably the majority of homosexuals serving in the R.A.F., do not seek psychiatric help.

DISCUSSION

The aims of this paper are to find out:

1. Whether male homosexuals seen in the R.A.F. are psychiatrically ill.
2. What are the causes of male homosexuality in R.A.F. personnel.

I understand a psychiatric disease to be a state of the mind which causes discomfort to the patient or to society, and this discomfort is great enough to make the patient seek medical help or to prompt society to enlist medical aid for its alleviation. Table II shows why the patients consulted a psychiatrist. Eighty-eight per cent of the neurotic group and 76 per cent. of the homosexuals sought psychiatric help for discomfort due to a state of mind, anxiety being the commonest symptom. Twelve per cent. of

TABLE II

Channel by which the man reached a Psychiatrist

	Homosexuals	Neurotics
Asked for medical help	76%	88%
Medical aid invoked by society	24%	12%

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neurotics and 24 per cent. of homosexuals were sent by society to see whether medical treatment could affect their behaviour (Table II). Therefore roughly similar proportions of both groups asked for psychiatric help and similar proportions were sent for psychiatric assessment.

In making a diagnosis of psychiatric illness in the R.A.F. I expect to find:

1. A neurotic symptom as the presenting complaint.
2. A previous history of neurotic traits in childhood.
3. A family history of neurotic complaints.

Table II shows that a high proportion (76 per cent. and 88 per cent.) of both groups consulted a psychiatrist because the patient or his doctor considered the main symptom was psychogenic: anxiety or depression was the commonest presenting symptom in both groups. Table III shows that neurotic traits in childhood were equally common in the homosexuals and neurotic patients. Similarly the family history of neurotic complaints was roughly the same in both groups. Only children are more prone than average to develop neurotic illness: there were approximately the same number of only children in both series.

TABLE III

Neurotic Predisposition in Neurotics and Homosexuals

	Homosexuals	Neurotics
Average number of neurotic traits per case	1·7	1·4
Family history of neurosis	28%	36%
Patient an only child ..	26%	20%

From these figures I conclude that apart from their presenting complaint the homosexual patients seen by me in the R.A.F. were indistinguishable as a group from the neurotic patients seen at the same clinics by the same observer. Seventy-six per cent. of the homosexuals had anxiety states or reactive depressions and most of the residual 24 per cent. showed psychopathic behaviour. In the majority of cases the psychiatric illness was related to the homosexuality, usually the result of it. This does not prove that homosexuality is a psychiatric disease, but only that neurotics and homosexuals as seen in R.A.F. practice are very similar in neurotic predisposition and family history of neurosis, and that a high proportion of homosexuals do develop neurotic illness.

Many causes have been suggested for homosexuality. One school believe the condition is inborn or at least genetically determined. This group includes Lang (1940), who supported the view that genetic intersexuality contributed to the causation of male homosexuality by the finding of a high sex ratio at birth. Recent advances in understanding of the functions of the sex chromosomes have shown his theoretical argument to be incorrect; but the observations he made on the unexpectedly high number of brothers in the families of his male homosexuals still stand. He found 121 male siblings to every 100 females in the families of 1,015 homosexuals, while the ratio in the general population was 106 : 100.

Table IV shows the ratio of male to female siblings in my homosexual and neurotic groups. In my neurotic patients the ratio of brothers to sisters, 156 : 100, was higher than in the homosexuals, in whom it was 135 : 100. These figures do not favour the view that homosexuality is an intersex condition.

Slater (1962) showed in his patients that homosexuality is more common in the youngest sons of elderly mothers. Slater's findings suggest that the aetiology of homosexuality and mongolism may be similar in that the age of the mother when the baby is conceived is important, and that both conditions may be due to chromosomal abnormalities. My material emphasizes a very salient difference between the two aetiologies. In my homosexuals 18 per cent. (9 patients) were reared by foster parents; none of the neurotics were. Foster parents are usually relatively elderly parents who adopt children only after years of barren marriage. Four of the nine foster parents were the patient's grandmothers and another two were more than 50 years older than their foster child. I believe that the big gap between the age of the mother or mother substitute and the child is important

TABLE IV

Numbers of Male and Female Siblings

	Homosexuals	Neurotics
Male siblings (brothers and stepbrothers)	66	67
Female siblings (sisters and stepsisters)	49	43
Ratio: brothers and stepbrothers to 100 sisters and stepsisters	135 males / 100 females	156 males / 100 females

in homosexuality, not for hereditary or genetic reasons, but for the environmental reason that elderly people are notorious for their permissive and indulgent attitudes to children. While the maternal age at conception is important in the aetiology of mongolism, the age gap between the mother or foster mother and her youngest son is the important factor in homosexuality.

One of the most impressive studies of the causes of homosexuality is Kallmann's (1952). He studied 40 male homosexuals who had univolar twin brothers. In 39 cases the twin was also homosexual, i.e. 97·5 per cent. mate involvement. Among the binovular twins there was only 11·5 per cent. mate involvement. Kallmann points out that most of his cases "assert to have developed their sexual tendencies independently and often far apart and all of them deny categorically any history of mutuality in overt sex relations". These figures seem to prove beyond doubt that there is a genetic factor in the aetiology of homosexuality. But it is not the only cause. In the 50 cases studied by me there was only one with a family history of the condition. There must be some other factor which decides when the inherited tendency shall manifest itself.

One factor which might manifest the inherited tendency to homosexuality is endocrine imbalance. Many endocrine studies in homosexuals have been made and none have shown convincingly that hormone imbalance is the cause of homosexuality. Against the hormone theory also are the many patients who are brought up as girls because of the appearance of the genitalia and are found at operation to have male gonads. Ellis (1945) lists 19 patients from the literature who were reared as females, were sexually attracted to males and yet were found at operation to have male gonads. Price's *Medicine* (1950) tells of a "young and beautiful woman with a feminine figure, well-developed breasts and normal feminine libido, who in spite of a short vagina, had satisfying intercourse with males"; at operation the gonads were found to be testes. Such cases suggest that upbringing has a lot to do with adult sexual behaviour patterns.

Freud held that incestuous wishes toward the mother were common in young boys. These incestuous wishes cause feelings of guilt about sexual desires and these guilty feelings are later transferred to sexual desires for other women; this inhibits the development of the normal heterosexuality. Strecher (1946) believes that homosexuals are made and not born; in many instances he says "it is reasonable to impute immaturity determined by Mom and her wiles" as the cause of homosexuality. He contends that the mother who continues to keep her son attached to her apron strings checks his development to heterosexuality. Table V shows my experience with "Mom and her wiles". Sixty-two per cent. of homosexuals were more attached to their mother than to father, while only 8 per cent. of neurotics were. In 24 per cent. of homosexuals (2 per cent. of neurotics) the father had been away from home for long periods while the boy was growing up, and this may have been the reason the boy preferred his mother. But in 28 per cent. of the homosexuals (6 per cent. of the neurotics) where the father had not been away from home, the boy found he could not form an affectionate relationship with his father and usually blamed the father's antipathetic personality. Of this

28 per cent. one-third did not get on particularly well with their mother. Therefore approximately 70 per cent. of the homosexuals (62 per cent. plus one-third of 28 per cent.) were either over-attached to their mother or did not get on well with their father. If we assume that the normal child is equally fond of both parents then 70 per cent. of these homosexuals did not relate normally with their father during childhood. The corresponding figures for the neurotics was 10 per cent. These figures suggest that failure to relate normally with the father is a very potent factor in manifesting the tendency to homosexuality. An alternative interpretation of these figures is that the child does not form normal bonds of affection with his father because of an inborn tendency to homosexuality. But if failure to relate with the father is the result and not the cause of homosexuality it is difficult to explain the greater number of times the father was absent from the home in the homosexual households (Table V).

Turning to Table VI we see that homosexuals are more often engaged on clerical work than on manual or mechanical work, their hobbies are more artistic and they avoid robust sport more than do neurotics. This confirms statistically the clinical impression that the homosexual, as seen in R.A.F. psychiatric practice, tends to conform to a set type. He is generally an unaggressive, artistic, pleasantly spoken young man who favours such occupations as nursing, photography, ballet dancing and clerical work; he fails to get on well with his father; he is over-attached to his mother and finally he often has symptoms of anxiety neurosis.

From these observed facts and Kallmann's findings I consider that homosexuality, as seen in R.A.F. practice, is due to an inherited trait which is likely to become manifest only if the boy is predisposed to neurosis and if, instead of being equally attached to both parents, he forms a poor relationship with his father. As

TABLE V

Comparison of Details of Family Interpersonal Relationships. In Each Case the Difference is Statistically Significant

	Homosexuals	Neurotics	Difference	Standard Error of Difference × 2
Subjectively more attached to mother than to father	62%	8%	54	18%
Poor relationship with father	28%	6%	22	15%
Father away from home for a long period during the patient's childhood and adolescence	24%	2%	22	13·4%
Reared by foster parents	18%	0%	18	12%

TABLE VI

Comparison of Details of Personality Delineation. In Each Case the Difference is Significant (exceeds Standard Error × 2)

	Homosexuals	Neurotics	Difference	Standard Error of Difference × 2
Preferred clerical and non-manual trades	75%	36%	39%	19·8%
Artistic hobbies	86%	39%	47%	19·4%
Liked robust sport	12%	60%	48%	19·2%

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children model their behaviour on their parents, he will then tend to model himself on his mother and imitate the feminine mannerisms (Case No. 27). This tendency delays the maturation of the sexual instinct either:

1. As the Freudians suggest (incestuous desires for the mother—guilt about all heterosexual desires—fixation of sexual development at an immature phase); or

2. As Case No. 44 said "I am deeply attached to mother: I have no sexual feelings for her and therefore no sexual feelings for any woman".

Either of three lines of development may follow:

(*a*) He may remain a bachelor, sublimating his sexual drive into socially acceptable channels, and never develop symptoms of anxiety or psychopathy. Such latent homosexuals are often eminent in their calling and never need to consult a physician or fall foul of the law.

(*b*) When he sees his coevals are sexually attracted to girls while he remains at the homosexual phase, he begins to worry. An anxiety state follows and further inhibits sexual maturation. This anxiety may be increased by reading books which suggest that the homosexual state is incurable. This homosexual will present as an anxiety state.

(*c*) If he frequents certain inns and other haunts where homosexuals foregather he is encouraged to practise homosexuality; frequent indulgence may remove the anxiety about failing to mature and at the same time satisfy the sexual drive. The mutual support given by the rest of the coterie encourages the homosexual to believe he is one of a race apart without hope of cure and therefore entitled to indulge in his now firmly established homosexual habits. This attitude of mind is liable to lead to conflicts with the Service authorities. If the outlook is hopeless and cure is impossible, the subject argues that he is entitled to indulge his sexual drive in the only way he can and that society must accept his homosexuality. This homosexual will manifest himself in the guise of psychopathy.

I believe that the latter two lines of development explain why 70 per cent. of the homosexuals seen by a Service psychiatrist present with anxiety or depressive reactions and most of the remainder with psychopathic formations.

When faced with homosexual behaviour, how then are we to approach the problem? We must decide (1) is it the stage of physiological homosexuality which is common in adolescent boys and should occasion no anxiety and be treated by explaining to the boy that he is misusing the function of reproduction? (2) Are we dealing with arrested development of the sexual instinct due to one of the psychological and genetic causes mentioned above? Here the patient needs help and his problem should be tackled by a psychiatrist. (3) If the homosexual behaviour takes place between consenting adults legal sanctions are not nowadays usually applied. But if a man seduces a youth, especially if he does so repeatedly and thereby abuses his position of authority, as in the case of teacher, cleric or scoutmaster, or if he practises homosexuality for financial gain, the law will continue to apply sanctions in such cases despite obvious psychopathology because of the overriding need to protect society. This then is the explanation of the sometimes divergent views of the judge and the psychiatrist.

Summary and Conclusions

Fifty homosexuals were compared with 50 neurotics seen in R.A.F. psychiatric practice. There was a high incidence of neuroticism amongst these male homosexuals. There is evidence that poor emotional rapport between father and son delays maturation of the instinct of self-reproduction. If anxiety about the arrested development causes neurosis or psychopathy the failure of maturation may be further delayed or fixated.

The syndrome of male homosexuality is fairly cohesive: unaggressive, artistic men devoted to their mothers were the prototypes.

Appendix I

Details of Fifty Homosexuals

Abbreviations: M.M. Mutual Masturbation
A.I.C. Anal Intercourse
A. Active
P. Passive

	Initials	*Age*	*Clinical Details*
1.	R.S.	19	Mild anxiety state *re* attraction to good looking coevals. Had a childhood sweetheart who has now lost heart. Infrequent M.M. at school.
2.	P.V.P.	20	M.M. at school: faint heterosexual trends *aet.* 16: *aet.* 18 came to London: introduced to homo. club where he has found great happiness: sought medical aid to avoid foreign service and separation from boy friend.
3.	D.R.	21	A ballet dancer, became involved in M.M. Tried A.I.C. but disliked it. Never lost heterosexual drive and is engaged. "I was only interested in fun in those days." An intercepted letter led to referral. Completed National Service. No psychiatric symptoms.
4.	W.C.R.	18	Anxiety state from teasing about his homosexual mannerisms which are obvious. Rare episodic indulgence in M.M. when drunk.
5.	R.S.R.	19	Continuous homosexual behaviour with ? similar twin: episodic indulgence at work, M.M. chiefly. Became anxious about himself when twin began courting.
6.	K.G.R.	20	From adolescent M.M. drifted to homo. clubs and now confirmed in his ways. M.M. and rare A.I.C. A. and P. Referred by police. No overt anxiety.
7.	O.N.S.	18	A solitary only child who drifted from adolescent M.M. through occasional homosexual attachments until he found happiness in West End pubs frequented by homosexuals. A.I.C.(P). Referred by police: no anxiety.
8.	A.N.N.	20	Anxiety state about homosexuality. Had three serious homosexual affairs.
9.	D.W.P.	21	*Aet.* 18 developed hero-worship for 30-year-old male. Now attracted to a coarse bully and is worried about this facet of his personality.
10.	A.M.K.	27	Claims harsh upbringing. Unstable work record. Recent Court Martial for accepting presents from airmen. Married but left wife after failing to adjust. A.I.C. A. and P. with pothouse acquaintances.
11.	A.M.W.	23	Homosex, commenced *aet.* 17 with a coeval who persuaded patient he was abnormal. Then became promiscuous. A.I.C.(P) now trying with religion to become heterosex. Mincing ways.
12.	A.A.G.A.	21	Happy childhood; folk commented on his feminine appearance and worry about this led him to a child psychiatrist. Drifted into casual A.I.C.(P). Mincing ways. Police case. No anxiety.
13.	A.N.H.	23	Illegitimate, reared by lady 60 years older. Attached to her. Adolescent M.M. has continued punctuated by 2 heterosexual affairs. Police case. No anxiety.
14.	D.W.K.	23	Very unstable home (5 changes) but wealthy. Solitary and shy; his career has been highly successful. Now worries *re* homosexual attraction to coevals; never gives way to temptation.
15	H.L.	23	Reared in a matriarchy, he resented father's infrequent sojourns from abroad. Very feminine mannerisms; tempted to imitate feminine hair style. Would like to be female. Two homosexual episodes. A.I.C.(P). No anxiety.
16.	L.L.	18	Reared by granny (no room at home) and never developed heterosexual ways. Wants to become a female and keep house for a male. Infrequent A.I.C.(P). No anxiety.
17.	J.H.	19	Reared in a matriarchy. "Father a decent sort but I am an actor with little in common with him." Selfish; using homosexuality to avoid National Service. No serious indulgence. Desires A.I.C. or P. with older men. Anxiety to avoid N.S.
18.	A.I.	42	Childhood memories of mother goading father's lack of drive. "All my success due to her." Scoutmaster who used to masturbate small boys. Only one indulgence in past 5 years. Wants to marry and is seeking advice. (Prem. ejac. and fear of female criticism was a factor.)

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Initials	*Age*	*Clinical Details*
19. M.I.	26	Illegitimate, adopted by couple 50 years older. Disturbed adolescence ended in court order to board in special school; he traces this to discovering he was illegitimate. Aimed very high and almost succeeded in four spectacular careers. Recent M.M. with coevals. Police case? No anxiety.
20. W.J.K.	18	Referred by police for M.M. in public lavatory. Effeminate looks and mannerisms; drifted from school M.M. to loitering around cinemas and chance meetings. Fears impregnating female; now wants to marry and asks advice. No anxiety.
21. P.D.D.	18	Recurrent depression because he lacks heterosexual drive. A sensitive mother's boy who cannot mix with N.S. airmen. Homosexual indulgences rare M.M. with older men but temptations are strongly felt.
22. M.R.E.	23	While serving abroad developed anxiety state fearing he would give in to his homosexual urges. He practised M.M. at school and has never developed heterosexual urge. With reassurance he has lost symptoms and is adjusted to heterosexuality.
23. M.J.F.	20	Very disturbed home; reared by granny; attended child psychiatrist. Effeminate in manner. A.I.C.(P). No desire for cure but homesick.
24. G.G.	19	A mother's boy who never developed heterosexual drive. Practised homosexuality (M.M. and A.I.C. A. or P.) from school days onward. No real desire for cure; using symptoms to get his own way.
25. G.G.	22	A "sickly" child and mother's boy; effeminate. Adolescent M.M. continued into adult A.I.C.(A) frequent and casual. Chronic anxiety neurosis led to referral.
26. A.H.	20	Very unstable home. Attached to mother. Normal development until *aet.* 18, he became attached to homosexual group; now frequent M.M. with pothouse acquaintances.
27. J.J.P.	20	Effeminate, passive homosexuality with older men since adolescence. Proud of power over men. Can remember consciously imitating mother's mannerisms, e.g. feminine way of sitting down. M.M. and A.I.C.(P). Police case, no anxiety.
28. M.J.W.	23	States 4 relatives homosexual. He has had satisfactory heterosexual i.c. Adolescent M.M. continued infrequently A.I.C.(P) $\times 6$ and he is worried because he likes it so much.
29. M.M.	20	Anxiety state because girls find him slow. He attributes this to his homosexual practices. Infrequent M.M.
30. C.B.	19	Timid, neurotic, demanding youth. Adolescent M.M. has continued; now frequent occasions M.M. Using complaint to escape National Service.
31. P.B.	21	Played with dolls and felt guilty about this. Truanted from school and now wants to leave R.A.F. Once seduced by female—disgusted him. M.M. and A.I.C.(P) frequent.
32. M.T.	19	Anxiety state *re* lack of heterosexual interest. Infrequent M.M.
33. M.T.	23	Became potent *aet.* 18. The late maturing and lack of heterosexual drive worried him. Formed lasting homosexual attachments. M.M. frequent.
34. F.B.	19	Unstable work record and now wants to change out of R.A.F. M.M. since adolescence infrequent. One heterosexual attempt under alcohol.
35. G.A.B.	20	Dominant mother; he always turns to her for help. Regularly seduced by cinema manager from *aet.* 8 years. Later pen friends 3 heterosexual affairs and likes petting. No heterosexual i.c. Anxiety about persisting homosexuality.
36. I.C.B.	18	Spoiled by granny who "lived in". Selfish demanding and wants to get out of R.A.F. A.I.C.(P) and fellatio; drinks excessively. Effeminate.
37. P.J.C.	21	Drifted from adolescent M.M. to promiscuous homosexuality with coevals. M.M. chiefly. Manly lad. Probably wants to avoid National Service.
38. J.C.	20	Continued adolescent M.M. into adult life. Practises monthly with casuals. Worried and keen for cure.
39. F.A.P.	19	A timid mother's boy worried that he has not yet developed heterosexual ways. No adult homosexual indulgence, only temptation.
40. R.L.W.	20	Unaggressive youth without heterosexual development. Adolescent M.M. and now frequent male prostitution. Upset by Service discipline and mentioned homosexuality to get discharged.

Initials	*Age*	*Clinical Details*
41. W.H.D.	22	Timid mother's boy with feelings of inferiority; shy of females; tried a prostitute but failed to reach orgasm. M.M. and A.I.C.(P) with coevals or older men. Keen to be cured.
42. D.H.	19	Mother makes all decisions in family. Weakly child drifted from adolescent M.M. into adult M.M. Now worried by loneliness of his state and wants invaliding as temptation too great in Service.
43. R.P.L.	19	Mother died at his birth. Reared by and attached to Granny. A.I.C.(P) with brothers; they became heterosexual, he hasn't and now he is worried.
44. M.M.	20	Worried when coevals became heterosexual *aet.* 15 and he didn't. "So attached to mum and no sexual feelings for her; therefore no sex feelings for females." Adolescent M.M. continued into manhood. Wants to get out of R.A.F.
45. J.B.M.L.	33	A shy self-effacing little man too timid to give vent to his heterosexual urges, but did so *aet.* 23. Now M.M. with younger men under his control.
46. T.H.	20	Attached to mother. "She always let me have my way." Jilted by girl friend 2 years ago; they had frequent satisfactory intercourse. Never interested in female since. Frequent A.I.C.(P) in past six months; no desire for cure. Wants to avoid National Service.
47. J.B.M.	25	Spoiled boy; brief heterosexual phase *aet.* 17–18 but lacked drive. *Aet.* 18–20 no outlet. Since then prolific. M.M. and A.I.C.(P). Marked female mannerisms. Developed insight during National Service. Now engaged.
48. J.H.	20	Manly manner, attached to permissive mother; never heterosexually minded; artistic and homosexually tempted but only one M.M. which caused present guilt reaction.
49. A.H.J.O.	18	Reared by permissive granny. Hates both his wealthy divorced parents. Drifted from M.M. at school to M.M. with coevals on stage. Wishes to avoid National Service not to be cured.
50. A.M.G.	19	Timid, neurotic attached to father who died 6 years ago. M.M. at school and now M.M. and A.I.C.(P)

Appendix II

Details of Fifty Neurotics

Initials	*Age*	*Clinical Details*
1. D.H.	28	Poor work record. Hysterical symptoms motivated by desire to get out of the R.A.F. Lacks tenacity.
2. B.H.	20	Anxiety prone. Attempted suicide because of headaches. Now indecent assault on a girl when his wife was pregnant.
3. B.H.	18	Anxiety prone; joined R.A.F. to become an aerial erector and became frightened of heights—anxiety neurosis.
4. H.S.H.	20	Made offensive phone calls. Diarrhoea, dyspepsia, and headaches under moderate stress.
5. F.D.H.	51	Unable to cope with his difficulties (Rh. heart disease and dislike of clerical work; domestic stress). Reactive depression, not needing E.C.T.
6. A.C.	36	Ran away when bombed during war. Rejoined R.A.F. because he resented his new stepmother. Married 2/12 and wants to get out of R.A.F. "because of wife's ill health" —she refuses to occupy Service married quarters.
7. A.B.	18	Neurotic family; very neurotic youth. Psychogenic headaches closely related to desire to avoid National Service.
8. S.B.	20	Anxiety neurosis *re* own health. Headaches, anxiety, irritability, disturbed dreams plus increased daydreaming about imagined slights.
9. A.J.	20	Anxiety state in unstable youth. Neurotic parents; truant, aggressive, neurotic headaches related to dislike of R.A.F. Eczema.
10. C.C.C.	24	Anxiety state *re* fear of formation flying precipitated by accidental death of a friend in the air coupled with break up of marriage.
11. D.J.J.	18	Tic-like cough and anxiety neurosis reactive to dislike of Service where he "misses all the things I am used to".
12. D.L.	26	Anxiety neurosis reactive to Service life. Bought house. Settled family there and now separation irks him.
13. R.J.F.	32	Anxiety neurosis reactive to restrictions of Service life in an unstable man.
14. G.J.B.	18	Hysterical deafness helps him to evade duties.

Initials	*Age*	*Clinical Details*
15. D.G.McP.	15	Hysterical fugue on finding communal barrack room life too much.
16. D.A.	19	Post-concussional headaches perpetuated by separation from home.
17. Y.L.	22	Inadequate psychopath with endogenous depression.
18. C.C.	26	Headaches since new trade structure interfered with his life.
19. A.S.	19	Increase of tempo of symptoms of chronic neurosis reactive to Service conditions.
20. L.J.B.	20	Anxiety state reactive to separation from home.
21. P.R.W.	24	Rigid sensitive man who gets asthma when he broods over imagined wrongs.
22. P.B.	24	Neurotic depression reactive to dislike of Service discipline accentuated by row with girl friend.
23. A.P.	23	Spoiled mother's boy—mild depression neurosis reactive to rigidity of Service life.
24. K.G.M.	22	Nocturnal enuresis which seems to be a hysterical reaction to dislike of R.A.F. Lack of application restricts progress.
25. F.C.L.	47	Anxiety *re* health and depression: second attack in five years. Over conscientious, wakes early. Reassurance, holiday and supportive psychotherapy. Still well after 2 years.
26. G.E.T.	21	Headaches and depression when he feels he is asked to do too much. Similar neurotic reaction since childhood.
27. A.R.T.	21	Anxiety and depression thought to be due to dislike of R.A.F.
28. W.H.	19	Reactive depression to National Service in a predisposed lad.
29. G.H.	35	Reactive depression to overseas service in a fairly robust character.
30. B.H.	22	Reactive depression to Service in a vulnerable lad.
31. F.L.	25	Chronic anxiety state in overconscientious man.
32. L.E.V.	24	Man of poor physique; failed O.C.T.U. reactive depression.
33. W.S.J.	36	Anxiety state in an over conscientious man.
34. L.J.	19	Schizoid reaction, transient, resolved; followed a bowel upset; ? toxic reaction.
35. C.A.	20	Under-confident man who failed to fly fast aircraft.
36. R.M.P.	25	Bully who lacked courage to pilot aircraft—acute anxiety neurosis till takes off; denies he is scared.
37. M.J.D.	22	Anxiety neurosis about failure to progress at his job.
38. J.C.H.	24	Accident neurosis in an unstable personality.
39. G.J.G.	26	Couldn't settle in chosen career (Chartered Accountant) volunteered A/C—acute neurosis *re* flying.
40. P.G.H.	19	Fear neurosis which he cannot admit to. (Headaches when trying to persevere in spite of fear.)
41. M.O.R.	11	Anxiety state in an obsessional who worries about his own shortcomings, fears exams and has to take sedatives before competitions.
42. R.B.S.	23	(1) Obsessional neurosis; tics; compulsive thoughts: (2) stammer.
43. J.E.E.	19	Schizoid reactions; recent increased introspection; worried about bowels; brooding on religious topics.
44. H.H.	19	Stammer when embarrassed; increased on joining R.A.F.: subsided on speech therapy.
45. G.H.R.	21	Stammer increased on joining R.A.F. fair result from speech therapy.
46. R.F.K.	22	Reactive depression to life in R.A.F. discipline in U.K. after the slacker discipline abroad.
47. H.H.D.H.	22	Claustrophobia in an underground worker.
48. T.L.H.	21	Neurotic reactive depression to wife's ill-health.
49. G.W.F.	18	Hysterical reaction to joint aches in relation to Service life.
50. L.A.	20	Anxiety state with schizoid features; neurotic headaches, irritability, disturbed dreams, plus increased daydreaming about imagined slights.

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REFERENCES

ELLIS, A. (1945). "The sexual psychology of human hermaphrodites", *Psychosom. Med.*, **7**, 108–120.

FORD, C. S., and BEACH, F. A. (1952). *Patterns of Sexual Behaviour*. London.

KALLMANN, J. (1952). "Comparative twin study on the genetic aspects of male homosexuality", *J. nerv. ment. Dis.*, **115**, 283–297.

KINSEY, A. C., POMEROY, W. B., and MARTIN, C. E. (1948). *Sexual Behaviour in the Human Male*. London.

LANG, T. (1940). "Studies on the genetic determination of homosexuality", *J. nerv. ment. Dis.*, **92**, 55–64.

PRICE, F. W. (1950). *Textbook of the Practice of Medicine*. London.

SLATER, E. (1962). "Birth order and maternal age of homosexuals", *Lancet*, *i*, 69–71.

STRECHER, E. Q. (1946). *Their Mothers' Sons*. Philadelphia.

P. J. O'Connor, O.B.E., M.D., F.R.C.P.E., D.P.M., *Consultant in Neuropsychiatry, Royal Air Force*