THE INCIDENCE AND RELATIONSHIP OF HOMOSEXUAL AND PARANOID FEATURES IN SCHIZOPHRENIA

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THROUGH the interpretation of certain features of the schizophrenic process, psychoanalytic theory links homosexuality and paranoid schizophrenia. This theoretical link derives from a concept of the dynamic development of the individual constructed from observations about individual cases rather than from any knowledge of the frequency of the linkage in the population of schizophrenic patients.

In spite of widespread acceptance, the traditional Freudian interpretation of paranoia has not remained unchallenged. In such standard texts as Henderson and Gillespie (8, p. 381), it is stated: "We do not believe that homosexuality in the etiology of paranoia is so widespread or so specific as the psychoanalytic school would have us believe." Mayer-Gross (16) also minimizes the role of homosexuality in paranoid schizophrenia, and Arieti (1, p. 141) observes that paranoid cases " . . . show an uncertainty about their own sexuality and a general sexual maladjustment rather than a clear-cut homosexual pattern".

Of the few actual clinical studies reported, some suggest a connection between homosexuality and paranoia, while others fail to find evidence of such an association. In comparison with a control group of normals, Chapman and Reese (3) found significantly more homosexual signs on the Rorschach test in acutely disturbed schizophrenics. However, three psychotic cases with persecutory delusions produced slightly fewer homosexual signs on the Rorschach than did the remaining three patients with a diagnosis of simple schizophrenia. Norman (17) likewise found homosexual behaviour and homosexual symbolism in both paranoid and catatonic schizophrenic patients, although the incidence was greater among the paranoid group. Zeichner's (23, 24) studies fail to confirm conclusively a relationship between psychosexual identification and paranoia, and furthermore his paranoid group did not differ significantly from the non-paranoid group in their concept of male and female roles as measured by projective test responses.

Salzman (21), after reviewing several cases of paranoia, concluded that ". . . sexual pathology appears to be the least significant issue in the largest number of cases", and Grauer's (7) survey of 24 cases of paranoid schizophrenia revealed only five with homosexual content in their delusions. These findings confirm Kolle's (14) earlier report of his thorough study of 127 typical paranoid cases in which he found only two or three men with definite homosexual problems.

Finally, Klein and Horwitz (13), in an ambitious study of 80 cases diagnosed paranoid state or paranoid schizophrenia, summarized: "The paranoid mechanism cannot be explained solely by homosexual conflict despite the convincing evidence of its pertinence in certain cases."

By contrast, Klaf and Davis (12) compared 150 cases of paranoid schizophrenia with non-psychotic controls and confirmed their hypotheses that the paranoid cases had more actual homosexual experiences, more homosexual preoccupations during their illness, and more delusions and hallucinations of a sexual nature. These comparisons, however, were made with subjects described as neurotics and character disorders; not with non-paranoid psychotics. Aronson (2) found that paranoid patients produce more "homosexual signs" on the Rorschach than do either non-paranoid psychotics or normals, although signs of disturbance in the sexual area were prominent within both psychotic groups.

The discrepancies suggested by these findings, as well as our clinical observations of acutely disturbed schizophrenic patients, led us to a study of the meaning of homosexuality in the schizophrenic syndrome. Our approach was to study all kinds of homosexual features in schizophrenic patients, irrespective of clinical subtypes. To avoid another source of bias, systematic observation was made of the occurrence of all types of sexual difficulties and concerns which were conspicuous in the life of the subjects. Thus homosexuality was studied as just another facet of maladjustment in the sexual area.

The Sample

A sample of 150 male patients with functional psychosis was drawn from the resident population of a building routinely accommodating suicidal and assaultive patients in a 1,600-bed VA Hospital. In addition, all consecutive new admissions and inter-ward transfers to this unit for five months were included to obtain the present sample size. Most of the transfers had been considered suicidal risks or management problems on other units. These patients were acutely disturbed, either in the early phase of schizophrenia or during a sudden relapse. Although requiring considerable nursing attention because of exaggerated affective display, this group did not appear to produce symptoms which differed qualitatively from those of other patients in the hospital. Agitated patients are especially suitable subjects for this type of investigation since they are brought to the ward in a decompensated state, acutely fearful and hallucinating. In this state of accentuated personality disintegration, they reveal thoughts and feelings which remain hidden during their quiet periods. All patients carried a staff diagnosis of some form of schizophrenia, although seven cases had once been considered manic-depressive, paranoid, or involutional psychosis. Cases of psychoneurosis, character disorder, and organic brain damage were excluded. The ages ranged from 23 to 59 years and averaged 36·9 years. At the time of tabulation, 96 patients (64 per cent.) had never married and of the 54 (36 per cent.), who had once been married, 19 now were divorced, or separated, or had had their marriage annulled. The sample is probably typical of a VA Hospital population on a disturbed ward. The study was not conducted in a special research setting but was a by-product of daily service work.

Procedure

Data were gathered by thorough examination of the current hospital clinical records, nurses' notes, social services' and psychological records. In addition, since our patients are veterans, all past hospital records were available in VA "Claims Folders". Thus medical data were found pertaining to psychiatric problems beginning with the patients' entry into service up to the present, including summaries of all service hospitalizations and frequently including

state hospital data. Descriptions of these patients in original longhand notes by resident physicians and nurses were especially helpful, since they provided direct clinical observations made in the initial phase of psychosis.

Information was summarized on 5 x 8 cards under the following categories:

1. Heterosexual symptoms associated with psychosis.
2. Actual homosexual experiences.
3. Homosexuality expressed in psychosis, e.g., in delusions, hallucinations, obsessions.
4. Sexual difficulties stated in psychological test reports.
5. Direct (non-symbolic) statements of problems of personal identity.

A list of symptoms widely recognized as diagnostic of paranoid schizophrenia was printed on the reverse of the cards and evidence of these features was recorded to estimate the "degree of paranoidness" in each case:

1. Ideas of reference or influence.
2. Delusions of persecution.
3. Aggressive, hostile, attacking behaviour—patient not meek or passive.
4. Delusions of grandeur.
5. Rigidity in everyday personality; suspicious-evasive.
6. Persistent use of adjustment mechanisms such as projection, denial, intellectualization.
7. Slow rate of deterioration.
8. Psychotic thinking presented in a logical, systematized and pervasive manner.

In each case, an estimate of the "degree of paranoidness" was made by global impression of the material and later by counting the number of symptoms. This was done without the knowledge of the patient's name or sexual history listed on the reverse of the cards.

After a thorough evaluation, it appeared logical to divide the total patient sample into four degrees of paranoidness categories as follows: (*i*) No trace of paranoid symptoms; (*ii*) One or two symptoms, usually transient and not reinforcing each other; (*iii*) Three or more symptoms forming a fairly complete picture of paranoid schizophrenia—probably any psychiatric group would concur in diagnosis; and (*iv*) Unmistakable paranoid syndrome, well-organized, systematized, persistent; paranoid features overshadowed the evidence of schizophrenia in these patients. Apparently the mere number of symptoms present greatly influenced our assignment to these categories, since a contingency coefficient of ·74 was found between number of symptoms and judgment category.

RESULTS

A summary of the incidence of all sexual difficulties found in the total sample is presented in Table I. Cases in which the authors did the complete diagnostic study were tabulated separately from those worked up by others. The essential identity of the results indicates that the investigators' special interest did not cause a bias in their observations of the features tabulated.

TABLE I

Incidence of Sexual Problems in a sample of 150 Hospitalized Schizophrenic Men

	Total n	Case Work-up by Authors (n=76)	Case Work-up done elsewhere (n=74)	Total Incidence
Heterosexual problems in psychosis	150	56 (74%)	52 (70%)	108 (72%)
Recorded homosexual experiences	150	20 (26%)	16 (22%)	36 (24%)
Homosexual concern in active psychosis	150	39 (51%)	38 (51%)	77 (51%)
Sexual problems revealed on psychological tests	124	(n=68) 33 (49%)	(n=56) 22 (39%)	55 (44%)
Direct expression of confusion of sexual identity	150	11 (15%)	11 (15%)	22 (15%)

Heterosexual Problems in Psychosis

Confirming a widely-held clinical impression, 108 patients or 72 per cent. of the sample demonstrated noticeable difficulties in heterosexual behaviour. Tabulations within this category, as well as with some to follow, include patients under more than one sub-heading, thus percentages will not total 100 per cent.

Within this category 40 per cent were noted as being shy, reticent, bashful, and seemingly lacking in any interest in the opposite sex. Feelings of sexual impotence or of being sexually unworthy were expressed by 28 per cent. of the group. For example, one veteran severely beat his sister who he thought put saltpetre in his food to reduce his sexual power.

Unusual delusions concerning sexual practices, including obsessions about actual or fantasied incest, were reported by 20 per cent. of the group: to illustrate, one man who advocated incest and bestiality complained that he could not hold a girl friend in Greenwich Village since, ". . . the lesbians got all the stray girls". Another young man felt the Devil drained him of his sexual drive, and yet another exposed himself to his mother and made sexual advances towards her. At the onset of psychosis, a Catholic patient who believed his co-workers called him a hermaphrodite was in a panic state, believing he had sexually attacked the "Blessed Mother". Often these psychotic experiences were stated without obvious signs of personal involvement, and the patients gave the impression that their difficulties were simply demonstrations of perplexity and perceptual distortions accompanying their psychosis.

Bodily delusions with a sexual content were expressed by 14 per cent. of the group. For example, "They're having sex relations with me by electricity . . . I have a broken nature string. . . . There's no nature in my body." One man held the delusion that he had a vagina growing inside his throat; later he tied a rubber band around his penis, ". . . . to keep my insides from leaking out". Castration fantasies more clearly stated were also included in this sub-category, e.g., feelings of penis drying up, and biological sterility. Concern with genitalia is illustrated by the case of a young veteran who claimed his earliest memory was of an aunt making fun of the large size of his penis while his mother changed his diapers. He later clipped the frenum of his prepuce in a self-mutilation gesture when his wife did not take him immediately to a physician for circumcision.

Other sub-categories of less frequency were: (1) delusions of distant lovers, inaccessible either psychologically or geographically; (2) guilt about past heterosexual behaviour; (3) sexual overactivity as proof of masculinity; and (4) acting-out of oedipal problems by actually living with, or marrying a woman old enough to be the patient's mother.

Recorded Homosexual Experiences

In thirty-six cases (24 per cent.) of the total sample mention was made of actual adult homosexual experiences; childhood and adolescent experiences before age 15 were not included. Of the 36 patients, 11 assumed active roles, 11 passive, 5 both roles, and in 9 instances homosexual behaviour stated in earlier reports was not well described. The majority of these experiences (two-thirds) occurred outside a hospital setting and most of the cases were reported as isolated, accidental relationships—being picked up by habitual, non-psychotic homosexuals. Four patients were intoxicated; only one instance resulted in police arrest.

Except for three patients who could easily be considered habitual overt homosexuals, the bulk of the cases had reportedly only one, or very few homosexual experiences, and these occurred when they were frankly psychotic. Only in four cases of the 36 did the homosexual behaviour persist over several years time, and in these it was almost a compulsive feature. These men had not been habitually homosexual in their pre-psychotic life.

Homosexual Concern in Active Psychosis

Patients were included in this category when there was definite mention of any form of homosexual concern, from mere repeated affectless utterances to the horror of a homosexual panic. All of the instances tabulated occurred while the patients were psychotic, and the homosexual concern was stated by them explicitly, generally in the vernacular and not just in symbolic terms.

Although homosexual problems are frequently observed in daily work with schizophrenics, the large percentage found (51 per cent.) is still surprising. The most frequently encountered feature within this category was in the context of auditory hallucinations. Of the 77 patients having difficulties of some sort in this area, 33 (43 per cent.) reported hearing voices accusing them of being a queer, fairy, or homosexual. For example: "Voices call me a flute player . . . I'm a c.s., why don't you castrate me!", or "Voices are coming from upstairs, they're calling me a fairy and a queer!" An exceptional experience was mentioned by a man who had a visual hallucination, as he looked into his watch crystal, of seeing himself performing homosexual acts.

Twenty of the patients (26 per cent.), reported delusions that other people accused them to their face of homosexual behaviour or called them a homosexual. For example: "The FBI thinks I'm a queer", "I'm a homo because my mother told me so", or "The younger men (in the Army) made faces at me and called me a homo." Another veteran who imagined his father called him a queer, became enraged, assaulted and choked him. The term "queer" in every instance was found upon inquiry not to mean simply odd or unusual, but definitely homosexual.

Many patients (23 per cent.) complained of being teased or sexually stimulated by other men, e.g., patients, co-workers, etc. For example, one man was careful not to borrow cigarettes: "They may want me to perform fellatio on them." Another man felt that patients walked past him nude to tempt him sexually, and feared that, ". . . men might grab me and force me

to go down on them." A few patients were directly observed by the nursing staff making homosexual advances to other patients or personnel.

Possibly as part of the schizophrenic's ruminations, the more verbal, self-doubting and intellectualizing patients expressed serious concern about being a "potential homosexual". These patients (20 per cent.) scrutinized their everyday behaviour for signs of effeminacy and questioned their masculinity with neurotic-like persistence: "My girl friend called me a queer when I wouldn't sleep with her", or "I may be a homosexual, I was too fond of my father." In fact, one man who cut his wrists, when asked for an explanation blandly replied: "I'm a potential homosexual." Several other men who attempted suicide later revealed that the belief that they were homosexual prompted this action. Simply the fear of possibly becoming homosexual was enough to drive them to suicide.

True homosexual panic, when defined as anticipation of imminent homosexual attack accompanied by hallucinations, profuse palmar sweating, running around the ward, screaming for protection, and the like, was recorded in the past or directly observed during the current hospitalization in only eight cases. In addition, four men exhibited behaviour which seemed to be a "panic in reverse", that is, they sexually approached other patients in an uncontrolled, impulsive fashion as though compelled by voices or delusions. One such man, remarking about his homosexual practices, said: "It's the only way I can get along with my friends and remain on an even keel. This is one of the ways to be humble. You have to serve other people and therefore I have to lower myself."

Less frequently encountered types of behaviour included: delusions or thoughts of homosexual attack while under sedation or sleep, obsession of being homosexual by default due to heterosexual impotence, and ideas of being influenced to perform homosexual acts. "Somebody put something in my coffee to make me a homosexual—now I have to turn to being a c.s.". Only five patients clearly had guilt feelings over past homosexual behaviour of any kind. One very unusual statement of fantasied guilt feelings referred to homosexual relations with an 11 month old brother when the patient was two.

It is striking that the specific nature of homosexual concerns as stated by the patients during exacerbations of their illness was almost identical with the content presented at the onset of psychosis before their first hospitalization. Since these homosexual ideas were expressed either outside the hospital or during initial hospital interviews, sexual segregation in veterans hospitals does not seem responsible for the emergence of these concerns.

Sexual Problems Revealed on Psychological Tests

All psychological test reports (not original test protocols) available were read for mention of actual sexual problems, including homosexuality, concern with masculinity, and difficulties in sexual identification. Test reports on 124 of the 150 cases were available. In 55 (44 per cent.) of these patients, explicit mention was made of these three features. Homosexual fears or homosexual tendencies were reported in 21 cases; 14 patients had problems of assuming a male role or were concerned with sexual adequacy; and 20 patients were considered to have a confused sexual identity or to have strongly identified with female figures.

Direct Expression of Confusion of Sexual Identity

From patient interviews of various sorts, 15 per cent. (22 cases) reported doubts concerning their sexual identity. For an additional 13 per cent. of the

total sample definite signs of confusion of sexual role were mentioned in psychological test reports. Most of the former group expressed direct concern about being really men or masculine in a sexual sense—seven men even fantasied that they were women or had become pregnant and borne children, reminiscent of the Schreber case (5, 15). One of these seven men, diagnosed catatonic, actively solicited sexual attention from other male patients claiming he was indeed a woman. Another man, overtly homosexual and diagnosed chronic undifferentiated schizophrenia, displayed feminine mannerisms, wore lipstick, kissed docile patients, and asked repeatedly to be excused from recreational activities in consideration of his menstrual periods. Once during his hospital stay he assumed the role of an expectant mother—later he remained in bed, and groaned in labour for two days until the imaginary birth of his 9 lb. baby boy. Sexual confusion was expressed in the context of bodily delusions by one man alternately diagnosed as catatonic or hebephrenic. He complained that he was circumcised too early in life, that he had "an aperture as in females, but mine is only one or two inches deep", and that as the result of being the passive partner in rectal intercourse while in the service, he had become pregnant and had borne a baby boy. "My body feels like a woman's body—I have funny sensations". His goal in life was: ". . . . to be a male nurse and work with the female nurses". Feelings of sexual impotence accompanied the expression of confusion of identity in one man who resolved this through imaginary x-ray treatments given "long distance" by his mother. He felt that he was impotent, that his penis was becoming smaller, and that consequently he was changing into a woman. The fantasied x-ray treatments from mother arrested the process and he was able to salvage some of his masculinity.

More regressed, dull, and less verbally articulate patients were more simple and primitive in their exclamations: "I have a baby in my veins", "I think I'm in a family way", and "I have a woman in my stomach". Only one of these seven schizophrenic men had ever been diagnosed paranoid at any time throughout the course of their psychoses. The other six had variously been considered cases of hebephrenic, catatonic, or unclassified schizophrenia. Their records reveal very few signs of paranoia—all had been placed in categories I or II as to degree of paranoidness in this study.

Representing even greater distortion of self-image, or simply poorer reality testing, or perhaps distorted communication, were the doubts expressed by four patients that they were still within the species: "I am a wolf-man", "a crab", "a candy bar", and "a sparrow".

By inspection of Table II, it appears that no clear relationship exists between sexual difficulties and the degree of paranoidness within our sample of schizophrenic patients. Likewise no relationship appears between homosexual concerns or homosexual behaviour and degree of paranoidness. Chi square tests certainly show no significant relationships and corroborate the impression that homosexual problems and paranoid symptoms occur independently of each other in schizophrenia. Cases with recorded homosexual experiences have fewer paranoid signs, but not significantly so ($p = < \cdot 10 > \cdot 05$). When categories I plus II are compared with categories III plus IV, the differences are significant when evaluated by Chi square ($p = < \cdot 05 > \cdot 02$). Since no other data tabulated are affected by degree of paranoia, we are not inclined to place special significance upon this finding. Possibly the more paranoid men are more intact intellectually and simply do not admit past homosexual behaviour in interviews.

TABLE II

Summary of Data Showing Relationship between Sexual Problems and Degree of Paranoia

Degree of paranoia	n	Heterosexual problems in psychosis		Recorded homosexual experiences		Homosexual concern in active psychosis	
		Present	Absent	Present	Absent	Present	Absent
I	43	28	15	13	30	20	23
II	86	66	20	22	64	47	39
III	15	9	6	0	15	7	8
IV	6	5	1	1	5	3	3
Chi Square Test*		$\chi^2=1\cdot51$ df=2 $p=<\cdot50>\cdot30$		$\chi^2=5\cdot24$ df=2 $p=<\cdot10>\cdot05$		$\chi^2=\cdot97$ df=2 $p=<\cdot70>\cdot50$	

*Since the expected values in groups III and IV were small, these categories were combined in calculating the Chi Squares.

Since psychiatric staff diagnoses are often used as reference criteria, the relationship between homosexual concerns in psychosis and staff diagnosis of paranoid schizophrenia, made at any time, was examined. Within the total sample, 77 patients were at one time diagnosed as paranoid schizophrenia; 45 of these had homosexual concerns, 32 had none. Of the 73 patients not considered paranoid, 32 had homosexual concerns; 41 had none. Chi square test revealed no significant relationship here: $x=2\cdot68$, $\chi^2=<20>\cdot10$.

The features describing degree of paranoidness are listed below, showing the frequency of their occurrence within the entire sample:

	Per cent.
1. Ideas of reference or influence	80
2. Delusions of persecution	78
3. Aggressive, hostile, attacking behaviour—patient not meek or passive	54
4. Delusions of grandeur	25
5. Rigidity in everyday personality; suspicious, evasive ...	23
6. Persistent use of adjustment mechanisms such as projection, denial, intellectualization	18
7. Slow rate of deterioration	7
8. Psychotic thinking presented in a logical, systematized, and pervasive manner	5

Interestingly, ideas of reference and delusions of persecution, although generally accepted as features diagnostic of paranoid schizophrenia, were found in over three-fourths of the entire schizophrenic sample. Considering the paranoid features as a whole, Guttman's (4) scaling procedure was followed to determine whether the items might form a scale for use in diagnostic evaluation. The 86 per cent. level of reproducibility found does not meet the usual criteria of an adequate scale, but is perhaps worthy of further consideration.

As additional normative data, age of onset of psychosis was tabulated according to degree of paranoidness; categories I and II were compared with III and IV. The date of first psychotic diagnosis was arbitrarily chosen as time of onset of psychosis. An average age of 26·02 years was found for the total sample, with 25·00 years for categories I and II combined, and 32·29 years

for III and IV. The difference of 7·29 years suggesting later onset of psychosis in those patients displaying more paranoid features is statistically significant ($p=<\cdot001$) using Fisher's t test. This finding is not surprising since it is generally accepted that paranoid schizophrenia emerges later in life than do other types of schizophrenia. We may conclude that this finding gives additional support to the validity of our measure of paranoidness and judgments made as to category placement.

The relationship between degree of paranoidness and marital status was also investigated. A larger proportion of men with more paranoid symptoms were found to have been married, but the difference from men with fewer paranoid symptoms was not significant ($\chi^2=4\cdot94$, df=3, $p=<\cdot20>\cdot10$).

Discussion

Surprisingly high rates of incidence of homosexual features were found in our review of the course of mental illness in our patients. In spite of very thorough ascertainment, these rates were undoubtedly reduced both by concealment of information by patients and relatives and by lack of exhaustive inquiry or incomplete recording of homosexual material by observers. Yet at least half of our patients made clear, non-symbolic statements of homosexual concern—a much higher proportion than we would anticipate from general psychiatric practice e.g., one including neurotics and other non-psychotic patients. To support the original Freudian tenet, the homosexual concerns should be generated by true genital homosexuality. We would then expect that there should be a larger percentage of habitual homosexuals in our sample than in the general population.

However, the 2 per cent. incidence of habitual homosexuality (3 men out of 150), seems not to be grossly different from Kinsey's (11) finding that 4 per cent. of white males are exclusively homosexual throughout their lives, and Hirschfeld's data (9, 10) showing between 1·5 per cent. and 2·3 per cent. of active homosexuals within normal populations. According to these data our sample does not differ from normal populations in the incidence of homosexuality. They support the conclusion that habitual homosexuality is unrelated to psychosis rather than being an integral part of it.

It is not surprising that the incidence of actual homosexual experiences (occasional, non-habitual) were somewhat higher among psychotic men. More passive than normals, seeking any possible relationship on the one hand and abnegation on the other, they are more likely targets of habitual homosexuals' attention than average men of comparable age. No data for this comparison are available. Among psychotic groups, Klaf and Davis (12) found that 26·7 per cent. of their paranoids had homosexual experiences, which is roughly comparable to our finding of 24 per cent. for the entire sample. Interestingly, they report that 41·8 per cent. of their paranoid patients had homosexual preoccupations during psychosis, comparing well with the 48 per cent. (10 of 21) among paranoid patients (Groups III plus IV) found in our sample.

The thesis that the homosexual features of psychosis are not true genital homosexuality is supported by a consideration of patients' productions, their behaviour, and the reports and complaints of relatives and friends. The patients' troubles are almost without exception only secondarily sexual. A multitude of erroneous perceptions, improper decisions, losses in emotional control, and habits which make living together miserable are reported by relatives of acutely ill patients. These men have been equally unacceptable to wives, close

relatives, and friends because of their general ineptness, and inability to function as husband, provider, son, brother, father, companion, or neighbour. Sexual ineffectiveness appears to be simply another area of improper or inadequate functioning.

Ovesey (18, 19, 20) and Szasz (22) consider that a strict genital interpretation of homosexuality in schizophrenia is unnecessary. Certainly the non-genital aspects of the homosexual concerns in our patients are conspicuous. In nearly every case, homosexual material was produced when the patient was actively psychotic, either in the initial phase of schizophrenia, or upon readmission during an exacerbation of symptoms. Thus it is tempting to view the homosexual concerns as symptomatic of acute psychosis, best understood within the framework of general psychotic manifestations. The bizarre form in which such concerns are often presented only confirms the impression that we are probably dealing with ongoing products of psychotic distortion.

The perplexity which so typically accompanies homosexual preoccupation reveals that patients perceive their alleged homosexuality as something alien; as if something unwanted, undesirable, and above all, not under their control was happening to them. In fact, they continuously disclaim that homosexuality reflects their true selves. Perhaps most striking is the fear that accompanies patients' expressions of homosexual content in the hospital. At times, this fear reaches the intensity of panic; yet aggression is often a more prominent feature than homosexuality in these "homosexual panic" states (6). From our observations of such distressed patients on the ward these panic phenonema might be more accurately described as *schizophrenic* panics.

Since the homosexual concern in schizophrenics seems to be essentially of a non-genital nature, the origin and formal explanation could be sought in the effects of the psychotic process itself. One might speculate, for instance, that the effects of the psychosis—loss of ego functions, accompanied by perceptual distortions—result also in a loss of perception of the self, both physically and psychologically. The unaccountable, alien bodily sensations experienced by the acutely psychotic man, together with lessened self-awareness as a person of a sexual male, may contribute to the emergence of temporary, but serious homosexual concerns.

Even without a formal doctrine concerning the impaired awareness of the self or blurred identity, the globally incapacitating aspects of acute schizophrenia accompanied by diffuse impotence, both physical and mental, and the disintegration of emotional, intellectual, and motor control may find distorted expression in statements revealing simply painful discomfort. There is not yet sufficient evidence to link it with definite content. In fact, in the extreme, one may extrapolate to the nihilistic states of advanced schizophrenic disintegration: in anguish, the patient fears he is displaced from common masculine roles: "I am not a man, I must be a homo", and finally: "I guess I'm nobody."

Nearly all of our patients felt at one time during their illness that they were being watched or talked about, or that people were against them. Apparently a transition can be visualized from ordinary, initial feelings of self-reference to true delusions. In the beginning stages, the patient communicates that he feels differently than during times of good health, and takes note that he also differs from his peers. At this stage the feelings of bodily discomfort or loss of control are expressed as ideas of influence. These features seem not to be igns of the true paranoid state and should not be used as decisive diagnostic criteria of paranoid schizophrenia.

The crucial finding of this investigation is a decided lack of relationship between homosexuality and paranoidness. This was found whether only administrative diagnoses or our own more refined measures were used. In our sample, homosexuality was found to be associated with paranoid development neither to a greater nor to a lesser extent than it is with schizophrenia in general. Moreover, difficulties and concerns in both the heterosexual and homosexual areas appear to be equally distributed in all types of schizophrenia. An ontogenetic clarification of the relationship between paranoia and homosexuality is beyond the range of the present investigation, the scope of which has been essentially normative. However, our tabulations support a preference for considering the two features as developmentally independent of each other.

Summary

1. The incidence of heterosexual problems, homosexual concerns in active psychosis, and actual homosexual behaviour was obtained in a sample of 150 hospitalized male schizophrenics.

2. From clinical observations and all written information available, symptoms of paranoia were recorded and assessed in each case. Four categories of degree of paranoidness were differentiated.

3. The relationships between these paranoidness categories and the heterosexual and homosexual behavourial features were then evaluated.

4. No significant relationship was found between degree of paranoidness and, (*a*) heterosexual problems in psychosis, (*b*) homosexual concerns in psychosis.

5. Homosexual concerns occurred in one-half of our total sample of patients, and were essentially non-genital in expression.

6. It is concluded that paranoid development and homosexuality as found in schizophrenia are not specifically related to each other.

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