BOYHOOD GENDER ABERRATIONS: TREATMENT ISSUES

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IT IS REALLY SURPRISING—I do not know why it happened—that homosexuality (meaning herein erotic preference for a same-sexed person) has not been discussed more in the analytic literature. Even since Socarides (1968) noted this, the subject has not stirred much new thinking. Fortunately, we already have good theory and data, thanks especially to Bieber et al. (1962) and Socarides (1968), who, from different perspectives, carried forward, as had never previously been done, Freud's great studies on the origins of homosexuality in childhood. Bieber et al. stressed especially the flawed masculinity of boyhood that results from anxiety-provoking closeness with mother and the conviction that a masculine, effective father's presence prevents a homosexual outcome, while Socarides has pointed to disturbances in earliest childhood, in the boy's efforts toward separation and individuation.

Their invaluable findings, drawn from adults, should, however, be supplemented by observations from children. Only then shall we know if childhood experiences that adults report or relive in the transference are specific in causing homosexuality:[1] are these also actually found in children who,

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[1] Perhaps more accurately, "the homosexualities"; there seem to be a number of syndromes with different dynamics and causes.

when followed to adulthood, grow up homosexual? But this requires research only begun; we shall have to see if children with the same target experiences already described by the adults really become homosexual, or if some children with these same experiences do not, or if some with quite different experiences nonetheless do become homosexual.

How shall we know in advance which boys to choose for our study? The markers in childhood that may distinguish those who will become homosexual from a control group are gathered from the analyses of adults and are not always stated in terms that translate into observable behavior. If it is said, for instance, that someone is orally fixated—and if oral fixation is intended as an essential etiologic force in homosexuality—the exact nature of that oral fixation must be described or else I may only remember that "oral fixation" has been offered as an etiological agent in every condition ever observed in humans.

The Bieber research, although on adults and adolescents, points to factors in boys that may lead to adult aberrations. It suggests that we look for a mother who reacted to her son's budding masculinity and heterosexuality with both seduction and threats, a father who is emotionally detached, either in being withdrawn or overly hostile; and a shy, clumsy boy, fearful of physical injury, who avoids competitive sports and prefers to play with girls.

Green (1974, pp. 243-244) reviews the surprisingly limited research on feminine boys studied as they were growing up:

> John Money and I recently conducted assessments of five young adult males we initially studied (but did not treat) twelve to fifteen years ago. As young boys they had been very feminine. Three are now clearly homosexual. A fourth, who refuses to return for an interview, is reported by his family to collect photographs of nude males. A fifth has had a heterosexual affair but about one-third of his masturbatory fantasies are occupied by memories of

male-male oral-genital experiences during early adolescence. Additionally . . . first, he purchased a bikini-cut, rayon pair of men's underpants. To his surprise, trying them on and viewing himself in a mirror produced an erection. He had not cross-dressed since age six. Second, he was invited to the apartment of a male neighbor who asked, "Would you like a blow-job?" He found the sexual experience exhilarating and reports a compelling, but conflicted, drive to continue the relationship. Zuger (1966) has evaluated six adolescent and young adult males seen previously during childhood for feminine behavior. He found that three were homosexually oriented and a fourth possibly transsexual. Finally, Lebovitz (1972) has found that of 16 previously feminine boys, three are now transsexual, two are homosexual, and one a transvestite.

In another study, Green (1974) compares feminine boys to controls and shows that the feminine boys significantly differ from the controls and in just those factors Bieber et al. found in the boyhood of homosexuals.

The relationship between femininity and male homosexuality has been known for thousands of years, so those of us working on this subject are probably only tightening the fit of this observation. Here is the hypothesis, updated: the more feminine a boy, the more likely will he desire someone of the same sex, the earlier will overt homosexuality begin, and the less likely either the femininity or the homosexuality can be reversed by psychoanalysis.

Evaluation of Boyhood Femininity

I shall use "feminine behavior" and "femininity" herein to mean manifestations of a wish to be (like) a girl or woman. This implies some form of identification. Unless stated, I shall not be separating out degrees of identification, those aspects of

females (e.g., clothes, anatomy, procreation) with which one identifies, or how much hostility is mixed in with the identification (as in caricature). The problem is that there is no generic term to cover such disparate states as natural-appearing behavior (for which "femininity" is correct), mimicry (which one does not call "femininity"), fetishistic cross-dressing in an otherwise masculine-appearing man, or an isolated bit of identification with women (e.g., an obstetrician's pleasure in delivering babies) in a comfortably masculine man.

Since femininity in boys can lead to adult homosexuality, we need to know how to find those at risk. When should we be concerned and what outcomes can we expect; what is the differential diagnosis? Let us ignore, for simplicity, mixed types. We need to distinguish boys who will grow up to manifest any of several states, aspects of which at one time or another have been labeled homosexuality, in which some sort of femininity may be found: the intersexed (biological bisexuality), paranoid psychotics, transsexuals, "transsexuals,"[2] future transvestites, future homosexuals, and those who will develop no gross cross-gender behavior. But we cannot yet. What is possible? I shall not review here what is known about the origins of femininity in males (Stoller, 1975a), but can simply state that, except in the rarest cases when there are

[2] The informed reader will be puzzled if issues in nomenclature are not noted here. Several different sorts of people have been called transsexuals besides those few for whom I have used the term. The classification of Person and Ovesey (1974 a,b) comes closest to my experience. Their primary and secondary transsexuals are clinical entities to me also; however, I have not labeled these patients transsexuals but rather have restricted that term to those who have been feminine since any gender behavior has appeared (as early as a year or so), whose femininity is natural-appearing and uninterrupted, and who have never in their lives—even for a moment—felt or looked masculine. In the past, I have called Person and Ovesey's transsexuals "mixed group," to be distinguished by certain descriptive and dynamic factors from those more feminine males I called transsexuals. In this present discussion, those patients they call primary and secondary transsexuals shall be called quote transsexual unquote. This does not indicate that such patients are less genuine, but is simply a stopgap device used until these problems in classification are resolved.

biological *Anlagen* and in those who will be psychotic—not to be further discussed—most[3] feminine boys result from a mother who, whether with benign or malignant intent, is too protective, and a father who either is brutal or absent (literally or psychologically).

Let me categorize male femininity in two ways. The first, very rare, is natural-appearing, usually starting in the first year or so of life, and promoted primarily by a mother-infant symbiosis in which the mother's avowed purpose is to prevent her son from suffering pain or frustration. She tries to create a blissful ambiance. At the same time, the boy's father is not present to drive a wedge that would promote separation between the mother and infant and allow that individuation we call masculinity to occur. This family dynamic produces the most feminine of boys, the childhood transsexual, in whom one does not find the amount or kind of pain and frustration necessary for ordinary psychic development.

The second category includes the homosexualities, transvestism, and most of those who call themselves transsexuals. These conditions, much more common and not looking like ordinary femininity, occur in boys whose earliest development, however disturbed, allowed some commitment to being a male and to being masculine, because some separation from their mother's bodies and psyches has occurred. At the same time, such a boy's sense of self as a male and as masculine is being threatened, as, for instance, with a mother insulted by her son's budding masculinity. The result is signified in the term "castration anxiety,"[4] the precursor of such gender perversions as transvestism (fetishistic cross-dressing) and effeminate homosexuality. Contrasted with the first form, the

[3] An exception is the primary transsexual described by Person and Ovesey (1974a, b). I think some masculine-acting homosexuals are another.

[4] Though some of us think the anxiety is due not just to threat to one's genitals but, more primordial, threat to one's being, sense of existing, as is implied in "separation anxiety" (Person and Ovesey, 1974a, b; Socarides, 1968; Stoller, 1975b).

main quality here is intrapsychic conflict. The conflicts to be stressed for our present purpose are between wanting to be merged with or at least close to mother and wanting to be separate; between wanting to be like and to be different from her; between wanting to stay (to be passive) and to move (to be active). Milder versions of these conflicts lead, I think, to milder disorders: perverse tendencies in the average citizen, the innumerable defensive forms of masculinity, or perhaps even that odd hypothetical: "normal" masculinity (Stoller, 1975b).

The difference between the two forms of femininity can be found (1) clinically: the first, boyhood transsexualism, is a natural-appearing femininity, the other, which I think most often leads to homosexuality, is not; (2) dynamically: the first is not motivated continuously by rage, revenge, and other defenses, the other is; (3) etiologically: the first is the product of a mother's wish for eternal oneness with her son, the other of mother's (or her surrogates') hatred and blackmail of the boy (Bieber et al., 1962; Stoller, 1975a).

Both types can be treated in boys, probably only the second in adults (Stoller, 1975a); I think the approaches to the two forms should be rather different. The neurotic structures, as in transvestism and homosexuality, are best approached by the classical techniques of uncovering, interpretation, and the resolution of conflict via insight. But such an approach fails, I believe, in treating the comfortable, natural-appearing femininity of the transsexual child. (There are children with aspects of both the conflictless femininity and the neurotic, hostility-containing uses of feminine identification; in these children, both treatment approaches should be intermingled.)

Evaluation can tell one who needs treatment and if so, of what sort. Manifestations of femininity are common (e.g., Boehm, 1930; Freud, 1905) and most are insignificant. Which are not? The main criterion is intensity. How much does the boy want to be feminine: how often does he express the desire;

how persistently, especially in the face of efforts by others to stop it; how much does it seem part of his being and not just imitated? Let me sketch some of the findings of our research team (Green, 1974; Greenson, 1966, 1968; Stoller, 1975a).

Perhaps the most serious sign is a boy's clear-cut public statement—to members of his family or to others— that he is really a girl (or female), will grow up to be a woman (or female), or is seeking help to become a girl (or female). (Adding "female" indicates that at times the desire is expressed in anatomical terms.) The most pronounced expression is "I *am* a girl," the lesser "I *shall* become a girl," and still less "I *want* to become a girl."

Other criteria, growing out of the first, are: desire to wear girls' clothes, to play girls' games, and to have unremarkably feminine mannerisms. In regard to clothes, the prognosis is poorer if the boy wants to wear them all the time, fashions them himself if they are not readily available, uses other adornments like jewelry, has good taste, looks like a girl in them, puts them on spontaneously the first time rather than having them put on him by someone else, and is never sexually excited by them. A hunch: a little boy who enjoys the texture of cloth (not just women's apparel) is at risk for gender aberration (if his father is not a tailor).

Regarding games, the prognosis is poorer if he spontaneously requests that he play with girls; if he wishes to play exclusively with girls in girls' games; if he chooses a female role; if he is accepted by the girls; if he loves to play with dolls, especially female ones; if he does not choose to play with boys in boys' games; and if he plays creatively, such as by inventing new games or story-lines for games.

The next is feminine mannerisms, perhaps too complex to describe but easy to observe. If he walks, gestures, carries himself, talks, and otherwise behaves in a naturally feminine manner, does this not for show—not as a performance—but all day and even if punished and scolded, we can fear he is expressing his desire to be a girl. Boys who are gentle, artistic, or

uninterested in sports are likely to develop a gender disorder only if these are present with some of the characteristics just mentioned.

Our research team is convinced that the more the signs I have described are found, the less likely they will pass spontaneously and that these boys should be treated unless one believes femininity in males is a benign state.

Not enough is yet known for us to differentiate accurately the boys who will become transsexuals, "transsexuals," transvestites, or homosexuals; that work will require our following boys as they grow up. The next ideas are therefore only reasonable guesses.

1. If a boy has been feminine from the time that first gender behavior appears (around age one or so) and if he has never had any episodes of spontaneously masculine interests or behavior, he will wish only to be a girl (i.e., he is a transsexual). If, on the other hand, masculine behavior from earliest times is mixed in with strong feminine tendencies, he will defend the masculinity; the resultant clinical picture is a perversion such as homosexuality or transvestism.

2. If his mother has tried to protect him from birth to the present (whatever age that is) from suffering trauma or frustration, that is, if she has tried to create a blissful symbiosis, then the boy will become a transsexual. To the extent that she does not try with the greatest effort to create this ambience, the femininity is less pure. A corollary of this is that the more she adds blackmail and humiliation (especially that aimed at qualities she considers masculine) to overprotection, the less natural-appearing is her son's femininity. Rather, it takes on hostile elements as he responds to and defends himself against her attack; his manner can be summed up as effeminate, that is, a caricature of femininity. The end result of this is likely to be homosexuality. (If her style is purely attack and no seductiveness, I expect to find misogyny, not femininity or effeminacy.)

3. If a boy puts on female clothes or adornments spon-

taneously—i.e., on his own initiative—the first time and regularly thereafter (and this may start as early as age one or so), the outcome is boyhood transsexualism (which by definition implies that at no time will he be sexually aroused by the clothes). In cross-dressing, he indicates he wishes to be and at that moment senses himself to be like a girl. On the other hand, if he cross-dresses for a spectacle—to call attention to himself—if he wishes to do so only intermittently, and if the cross-dressing has a sarcastic quality, it is more probable that he is moving toward homosexuality. And if the first time he is in feminine clothes, they were put on him by a more powerful person (usually female) to humiliate and punish him, he may become a transvestite; that is, he will be a person of otherwise masculine appearance who intermittently puts on women's apparel to arouse himself sexually.

4. If the boy says he wishes to be a girl and by this indicates he wants his genitals changed to female, he will be a transsexual. If he enjoys his genitals and is sexually attracted to females, he will more likely become a transvestite. If he enjoys his genitals and is sexually attracted to males, he will probably become a homosexual.

5. In no case, regardless of diagnosis, will the boy's father be a masculine man attached to his family and in a loving relationship with this son. The transsexual's father will be physically absent almost all the time, but psychologically present in that he is constantly offered as a model of failure. Such a father is sometimes also found in families of homosexuals-to-be and transvestites-to-be, but less consistently.

6. Homosexual and transvestite boys are latent heterosexuals; no matter how flawed the processes of separation and individuation, they have developed some sense of self as a male, as one who desires females, as one who senses himself a separate person from his mother, and therefore as one who would like to possess her if she (and his father) did not make it too dangerous. In other words, however fragmented and primitive, an oedipal conflict develops. None of this, on the

other hand, appears in the transsexual boy's situation.[5] I shall discuss this at greater length in a moment.

7. The core gender identity—the sense of which sex one belongs to—is male in homosexuals, "transsexuals," and transvestites and female-ish in transsexuals. (By the last, I mean that although transsexual boys know their bodies are male, their inner sense is that somehow they are—should be—females.)[6]

A last thought on this differential diagnosis: as criteria, I mostly use data that can be observed in an evaluation. This is not as naïve as it sounds; although it is more gratifying for an analyst to differentiate people's—children's as well as adults'—behavior on the basis of dynamics and to use exciting concepts like "defusion of instincts" or "archaic cathexes," no one should forget that these have still not been objectified—that is, made visible.[7]

A Disagreement with Classical Theory

Certain theoretical issues can, perhaps, be clarified if we spread out for closer viewing the differences between the two complexes of behavior: femininity and effeminacy. As noted, femininity, whether in males or females, implies natural-

[5] If, as some colleagues theorize, such conflicts occur in his infancy and childhood, they can only be inferred; they have not yet been seen. There is no difficulty, however, in finding frustration, trauma, and intrapsychic conflict in the preoedipal and oedipal phases of those who become homosexuals (Socarides, 1968), transvestites (Stoller, 1975a), or most of those requesting sex changes (Person and Ovesey, 1974a, b; Stoller, 1975a).

[6] Males seeking "sex change" operations typically claim to be females in male bodies, but most reveal male core gender identities; they are not the people I am now discussing.

[7] We need clinical details others can observe if they examine the patient; for instance, "primary identification with mother" is not observable, but effeminacy is; "'intense oral-sadistic relationship with the mother" is not an observation, but constant nagging at her is. (And how much does it take to be "intense" rather than, say, "moderate"?) Can someone teach us how, in the observable world, one detects "incorporative anxieties"?

appearing, ordinary, unexaggerated behavior; manifest hostility, if present, is a contaminant, not an essential. On the other hand, effeminacy implies mimicry; hostility—especially envy and revenge fantasies—has been mixed in with the desires to be like a girl or woman. These clinical differences spring from different sources: one does not find a hostile mother- or father-son relationship in marked boyhood femininity. Neither parent communicates to the boy a stream of behavior he senses as dangerous, harmful, angry; and in return, the boy—during the time his femininity is being first created—is not defending himself from either parent by chronic hostility. On the other hand, the history of effeminate boys reveals overt, easily observed hostile behavior that mother and/or father delivers onto this son, the effects of which can be seen forevermore in the boy's caricature of femininity. In other words, these two categories of behavior, although similar in that they derive from impulses to be like females, are different in that femininity is produced nonconflictually and remains a nonconflictual, autonomous form of behavior, whereas effeminacy is conflict-caused and conflict-perpetuated.

A different perspective—oedipal conflict—can also help clarify these issues. The feminine boys (without treatment), though in an oedipal *situation*, do not suffer an oedipal *conflict*. The following ingredients (which we take so much for granted that we would never imagine them not being present) are necessary for oedipal conflict in boys. The boy must have developed some masculinity: a sense of being a separate person of a different sex from mother rather than primarily a part of her, plus a desire to have her sexually (that is, to return to oneness with her only within the knowledge of being separate from her). Parental contributions to the conflict include frustration by mother of her son's desire to have her, father asserting himself as a threatening rival for mother, and father being available as a model for masculinity. Given these factors, a boy has the opportunity both to yearn for his mother and to

fear the consequences. Perhaps the greatest of these consequences is that a part of his very being—his still-forming masculinity—could be taken from him. This is signaled, in its most concrete form, by castration anxiety, which, we know, is augmented when the boy discovers the anatomical differences between the sexes.

And how does this go on in the very feminine boy? First, he has a profound failure in separating from his mother's body and psyche, so that he does not come to sense himself clearly as a male who wishes to be masculine. From the start and on through the years of childhood, he identifies with his mother rather than needing her as an erotic object (a more advanced stage of development). As Greenson says (1966), the transsexual boy wants to *be* rather than *have* his mother. Second, his father is absent, and his mother has made it unendingly clear she finds this man weak and worthless. Father therefore does not serve as a rival or a danger, even if the boy had wished to displace him sexually with mother. Third, from earliest life on, the boy has experienced no pride in or need for his genitals, no need for maleness: he would hardly be threatened if notified that his maleness was in danger. None, then, of the essential ingredients for oedipal conflict are observed in this situation.

We find further confirmation in the response of these boys to treatment. When the excessively close symbiosis is loosened in the family's treatment, and when the boys, encouraged and taught to be masculine, begin preferring that mode, neurotic behavior—fighting with female siblings and peers rather than playing with and imitating them, physical attacks (intrusions, such as throwing objects) on mother, and nightmares and phobias—appears for the first time (Greenson, 1966, 1968; Stoller, 1975a). Where these might be reasons for treatment in more ordinary children suffering the effects of oedipal conflict, we look on such manifestations as evidence treatment is already rather successful.

Contrast this with the situation in effeminate males.

There, as many, from Freud on, have demonstrated, intrapsychic conflict—preoedipal and oedipal—is a crucial determinant. Bak has given us a powerful description of an argument for the contribution of oedipal conflict in perversions (perhaps best illustrated in his paper on "The Phallic Woman" [1968]). He says (p. 16):

> In all perversions the dramatized or ritualized denial of castration is acted out through the regressive revival of the fantasy of the maternal or female phallus. This primal fantasy constitutes the psychological core of the bisexual identification. In relation to the castration complex, Freud repeatedly emphasized the universality of this fantasy in the male, which is abandoned only reluctantly in the course of normal development. I believe that this fantasy becomes reinvested and is ubiquitous in perversions in the male and that it probably plays a similar, though not identical, role in the sexual pathology of the female. The central *defensive* [Bak's emphasis] position consists in the regressive alterations that this fantasy undergoes in the various developmental phases, as well as the search for, and the symbolic materialization of, the female phallus.

I agree with Bak that the fantasy of the phallic woman is ubiquitous in perversions and that it is used defensively, regressively (and I especially like the word "ubiquitous," because it does not mean "universal").[8]

But, in suggesting that femininity in boys (which is one form of what Bak calls "bisexual identification") arises in the first months of life out of the nonconflictual, excessively close and gratifying mother-infant symbiosis, I also disagree with Bak. One probably can sustain his argument that the

[8] I am thinking here of other analytic theorists who equate perversions with all sexual aberrations; I believe, rather, that there are aberrations that, not the product of conflict and defensive maneuvers, should not be called perversions, for they are dynamically different (Stoller, 1975b).

phallic-woman fantasy is the core of femininity in males only if, as do the Kleinians, one states that there is, in the first months of life, an innate memory of mothers with penises. Of course, this can be neither refuted nor proven. I think, therefore, that although one typically finds, certainly in males, that fantasies of phallic women underlie perversions (and to what extent are they also present in the less perverse?), femininity in males *precedes* oedipal conflict and regressive restitution via the fantasy of the phallic women.

One need not choose up sides, as if commitment to an oedipal rather than preoedipal explanation were a political act. Instead, let observations guide us. If, for instance, with our own eyes, we see femininity in a boy of less than two years, we need not argue that it results from aggression induced by oedipal conflicts of age five or six or later. Effeminacy, however, is a different matter.

Treatment

Since adults are the focus of our Panel, I shall make only a few more remarks on treating boys. The best treatment is prevention. If only we knew enough to advise parents how to raise their children; but probably analysts' advice, to ourselves or to the public, has never been prophylactic. Our best hope at present, therefore, is direct treatment; but let us remember that as yet we have neither sharp criteria for finding those who will be homosexual nor enough therapists even if we could pick the boys.

Still, there is reason for cautious optimism. Our group, concentrating on very feminine boys (those we think are transsexuals, not necessarily those who will become "merely" homosexuals), has regularly been able to diminish or remove that behavior;[9] Greenson's clear and touching reports (1966, 1968)

[9] So have those using behavior modification techniques (Rekers, et al., 1976).

show how one can work successfully with such a boy. Here are suggestions for treating feminine boys.

1. The therapist will encourage masculinity and discourage the femininity that reflects the boy's wish to be a girl. (See Green, 1974; Greenson, 1966, 1968; Sperling, 1964, for details.)

2. There is no use treating the child without involving his mother. Whether she also should be treated or simply advised how to help him develop masculinity depends on the specific case. My bias is always to treat the mothers, but one might argue that this is a luxurious ideal.

The following lists, from least to most, the goals of her treatment. The least one hopes is to help her not sabotage her son's treatment, which she may otherwise do when she recognizes that treatment aims to make him masculine, that is, to separate him from her. Next, when she can bear it, treatment will allow her to free her son from her embrace. Along with this, we can help her with the depression that occurs as her son's treatment begins to work, for she must now lose the most precious thing she has ever had. Next, we hope she can come to use her husband better. Up to this point, he has been her proof that men are worthless: her son is the only good male in the world (i.e., feminized). Sometimes, therefore, with treatment, a mother will finally end the marriage, perhaps to remarry with different motives or even to give up permanently on marriage. Less often, and probably only if the father changes, the two may reconstruct a better marriage. (I have not seen this yet.) The best outcome may be that such a woman's hatred and envy of maleness is markedly reduced, leaving room for other parts of her personality to shift.

3. The father should be treated, so that he increases his commitment to his son, wife, and family. So far, this has not worked; no father has yet entered analysis or even persisted in another kind of treatment—individual, group, or family—beyond a few perfunctory visits. This is not surprising, for he

was chosen by his wife to be a distant, passive, nonparticipating man.

We are left with the ethical question whether one has the right to treat a child for an ego-syntonic condition others define as pathological. There are militant groups in society who demand that feminine boys not be treated because femininity in boys would be no problem, fundamentally no worse than masculinity, if a pathological society did not so define it. This is, I believe, an irresponsible position to take with children in our society as it presently functions, ignoring the painful consequences that accrue later in life. In contrast, for adults who already know full well and accept these consequences, the choice to be left alone must be militantly protected; we should take seriously Freud's caution: "Let us remember . . . that our attitude to life ought not to be that of a fanatic for hygiene or therapy" (1910, p. 150).

Conclusions

From out of the behavior we need to observe in order to find those boys at risk for homosexuality, femininity, so far, best helps us predict. The data point to a connection between the boy's being feminine and the chance he will grow up to prefer males erotically. I have suggested that when this femininity starts early in life, is marked and natural-appearing, the outcome is transsexualism (in the limited for I have defined), and when more mixed with trauma and conflict, it will lead to various forms of transvestism (fetishistic cross-dressing), "transsexualism," and homosexuality.

It is the general impression of therapists from psychoanalysts to behaviorists that the more feminine a male, the poorer the prognosis for masculinity and heterosexuality (e.g., Ferenczi, 1914; Freud, 1905; Gelder and Marks, 1969); those of us who have studied feminine boys would add that the hope of changing the behavior decreases as the patient gets older. We should, then, learn to distinguish malignant

femininity from the more benign sorts seen in boys and, on finding the former, quickly begin treatment. We are probably competent to do this now. We have another task, however: to discover in children which signs, beyond femininity, indicate that homosexual erotic behavior will be preferred when the child grows up. I hope, in doing this work, that we do not settle only for data collected from adults but that we do the same sorts of prospective studies that are being done in regard to femininity, looking to see if the signs and symptoms to be studied can be found in children and if, in fact, these children become homosexual later on.

Regarding the treatment of those adult males who are markedly feminine, there is no evidence after all these years that analysis shifts such behavior. That is not to say we cannot treat effeminacy, i.e., behavior that mimics femininity. And certainly one cannot say it is useless to treat those committed to an exclusively homosexual preference.

Summary

Although it is not yet clear what boyhood behaviors indicate an adult homosexual outcome, femininity is one reliable marker. The earlier and greater the femininity, the more likely will it be resistant to treatment, in childhood or adult life. Once an evaluation has revealed the femininity is intense, treatment should quickly begin and, when possible, include both mother and father. If the boy is to become more masculine, his mother will have to allow—encourage—him finally to separate from her, and his father will have to start serving as an adequate model for masculinity.

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