SEXUAL DISORDERS AND MISCONDUCT IN SERVICE MALES

BY

Lieut.-Colonel HARRY POZNER, M.C., M.R.C.S., D.P.M.
Royal Army Medical Corps
Formerly Adviser in Psychiatry, H.Q., Northern Army Group

Sexual abnormality in the male population has latterly been the subject of much inquiry and forthright public discussion. Its aetiology has been investigated in detail and attention has been drawn to the possible environmental influence of military service in the genesis of homosexual behaviour. For several obvious reasons there is very little authoritative or accurate information concerning the true extent of sexual disorder in the Services, and the relevant published literature is sparse. Loeser (1945) has studied 270 sexual psychopaths in the American army, and more recently Pearce (1954) published a short paper on the problems of sex in the British Services during World War II.

Those military personnel suffering from sexual disorder and voluntarily reporting on this account to their service doctors are comparatively few, and in general only seek advice for some ulterior motive or when threatened by disciplinary action resulting from previous anti-social or indiscreet sexual misbehaviour. That they represent only a small section of the sexual deviates in the Services is confirmed by police reports, sociological surveys and semi-documentary modern novels (Westwood, 1952; Kinsey, Pomeroy & Martin, 1948; Cory, 1951; Garland, 1953) indicating the active participation of service men of all ranks and social status in the homosexual underground of every large port and city.
Despite the more enlightened lay and professional attitude towards sexual disorder, many officers and men, acutely concerned with personal difficulties of this nature and genuinely desirous of advice, are reluctant to ask for help from their own medical officers. They continue to serve with diminishing efficiency, or in a few cases refer their problems to civilian consultants at their own expense. Some, humiliated and over-sensitive, hesitate to disclose their impotence or defective virility in a predominantly masculine environment where personal sexual prowess is always a ready and intriguing subject of discussion. Many distrust the youth and inexperience of their unit doctors and fear a breach of professional confidence. Others, with some justification, resent the fact that specialist reports concerning themselves are not always such confidential documents as they are presumed to be, and are liable to come to the notice of unauthorized persons. Finally there is the attitude of the patient who feels that once he has confided in his doctor-officer the matter automatically becomes official, that embarrassing or incriminating material is detailed in his personal documents, and that his military future may be adversely affected by the stigma of abnormality.

Whilst all types of sexual disorder occur in service men as in civilians, these disabilities are mainly concerned with the various manifestations of homosexuality. Stekel & Liveright (1927) were of the opinion that after World War I there was a marked increase of "genuine" homosexuality in war veterans, "an up-flaring of their homosexual components and a corresponding accentuation of their antagonism to woman." The same observation would appear to be true of the present post-war era. Westwood (1952) points out that at a very conservative estimate 4 per cent. of all males in the U.K. are completely homosexual and 13 per cent. have strong homosexual tendencies. It is further emphasized that for those age-groups in civilian life from which the bulk of service men is drawn the percentages of homosexually involved males are considerably higher. Press reports and court-martial publicity give a somewhat distorted view of the extent of sexual disorder in the Services, and it is apparent from even the most cursory of surveys that the incidence of known homosexuality in service personnel is considerably less than in civilians. From an investigation carried out in Northern Army Group, where information was obtained from several sources, it was found that the frequency of men known to be suffering from any form of sexual disorder was less than 1 per thousand (0.07 per cent.). The impression was also gained that there was more sexual disability amongst officers and less amongst other ranks than would seem at first evident from the available official data.

The records of 500 consecutive male service patients drawn from the British Occupation Forces in Germany and referred to the writer over a period of eighteen months for psychiatric opinion were examined for evidence of sexual disorder. Forty-seven men comprising 8 officers, 17 warrant officers and N.C.Os. and 22 other ranks had initially been sent for interview at their own request owing to sex difficulties, or for a medico-legal report following some military offence with a sex element. These cases excluded soldiers accused of rape or
indecent assault upon females, patients with acute anxiety or depressive symptoms resulting in diminished libido, and those individuals in whom psychosis or organic cerebral deterioration had given rise to uninhibited sexual misconduct. Also excluded from this selected group was a small class of patients in whom certain hysterical disabilities or skin conditions, including a few cases of intractable anal pruritus, indicated on examination a deep-seated homosexual conflict. Whilst it is appreciated that the conclusions drawn from a study of this group have little direct statistical validity, the findings are of some interest. Of the 47 males examined, 42 were volunteer regular personnel and only 5 were National Service men; 26 were unmarried bachelors, and 21 were or had been married.

The distribution by age groups was as follows, and indicated that the greatest incidence of sexual disorder amongst service males occurred in the third and fourth decades (Table 1).

<table>
<thead>
<tr>
<th>Age in years</th>
<th>No. in group (47)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Under 20</td>
<td>7</td>
</tr>
<tr>
<td>20–25</td>
<td>10</td>
</tr>
<tr>
<td>25–30</td>
<td>13</td>
</tr>
<tr>
<td>30–35</td>
<td>6</td>
</tr>
<tr>
<td>35–40</td>
<td>7</td>
</tr>
<tr>
<td>Over 40</td>
<td>4</td>
</tr>
</tbody>
</table>

The reasons for which these patients were referred for psychiatric opinion are given by general groups below (Table 2).

<table>
<thead>
<tr>
<th>Group</th>
<th>No. in group (47)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Homosexual behaviour with willing adult partners</td>
<td>15</td>
</tr>
<tr>
<td>Indecent assault on children or unwilling male adults</td>
<td>14</td>
</tr>
<tr>
<td>Exhibitionism and indecent exposure</td>
<td>7</td>
</tr>
<tr>
<td>Impotence</td>
<td>7</td>
</tr>
<tr>
<td>Transvestitism</td>
<td>2</td>
</tr>
<tr>
<td>Fetishism</td>
<td>1</td>
</tr>
<tr>
<td>Excessive masturbation</td>
<td>1</td>
</tr>
</tbody>
</table>

In most cases there was no difficulty in reaching a clear diagnosis (Table 3), but in a few instances where there was conflicting evidence of misconduct, disciplinary or marital threats, and alcoholism, there was considerable doubt as to whether the psychiatric disability claimed was genuine or simulated.

<table>
<thead>
<tr>
<th>Diagnosis</th>
<th>No. in group (47)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Psychopathic personality types:</td>
<td></td>
</tr>
<tr>
<td>Emotional abnormality</td>
<td>3</td>
</tr>
<tr>
<td>Pathological sexuality</td>
<td>16</td>
</tr>
<tr>
<td>Paranoid schizophrenia</td>
<td>1</td>
</tr>
<tr>
<td>Endogenous depressive states</td>
<td>2</td>
</tr>
<tr>
<td>Anxiety states</td>
<td>4</td>
</tr>
<tr>
<td>Obsessive-compulsive states</td>
<td>1</td>
</tr>
<tr>
<td>Mental defect</td>
<td>1</td>
</tr>
<tr>
<td>Chronic alcoholism</td>
<td>4</td>
</tr>
<tr>
<td>No ascertainable mental or physical disability</td>
<td>15</td>
</tr>
</tbody>
</table>
It was noticeable that throughout the series of life histories of these subjects there frequently recurred similar constellations of aetiological and environmental factors. The commonest features were family disharmony, only children, dominating and possessive mothers, the death or loss of a father, seduction at an early age, a degree of personal inadequacy and occasionally a background in the home of religiosity or stern morality. During military service these influences were complicated by separation from a familiar circle, marital difficulties, boredom, alcohol, opportunity, isolation from a stable heterosexual social community, and not infrequently segregation in all-male groups in which there was already a small but established homosexual focus.

**IMPOTENCE**

The impression gained from the clinical examination of service personnel is that impotence is the most distressing and humiliating of the male sexual disorders. This disability may be represented as a primary complaint or be elicited as a secondary symptom of physical or emotional disturbance. Patients express themselves in a variety of obscure or misleading ways, but fundamentally they complain either of a lack of or a diminished normal sexual desire, weak erections, sudden detumescence immediately prior to or at the moment of penetration, or most commonly premature ejaculation.

In the series under review, commissioned ranks predominated and fell into the 35-45 years age group, whereas the other ranks, including a large percentage of senior N.C.Os., were found between the ages of 25 to 30 years. All these patients were married and had, except in one case, fathered one or more children. They possessed remarkably similar personal characteristics. All of good intelligence and in some instances artistically gifted, they were ambitious, conscientious, and able without being in any way outstanding. It is interesting to note that without exception those patients in whom impotence was the presenting and disturbing symptom were employed in subordinate administrative and staff appointments without any real powers of command.

There was no case in which a physical causation could be clearly demonstrated, although in a few instances a transient sexual dysfunction followed some surgical procedure. The cycle of apprehension, inadequate sexual performance, humiliation and reinforced anxiety was a salient feature of every patient who did not respond initially to reassurance and simple explanation. The main symptom complexes associated with impotence were as follows:

1. Fatigue with physical, emotional or intellectual components.
2. Over-anticipation of physical reunion with wives from whom there had been a prolonged separation.
3. Specific sexual inhibitions towards the wife brought about by various psychopathological mechanisms which did not necessarily prevent the patient from obtaining full sexual gratification extra-maritally.
(4) Guilt due to infidelity towards the wife, and fear of social or professional repercussions in the event of exposure.

(5) Resentment in the frequent cases where there were sexual incompatibility or rejection of the patient for other reasons on the part of the wife.

(6) Aggression in those cases where impotence was the resultant manifestation of some deep-seated sadistic criminality or a basic inadequacy with over-compensation.

Some knowledge of the management and treatment of a case of impotence should come within the clinical scope of every service medical officer. An essential first step is the full and careful examination of the patient with particular reference to the possible existence of endocrine dysfunction or neurological disease. It is rarely that any such disorder is found, but the negative result in itself is reassuring to the patient. At the first interview a detailed and unhurried history is taken, but it is stressed that nearly always in the beginning the sufferer tends to give a distorted or incomplete account of the development of his symptoms. It is only when his confidence has been gained after possibly two or more interviews that the true picture begins to emerge with a significant psychological background. With the establishment of a case of psychic impotence the doctor can adopt a more positive and encouraging approach. The occurrence of early morning erections, a history of previous satisfactory heterosexual relations, and the existence of temporary environmental or emotional stresses all indicate a relatively good prognosis. In some cases there is concealed guilt over masturbation persisting into adult life, and a frank and objective discussion of this and related problems will often produce immediately satisfactory results. With the patient's consent it is occasionally possible to discuss his difficulties with his wife, and her information, understanding and co-operation can prove invaluable.

The most successful therapy in the not too deeply complicated cases is a combination of common sense, careful investigation, a positive attitude towards cure, and the occasional resort to mild barbiturate sedation and the administration of male hormones either by mouth or by subcutaneous implantation.

**INDECENT ASSAULT, INDECENT EXPOSURE AND EXHIBITIONISM**

Criminal acts involving indecent assault, indecent exposure and varying degrees of exhibitionism comprised by far the largest group of sexual offences committed by service personnel brought to official notice. During the period covered by this survey there was, in over 50 per cent. of the incidents of this nature coming to the attention of the Special Investigation Branches of the Army and Royal Air Force, insufficient corroborative evidence to bring specific charges against individual suspects. Of the accused persons eventually brought to trial nearly all were referred for psychiatric examination.

Certain salient features emerging from the investigation constantly recurred. Indecent assault on soldiers and young male civilians was very frequently
Sexual Disorders and Misconduct in Service Males

associated with alcohol. Most of the incidents of exposure appeared to be unpremeditated, involved young children of both sexes, were fortuitous in nature and frequently took place, when the offender was married, in or near his family quarters. When faced with charges, the suspects invariably denied any criminal intent, and stated that they were the victims of either mistaken identity or misrepresentation, that their innocent actions were misinterpreted, or that they had no recollection of the relevant time due to transient "black-outs" or alcohol.

All these men revealed similar characteristics in their personalities and backgrounds. They were mostly regular senior N.C.O.s., between 25' to 35 years of age, married and in a few cases with children of their own. They were all of average intelligence, not commonly given to habitual excessive drinking, leading quiet and comparatively steady lives. The married personnel frequently gave a history of marital difficulties, generally associated with sexual incompatibility between husband and wife and often due to the wife's distaste for physical intimacy or fear of pregnancy. If the offender was unmarried he usually gave a history of being an only child, of the loss of a father or of parental rejection at an early age, or of the loss of a fiancée by illness or accident in later years. In his service life there were added features of loneliness, social inadequacy and drinking for companionship.

On examination there was in the majority of patients little evidence of any gross psychiatric disturbance. Some exhibited anxiety or emotional tension arising from local and family stresses, and in a few there were features of pathological inadequacy. Contrary to general belief, obsessive-compulsive disorders were not apparent in any of the patients even in those few accused of frank exhibitionism. It was found that self-exposure often resulted in a slackening of sexual tension.

In a small group of cases it was considered that whatever the underlying mechanisms there was no obviously conscious intent to commit an offence. Predominating causal factors in the misconduct of the younger unmarried men and those living apart from their wives were fears of intercourse and venereal disease and the need for some demonstrative show of affection. In men of lower intelligence there was a naive outlook associated with limited worldly experience. The inadequacy of married men in normal sexual intercourse often led to attempts at sexual gratification at a more immature but potentially less humiliating level of conduct.

Specialist treatment for these offenders is not often considered necessary, but when recommended it is generally confined to psychotherapy and social reorientation. Advice in marital difficulties is helpful, and it is possible in the Services to reduce environmental stresses and the opportunities for misbehaviour by appropriate postings or change of employment.

From a medico-legal standpoint there is generally no psychiatric contraindication to disciplinary action being taken against a proved offender. It has been found from experience that few service personnel ever indulge again in misconduct of this nature if they have been firmly dealt with for the first offence.
TRANSVESTITISM, FETISHISM AND SADO-MASOCHISM

The importance of this group of sexual abnormalities in service men lies not in its numbers, which are comparatively few, but in the frequency with which it is associated with undesirable and sensational publicity.

Transvestitism, the wearing of clothes appropriate to the opposite sex, is not widespread in the Forces, but is more common than one would suppose from the incidents which come to official notice. In the writer's experience this phenomenon is seen equally amongst officers and men, but is more florid in the officer group. An individual in the privacy of his own quarters has been known to transform himself, with the help of cosmetics, wig, and a complete feminine wardrobe and accessories, into a passable imitation of an elegant and attractive woman. Barrack-room life does not lend itself to this type of masquerade, and the other rank transvestite is usually restricted to the furtive donning of exotic feminine underwear. It is mainly from this group that come those patients whose transvestitite tendencies conflict with a very real fear of exposure and public ridicule. In no case of this nature investigated has there been evidence of any strong sexual gratification obtained from the practice, nor any obvious inclination towards overt homosexuality.

Certain aetiological factors were common to all the known transvestitites. They were for the most part youngish bachelors with a sprinkling of recently but not very happily married men. Basic good intelligence was a group attribute, and each person was either an only child, an only son, or separated from his siblings by a significant difference in age. Dominating the background in every case there was a mother or mother-substitute, towards whom was exhibited invariably strong ambivalent feelings. The attitude of these men towards service life was surprisingly good, their efficiency usually high, and in most cases they apparently had no great difficulty in mixing on satisfactory terms with their comrades. It was only when they were prevented from indulging, without fear of detection, in their phantasies of feminine identification that they became frankly neurotic and reluctantly sought medical aid.

Transvestitism, except when it is associated with male prostitution or intent to defraud, is not in itself a recognized civil offence. Service amateur theatricals, particularly in isolated units and P.O.W. camps, permit the latent transvestite to indulge his inclinations with public approval and encouragement. In such cases it is more usual to find grotesque and comic female characterisations rather than those portrayals of simple feminine appeal which might offend or inflame virile masculine susceptibilities.

Although obviously undesirable, transvestitism is not incompatible with a useful service life. When, as a result of it, fear and frustration give rise to anxiety and obsessional preoccupation, medical action is necessary. A brief course of modified analytical therapy has, in a few cases, led to a satisfactory readjustment with retention in the Services in full employment. In the majority of cases it has been necessary to recommend medical invaliding from the Army on the grounds of unsuitable psychopathic personality traits.
Fetishism may be defined as a preoccupation with some article, usually inanimate and by itself inessential, but symbolic by association with an object of sexual desire. The fact that it exists in many varied and acceptable forms in the traditions of the Army would make an interesting thesis but one outside the scope of this paper. Fetishism is no crime unless it is accompanied by a criminal act. In the Army it most often comes to light in the apparently profitless theft of women's underclothing, in bizarre homosexual offences frequently involving civilians, and occasionally in unusual acts of larceny or sudden assault upon the person. A varied group of fetishes seen in military patients has included nearly every article of feminine apparel, polished boots, a fur coat, swagger canes, tresses of hair, rubber sheets, old socks, horse saddlery and cannon balls.

When reviewing a larger group of service fetishists than those included in the present survey it has been observed that they can be separated roughly into two main groups. There is the smaller group of other ranks, usually of regular N.C.O. status, married and possessed of inadequate, colourless personalities. Mediocrity is their outstanding characteristic. For them the fetish is probably the stimulus of an erotic imagery and the means of escape from a monotonous and dutiful marital and military regimentation. Bachelor officers, genuine or obligatory, form the second group. Generally of good intelligence, with some degree of culture, they are apt to be egocentric and hypercritical. Often regarded as amusing and harmless eccentrics by their colleagues, they are usually sensible enough to restrain their proclivities within law-abiding limits.

Fetishism in its more conscious sexual setting may cause the patient acute distress, particularly when sexual excitement becomes diverted from the fetish to the means by which it is obtained. Therapy on analytical lines with explanation and reassurance can do much to reinforce the patient's self-control. It has rarely been found necessary to recommend a discharge from the Services on psychiatric grounds. If, as may happen in a case of theft or assault, he is brought to trial he usually pleads that he is the unfortunate victim of an irresistible impulse. Such a defence can hardly ever be substantiated on psychiatric examination, and in these circumstances there is no valid contra-indication to trial or punishment. When there is evidence of genuine anxiety associated with the abnormality it is usual to recommend an attempt at treatment after all disciplinary proceedings have been concluded.

Sadism and masochism, the practices of deriving pleasure respectively from inflicting or being subjected to pain and humiliation, often coexist in the same individual and may be associated with sexual perversion in certain military offences. Sexual gratification is not the inevitable aim of sadism because in the Army there are ample opportunities for those whose egotism demands submissive recognition to express themselves in unmistakable though legitimate ways. Masochism is less prevalent, and its primary importance in service life is as a possible factor in those incidents where death has occurred in bizarre and apparently suicidal circumstances. Three cases of so-called inexplicable suicide have revealed on investigation that death was most probably
due to vaso-vagal shock or asphyxia arising by misadventure during the process of some complicated masochistic ritual. In other instances masochistic tendencies have proved to be the residual effects of extreme privation or punishment endured in P.O.W. camps.

Sadistic acts with an element of perverse sexuality often occur in improper associations between service men and civilians. Flagellation, deliberate sordid assault and acts of gross violence on provocation, leading in a few instances to murder, have all been reported. The factor of aggressive sadism is inherent in those offences where service men have been known to mutilate a woman's clothing or hair. From another aspect two cases have been reported to us of soldiers whose pyromania was associated with temporary relief from sexual tension.

The etiological factors in the life histories of these offenders follow the pattern found in other sexual deviations, but it has been noticed that sadomasochism occurs with a significant frequency in personnel of Eurasian antecedents. Masochists tend to exhibit schizoid and obsessional personality traits, whereas sadists are usually more obviously psychopathic in an aggressive and anti-social manner. So far from being virile, many of the men in this group are undersexed, and this is a factor of some importance in certain cases of sadism where a progressively greater degree of violence has to be exercised to obtain sexual gratification.

Most of these offenders are genuinely psychologically disturbed. Because treatment is often custodial, therapy unduly prolonged and the results unpredictable, the main function of the law is to protect society. In the Army the aggressive and psychopathic sadist may be capable of restricted employment in total war, but on general principles his retention in any unit is undesirable. His presence is corrosive to good morale, and it is recognized that any sadist with a history of violence is a potential murderer.

**UNDINISM, COPROLALIA AND PORNOGRAPHY**

Undinism, an abnormal interest in urine or urination, coprolalia, excessive swearing with frequent references to the bodily excretions, and pornography, the expression of obscenity, occur frequently in association with sexual abnormality. Psychiatrists are occasionally asked to examine service men who have been apprehended by the civil police for loitering in public urinals. During the last twelve months we have reported on three soldiers who drank urine when engaging in other acts of perversion. Behaviour of this type can only really be satisfactorily explained in terms of analytical psychopathology, and the individuals concerned are to be regarded as immature psychopaths with fixations at more primitive levels of psychosexual development. Long-term therapy is impracticable under service conditions, and these offenders should be separated from the Army by administrative or medical means.

Pornographic expression in its various forms is a recognized and understandable feature of military life. When it becomes part of an obsessiona
pattern of behaviour it is liable to result in criminal acts. In this connection we have interviewed soldiers admitting to making offensive and distressing telephone calls to female personnel, a chief clerk who typed away industriously for days at a book-length erotic odyssey, and an officer who, under a pseudonym, wrote an extraordinary series of obscene letters for distribution to a select circle of subscribers. The contrast, as always, appears between the private and professional lives of these individuals. They are mostly known to their associates as quiet and efficient workers, and as dutiful sons and husbands and benevolent fathers. Their acts arise from psychological immaturity, and Clifford Allen (1949) suggests that these and allied patterns of behaviour can be labelled as “perversion-fetishes.” Medical disposal depends on the individual case, but in the more florid instances the service prognosis is poor, and there is usually no psychiatric contra-indication to disciplinary action when a definite charge can be brought.

HOMOSEXUALITY

For the purposes of this paper the definition of homosexuality has been restricted to homosexual physical contact between consenting males. In the group under discussion it is concerned mainly with sodomy, which in a little more than 30 per cent. of all the cases of sexual abnormality was the presenting reason for psychiatric referral. The offenders fell roughly into two distinct age groups. Between the ages of 18 to 20 years were found the immature and sexually psychopathic young soldiers, and in the group of 25 to 40 years there were the confirmed and habitual officer and other rank perverts. In each case regulars significantly outnumbered the National Service men.

A widespread investigation by military psychiatrists into the nature of this problem in the Army revealed that four major groups of homosexuals could be distinguished:

1. The essential or true homosexual who by sub-limiting his tendencies managed to live a chaste life, but who occasionally was prone to acute anxiety if exposed to constant temptation or a strong physical attraction.

2. The essential homosexual who had no moral objection to indulging in his activities with other service men but who preferred a more permanent association.

3. The promiscuous male prostitute whose homosexuality was either essential or acquired and who profited from his abnormality, and constituted a serious menace to unit morale.

4. The active opportunist, bisexual or immature heterosexual, who for various reasons engaged in casual homosexuality. In this group were included the more vicious perverts who had no hesitation in corrupting suggestible young soldiers of weak character.

From the available information it has been concluded that very few National Service men are permanently affected by a subjective homosexual experience.
during military service. On being removed from undesirable influences they quickly revert to a stable and satisfying heterosexuality. The young soldier seems to be sexually most vulnerable during the first few months of his training. Confined to barracks and impersonally regimented, he may have difficulty in adjusting himself to a frequently new and disturbingly less inhibited form of communal existence. If exposed to homosexual suggestion from somebody who can apparently help him to settle down he may disregard moral scruples for the sake of his personal convenience. Those who do succumb to this sort of pursuasion are recruits with either pre-service abnormal tendencies, or are of low intelligence and immature emotions, tending to drift aimlessly through their lives without any strong moral or social sheet-anchors.

In the Services confirmed homosexuals tend to congregate in certain units or localities, and it is suspected that such cliques are created by design rather than by the accidents of posting. In these situations the dominant character is nearly always a long-established pervert of some seniority and local influence. He has usually managed to find employment for himself so that whilst he continues to carry out his military duties adequately, he remains free from rigid supervision and is given a comparatively free hand in dealing with subordinates. Surprisingly enough, when unpleasant revelations ultimately oblige his unit to initiate drastic disciplinary action, it is often disclosed that, although he has long been regarded by superiors and others outside his circle as sexually abnormal, no attempt has been made to warn him or curb his activities in the Army.

A special committee of the Council of the British Medical Association in a recent pamphlet (1955) recognized two groups of homosexuals: (1) The essential type in which homosexuality was determined possibly by genetic or endocrinological factors and more probably by environmental influences in very early life; (2) the acquired type in which new factors arising in later childhood, adolescence or adult life were predominant. From a service standpoint acquired homosexuality, with its possibilities of control and prevention, merits most attention. Nearly always significant in the aetiological factors are the following: (1) A disturbed early background as in the case of an only child with a possessive widowed mother. (2) Seduction at an early impressionable age. (3) Persistence of adolescent sexuality into adult life. (4) Segregation in male communities, e.g. the Services, penal institutions, P.O.W. camps. (5) Fears of venereal disease or the responsibilities of heterosexual liaisons and marriage. (6) Curiosity or a tendency to depravity in the bored sensation-seeking individual. (7) Alcoholic intemperance tending to break down inhibitions, blunt the appreciation of moral values and allow the individual to indulge in homosexual gestures under the guise of good fellowship.

The most common diagnostic finding in confirmed service homosexuals is a basic personality disorder, although homosexual behaviour is frequently observed in subjects without any ascertainable evidence of significant psychiatric disability. The correct diagnosis is of importance in determining the methods of control and disposal. Unfortunately the attitude towards service homosexuals is not uncommonly prejudiced by subjective emotional factors which may lead
to an over-aggressive or in some cases to a surprisingly lenient approach. Psychological and physiological factors influencing homosexual behaviour are of undoubted importance, but they are occasionally over-emphasized at the expense of the principles of self-discipline and personal responsibility. The crux of the matter seems to be summed up in an extract from a confidential report by the Church of England Moral Welfare Council (1955) on homosexuality:

"Where inversion is the settled condition of a person (innate or acquired) it will be important to make a very clear distinction between this condition (which is morally neutral) and the invert's homosexual practices, which are within the range of choice and to which moral categories therefore apply."

Whilst it is possible in special circumstances for a confirmed homosexual to be retained in the Army, such a course should only be taken when retention is of benefit to the Service. Promotion and wider responsibilities, if compromised by homosexual indiscretions, increase the possibilities of blackmail and divided loyalties, and constitute a potential threat to service security. When the conservation of manpower was an essential priority it was often considered practical and realistic to post known homosexuals of good intelligence and proved ability to large towns, where their private indulgences were less likely to be inimical to the best interests of their Service. Nowadays such considerations are of less moment. The normally chaste homosexual who has momentarily yielded to the urgency of a drive, which most of his life he has repudiated, can with sympathetic, skilled assistance be returned to full and profitable military employment. The danger lies in the possible loss of self-confidence in his ability to resist further similar stresses. On reflection he may feel that the heart-searchings and spiritual torments to which he has voluntarily subjected himself are inadequate compensation for a lonely and emotionally sterile future. Constantly guarded in his social relationships, he is at a permanent disadvantage in a predominantly male community.

THE LAW, PUNISHMENT AND HOMOSEXUAL OFFENCES

It has become almost customary for a soldier charged with sexual misconduct to be referred for a psychiatric report irrespective of whether or not he exhibits any features of mental illness. The request for this examination may come either from the prisoner, who has belatedly volunteered to undergo treatment for an abnormality of which often he has previously never complained, from the prosecution with the idea of refuting any suggestion of diminished responsibility on the part of the accused, or from the defence which will snatch at any shred of medical endorsement to patch up a threadbare plea of mitigation. The relevant portions of the psychiatric disciplinary report available to opposing counsel are frequently misleadingly brief and uninformative. When called upon in open court to give expert testimony, the psychiatrist, who considers himself to be impartial and acting in good faith, may be asked to reply to categorical questions to which there are no generally accepted right answers but only expressions of personal opinion. Objective and knowledgeable evidence can be of great value...
to the court, but it is considered from experience that the request for a psychiatric report should come only from the court after a preliminary hearing of the case. In this way the members would have the opportunity of discussing his conclusions and if necessary of calling before them in private the psychiatrist to clarify or enlarge upon any points of importance or interest. Certain fundamental questions are always asked and an attempt is made below to give the substance of the usually accepted answers.

1. Is the accused suffering from any psychiatric illness which might have influenced his behaviour?

In a large number of cases no psychiatric disability severe enough in degree to warrant a specific diagnosis can be found. Alcoholism, mental dullness, ignorance, temporary amnesia and neurosis of short duration carry little weight in law. The psychopathic personality with its concept of impulsive, short-term self-gratification, is a difficult one to impress upon a lay audience, and usually only strengthens its conviction that society must be firmly protected from the person on trial.

2. Does the accused require special treatment, and can he be cured?

Essential homosexuality is an irreversible condition and a permanent cure is unlikely. The most that can be expected is that the true invert with skilled support can exercise sufficient self-discipline to prevent himself from committing overt anti-social acts. In acquired homosexuality the prognosis is theoretically better, provided the full co-operation of the patient is assured and adequate facilities for treatment are made available. Treatment is only likely to succeed in carefully selected individuals, and Sessions Hodge (1950) states: "The old, the adjusted, the feminine and those with strong tendencies are for the most part beyond the reach of complete cure at the present state of psychological knowledge."

A strong and sincere wish to be cured is a prerequisite for all forms of therapy, but it does not necessarily lead to a successful outcome. It is known that many offenders who request treatment only do so to avoid possible imprisonment, and have no genuine intention of desisting from their activities once the threat to their liberty has passed. The effectiveness of treatment is ultimately dependent upon the intelligence, good will, adaptability and relatively intact personality of the patient.

3. What forms of treatment are available?

An eclectic brand of analytical psychotherapy is often of considerable value in selected cases. Superficial psychotherapy of a more direct and realistic nature can be used in association with an attempt to manipulate the environment of the patient. Estrogens such as stilbœstrol can be employed as a temporary measure to tide over a difficult period in a homosexual with reactive anxiety, but they have no permanent value in suppressing sexual desire. Castration has little scientific justification and is applicable only to a very few incorrigible
offenders. Service patients who require prolonged intensive treatment likely to interfere with their military activities are medically unsuitable for retention in the Army.

4. **Will punishment have any effect on the prisoner?**

It is often noticed at courts-martial that there is an apparent difficulty in distinguishing between punishment and imprisonment. In the vast majority of cases where a homosexual offence has been deliberately committed in full awareness of its socially unacceptable nature no sensible psychiatrist will deny the necessity for punishment. Unfortunately there are some unusual discrepancies in the types of punishment awarded. It sometimes appears that extraordinary leniency is shown for reasons other than medical, whereas in certain cases in which the medical considerations are important and relevant, unduly heavy prison sentences are imposed. For vicious perverts and persistent offenders imprisonment is the only practical answer under present-day conditions. For the young, unsophisticated and impressionable first offender it seems illogical to segregate him in a male community where there are most probably degrading criminal and predatory influences. The general opinion is that if a homosexual is sent to prison he should be carefully supervised, the length of his sentence should be related to his psychiatric assessment, long enough to be effective and capable of being reviewed in the light of his response to any available treatment.

5. **Will a prisoner receive any treatment in a military corrective establishment?**

The facilities for treating confirmed homosexuals in military custody are for various reasons quite inadequate. This is not unreasonable if the view is accepted that the Army is not the place to treat social aberrants. In civilian prisons the prospects of treatment are definitely better, but there is considerable room for improvement, and it has become obvious that psychopathic homosexuals must eventually be treated in specialized colonies.

6. **Is the prisoner liable to commit similar offences after punishment?**

In some cases it is possible for the psychiatrist to affirm with reasonable confidence that the prisoner under consideration will commit no further homosexual offences. But he should not be placed in the invidious position of guaranteeing another person’s future good behaviour. Loeser (1945) points out: “There is nothing about the homosexual drive which deprives the sufferer of ability to restrain his sexual actions.” There are many homosexuals who regard themselves as members of a privileged group, endowed by circumstances beyond their control with instincts which, despite public disapproval, they consider to be normal. They see no convincing reason for accepting heterosexual standards. The threat of public exposure and punishment may cause them to avoid a conspicuous indiscretion, but they will certainly continue to exercise in private their choice of sexual activity.
H. Pozner

THE PREVENTION OF SEXUAL DISORDER IN THE SERVICES

A recruit with a homosexual orientation is a potential vector of sexual abnormality in the Army and requires more than a purely passive or disciplinary attitude on the part of those in authority. Much can be done to rectify what is largely a disorder of human relationships. This is an essential part of early military training when it is possible to indoctrinate the principles of self-reliance, personal discipline and the obligations of the individual to the group. An impersonal authoritarian approach is not enough, and all ranks who are responsible for dealing with recruits should be carefully selected for their qualities of leadership, strength of character and personal integrity. Because a high morale militates against social degeneracy, any measures which tend to raise the status of the soldier and emphasize his service loyalties should be employed to the full. A sincere religious belief is often effective against homosexual temptation, and from this aspect the assistance of wise and experienced chaplains with a true sense of vocation is invaluable. Confirmed homosexuals whose rehabilitation is unlikely should be removed from the Army by the most expeditious and appropriate means. Any soldier who feels he has cause to worry over apparently abnormal tendencies should be able to see his medical officer with the reassurance that any disclosures he may make will be regarded as confidential and will not lead to disciplinary repercussions.

The attitude of public opinion towards sexual abnormality has in the past undergone many changes and even in these days is inconsistent owing to widely varying cultural, religious and economic factors. The only safe and logical conclusion that one can draw from history is that in any nation the incidence of homosexuality is directly related to its vicissitudes in world affairs. Sound and acceptable moral standards are implicit in the structure of an influential and progressive civilization. At this time when there are many factors in modern life tending to depreciate the finer human values, the fighting services are important custodians of the nation’s youth, and their efforts to combat any threat to a moral society must have far-reaching results in larger spheres.

SUMMARY

1. In a series of 500 consecutive male personnel referred to a military psychiatrist, 47 were examined for sexual disorder or misconduct. The incidence of sexual abnormality in the Services is considered to be greater than that which comes to official notice, but is significantly less than that estimated in corresponding age groups in civil life. There is no indication that a service environment tends to corrupt the average type of emotionally stable recruit in the absence of any pre-service homosexual orientation.

2. The incidence, nature and management of sexual impotence in service males is discussed in relation to available treatment.

3. Sexual misconduct in its most frequent forms in service offences is considered with reference to ætiology and the disposal of the offenders. Brief
mention is made of the mechanism and manifestations of other reported sexual perversions and abnormalities.

4. The aetiology and implications of essential and acquired homosexuality are discussed. The essential homosexual is at a permanent disadvantage in any fighting service. Rehabilitation of the acquired homosexual depends on his environment, psychological maturity, good will, strength of character and personal integrity. The medico-legal aspects of homosexual offences in soldiers are considered with reference to the merits of treatment and punishment.

5. Prevention of homosexuality in the Army is briefly mentioned with emphasis on early recognition, correct management, and desirable influences.

I am indebted to Major-General F. M. Richardson, D.S.O., O.B.E., for his interest and encouragement, and to the Provost Marshal and Deputy Director of Army Legal Services, H.Q., Northern Army Group, for their generous co-operation and advice.

REFERENCES


