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MALE HOMOSEXUALITY:

A STUDY OF PSYCHOLOGICAL CHARACTERISTICS AND OF SOCIAL AND FAMILY BACKGROUND.

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SUMMARY

The purpose of this study is to compare male homosexuals and heterosexuals on a wide range of well-defined, psychological and social variables. Fieldwork was carried out, partly in Glasgow special clinics and 'employed' compliant male homosexuals, attending for the treatment of venereal and other sexually-acquired diseases. In order to identify and to assess their typicality or otherwise, when compared with male homosexuals generally, it was necessary to recruit a representative sample of the latter population, in fact by courtesy and with the cooperation of the Scottish Minorities Group's organization. The decision to involve homosexual special clinic attenders, necessitated similar recruitment of male heterosexual special clinic patients and heterosexual non-patient control subjects. The deployment of this strategy facilitated the following comparisons:-

1. Male homosexuals attending a special clinic (or with a history of such attendance) with male homosexuals possessing no such history of clinic attendance.
2. Male heterosexual special clinic patients, with male heterosexuals drawn from the normal population.
3. Male homosexual special clinic attenders, with male heterosexual special clinic patient subjects and
4. Members of the male homosexual special clinic patient group, with members of their male heterosexual special clinic patient counterparts.

The overall number of subjects who successfully participated in this study was 617.

Major published reports relating to, a) aetiological theories of

homosexuality, b) personality and homosexuality, c) homosexuality and special clinic attendance and d) other systematic studies which have previously been carried out are all extensively reviewed. This first part of the thesis is used as the basis for and to generate testable hypotheses which thereafter, are stated formally under the following headings; "family and domestic", "educational and occupational", "sexual", "social and psychological", "psychiatric", and "other behavioural".

A 'battery' of self-report questionnaires and a structured interview schedule were devised specifically for the purpose of this study. Other well-known and validated self report questionnaires and inventories were also included in the overall 'package' of survey instruments. The data which were obtained by these means were subjected to the appropriate form of statistical computation and analyses. In particular and where it was appropriate, correlation matrices were computed in the process of subjecting raw data to principal components and factor analysis. In such cases, factor-scores were then computed as the basis of comparison for all groups previously referred to.

Ensuing results are set out and discussed within the context of the study's declared aim and purpose and with particular reference to specific hypotheses, under the headings also previously referred to. In summary terms, the following conclusions are drawn:-

1. Members of the two homosexual groups are shown essentially to belong to the same population. There is evidence of greater sexual promiscuity among special clinic patient subjects, as well as of discordance in relation to specific "educational and occupational" variables. The "one population" thesis is consistently

confirmed by the very high level of support for hypotheses relating to "sexual" and "other behavioural" variables and by evidence of comparability on variables relating to personality and psychiatric morbidity.

The decision to investigate the typicality or otherwise, of male heterosexual special clinic patients, as members of the wider heterosexual population, is well justified. It is clear from the results which are here reported that members of the former group do differ in a number of important respects from male heterosexuals as a whole. however, attention is drawn to the relative smallness of the latter sample which came about for reasons which were outwith the study's ability or power to control.

Comparison between male homosexuals and heterosexuals is inhibited by the relative paucity of data referred to above. However, important differences between the two special clinic populations do emerge and from these data it is apparent that failure to enjoy sexual activity and in consequence, to experience feelings of guilt etc. is more in evidence among homosexuals. There is evidence of greater involvement in such practices as co-masterbation among homosexuals and indeed, of higher levels of sexual promiscuity generally.

Where comparison between homosexuals and heterosexual males generally, is feasible, comparability on a wide range of "family and domestic" and "personality" variables is indicated. By contrast, there is evidence of significant difference on the important variable of psychiatric morbidity, with higher levels being in evidence among the former of these two groups.

Copies of all instruments of assessment, as well as a detailed description of statistical procedures employed in the analysis of data, are included as appendices.

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INTRODUCTION

Historically, special clinics have been concerned first and foremost with the direct treatment of venereal and other sexually transmitted diseases. In recent years however, interest in the special clinic patient has become both broader and deeper.

In the past, it was common for treatment centres to be confined to comparatively isolated hospitals or other outposts but in many areas, this has now been superseded by the provision of more modern and central facilities. This welcome advance is in itself, indicative of a significant change in attitudes towards the special clinic patient. There is also mounting evidence, especially in published reports, of a heightened interest in the circumstances in which patients live and the influences to which they are subjected.

It has become increasingly clear that social and cultural changes have a profound impact on the frequency and distribution of sexually transmitted diseases. These changes include greater population mobility and new patterns of migration and settlement, as well as general shifts over time in social standards and accepted ethical values. Their influential role now receives a more open acknowledgement than was the case in the past.

Special clinics are now not only better sited, they also offer improved staffing and treatment facilities. Many such treatment centres are now served and supported by multi-disciplinary teams of workers, headed by the specialist physician in genito-urinary medicine. The clinical nurse is one such member having a crucial supporting role to play. In a recent review of the increasing skills and responsibilities required by this highly specialized member of clinical staff, a tendency in the direction of nurse-

training in tasks which hitherto have been carried out only by the physician, is commended and encouraged (DHSS, 1977). Another team member whose contribution to epidemiological significance as a factor in disease control is being increasingly acknowledged, is the clinic's contact tracer. This essential link between the special clinic and the individual patient's social and domestic environment entails no small measure of skill, of sensitivity and of discretion, (Wigfield, 1972; Harris, 1975).

Comparatively greater interest in and awaremess of the behavioural consequences of infection is evident in reported attempts to objectively assess patients' psychological and psychiatric morbidity, (Wells 1969, 1970; Pedder and Goldberg, 1970) together with an accompanying requirement for more accurate understanding of the relevance of intrapsychic, interpersonal and social influences upon ensuing behaviour, (Bindemann et al, 1978).

Behavioural scientists - medical sociologists, caseworkers and health educationalists are similarly developing an increasingly keen awaremess of the complexities of health knowledge, recognizing not only the importance of wider dissemination but also the relationship between levels of intelligence and the assimulation of facts and ideas. Equally, however, satisfactory understanding of their influence upon and interaction with domestic and socio-economic variables has not to date, been achieved and in consequence, urgently merits further controlled study. Other key factors relevant to attitude-formation and 'set', e.g. a need to conform to 'peer' pressures many of which are being daily re-inforced by an influential mass-media, are similarly a potentially rich target for intensive scrutiny and evaluation.

Such measurable factors and forces, taken as subject-matter

matter for relevant and profitable study are most likely to facilitate a more balanced understanding of the special clinic patient. Indeed, arguably it is only by such an appropriately motivated desire to so understand and thereby improve upon such services as are currently available, that a comprehensive approach to therapy is likely to be effectively devised and efficiently directed. Hopefully, the time is not far distant when such advice and counsel will be made routinely available at special clinics and similar treatment centres to all who manifest the need.

Such progress as has to date been achieved within this medical speciality with its concommitant expansion of staffing requirements, has accordingly focused upon the need for baseline data covering a range of behavioural variables relating to individual differences in patients and their functioning within their social environment. Until approximately the mid-1960s, clinical impression and anecdotal report had constituted the central 'core' of the available material. However, the manifest need for 'hard data' such as are able to satisfy demanding but essential methodological criteria of objectivity and reliability, has imposed more exacting demands for representatively designed and adequately controlled studies.

Other major variables of considerable interest, which must be similarly controlled if the need for relevant and current data is to be satisfactorily met, relate to differences between the sexes as well as to the particular orientation, preference and life-style of minority groups within patient populations.

The first of these variables - that of differences between the sexes - is routinely controlled in all research data where both male and female subjects have participated. This practice assumes even greater significance in studies involving a special clinic population, since it is the highly promiscuous female patient

population which is thought to constitute the main 'reservoir' of disease contagion. Reference has previously been made to studies which have consistently differentiated male special clinic patients from their female counterparts, on a wide range of variables relating to both intra-psychic functioning as well as to interpersonal development. Interesting and important data are also now available concerning other behavioural variables such as patients' level and frequency of alcohol consumption, psychoactive drug misuse and the nature of their influence upon sexually promiscuous behaviour, (Bindeman et al, 1978).

The second need stated above also relates to a 'well-defined' dimension of differentiating behaviour; namely that of sexual-sensitization, together with its sexual and social consequences in terms of preferences of sexual appeal and attraction. Interest in the behavioural phenomenon of homosexuality per se, is a development which is increasingly well reflected in the appropriate literature. (See section "Other Relevant Studies and their Implications").

One particular and well-known problem however, in carrying out such research, concerns the difficulties of gaining access to truly representative and bias-free samples of such minority groups. All too often, studies which hitherto have focused upon the behavioural phenomenon of homosexuality have in reality, been carried out on wholly unrepresentative samples; e.g., homosexuals with a criminal record or who have volunteered for psychiatric treatment. Other researchers - especially those who have reported upon studies carried out in the USA have frequently recruited their subjects at such well-known meeting places as public baths and wash-houses or, (in a concerted attempt to reduce the stubborn influence of bias in selection) have issued either verbal or written requests to member of homophile

groups inviting compliance with their proposed investigations. Even the latter method of recruitment - although enthusiastically hailed as a vastly improved method of subject-recruitment, (Bell 1973) is, because of its likely tendency to attract the more extroverted and socially-outgoing members, similarly beset by problems associated with bias in subject-selection and recruitment. Clearly a need exists for the location of recruitment sites which can be seen to facilitate a more proportionate and representative homosexual male population for in-depth study.

Several valid reasons might be advanced in support of the hypothesis that the special clinic might facilitate just such a centre for subject-recruitment which could effectively answer some (although by no means all) of the criticism of sampling methods previously referred to. Firstly, with the exception of the individual who is able to sustain an enduring relationship with a single male partner, or who is sexually* inactive, (both being groups which are widely held to comprise a small minority) all homosexuals are likely to be continuously exposed to sexually acquired infection during at least some and perhaps for a considerable period of that time. Evidence in support of such a statement (which would also require to be further tested empirically), would predict for homosexuals:-

1) A higher incidence of sexual activity.
2) A high incidence of casual sexual relationships.
3) A more sexually orientated 'life-style' (greater enthusiasm for and mobility in 'cruising' activities).
4) A significantly higher risk of exposure over time than sexually promiscuous heterosexual males.

The special clinic might be thought to constitute a satisfactory

*According to criteria established for the study and set out in Section 2

locus for homosexual research on another important ground. Several recent studies have reported the tendency for homosexuals to be less open and forth-coming concerning their sexual predisposition and practices due to embarrassment, feelings of fear, or of guilt. Although such reactions are unlikely to be in any way ameliorated by special clinic attendance for treatment for their physical disease, the homosexual may well find it easier - given an enlightened and understanding approach by clinics' reception, medical and nursing staff - to indicate his sexual preference, which it is clearly in his best interests so to do.

A further related point in favour of the special clinic as an appropriate locus for recruitment of subjects for research into male homosexuality, has recently been made by Fluker (1976). Fluker has referred to clinic attendance of patients with alleged physical symptoms but which have subsequently been shown to represent a "cry for help" in the management of their sexual drives and desires. If the special clinic can be seen to represent an environment which is as free from constraint to change in sexual preference as it is from threat of legal contravention, covert desire for psycho-sexual counselling may well become overt.

In the interests of balance and of a fair appraisal, it must be stated that there also exist (if only by inference) important objections to the proposed deployment of the special clinic for such research-subject recruitment. Of considerable weight and substance is the expressed fear that subsequent clinic attendance for treatment could be adversely affected. Any encouragement or cause for default is likely to have undesirable epidemiological consequences. It is, of course, axiomatic that any research into human behaviour is acceptable only in so far as it can be shown

to be in the best interests of those members of the group under scrutiny. Accordingly, there resides an important ethical as well as a likely epidemiological issue involved in the proposal to so recruit, which would undoubtedly require effective and regular monitoring by both clinician and researcher.

A second unfavourable reaction focuses upon the point that special clinic patients, who are also homosexuals, are very likely to differ markedly in important social and psychological dimensions to homosexuals with no history of clinic attendance or of previous infection. Homosexuals - so the argument goes - should not be presumed to be sexually active all of the time.

Without doubt, this latter unfavourable reaction represents a most formidable challenge to any proposal which favours the special clinic as a locus for homosexual male subject-recruitment. It is therefore of the utmost importance to consider the ground upon which such an objection is based in order to assess its validity.

There is of course, a particularly important preliminary point which requires to be made explicit. Although comparison studies between heterosexual special clinic attenders and non-attenders seem to suggest that there may be parallel differences between clinic and non-clinic homosexual populations, the hypothesis appears never to have been specifically tested. This omission will be remedied in the study which is here proposed. In the event of evidence emerging to indicate clear and distinct differences between special clinic and non-special clinic male homosexuals, then clearly such a location could not be regarded as constituting a satisfactoty site for any form of general study of homosexuality. Nonetheless, it would - if only for this very reason - constitute an important finding

in its own right.

It is arguable however, that good grounds do in fact exist in support of a counter-prediction: ie, that homosexual male special clinic patients will as a group, (unlike their heterosexual counterparts) be shown to be undifferentiated from their homosexual non-special clinic attender counterparts.

Such studies as have been referred to previously, have consistently indicated that it is the more sexually promiscuous indivioual who most markedly influences reported inter-group differences and not the special clinic patient attender who is ordinarily not exposed to contagion and whose clinic attendance is more likely to seem to be in the nature of an isolated event. Indeed, members of this latter group have in the past been shown to be statistically undifferentiated on key variables of interest from members of the normal population, (Bindemann et al,1978). By contrast, the 'archetypal' heterosexual male special clinic attender would, on the basis of current evidence, appear to reflect a distinctive pattern of personality trait, of social and sexual functioning, as well as to possess other distinctive but typical characteristics and features, all of which have been previously well documented, (Wells, 1969, 1970; Bindemann et al, 1976, 1978). Indeed, within this particular context, it is well worthy of note that Wells and Schofield, (1972) have reported significant differences on major personality parameters between homosexual male and heterosexual male special clinic patients. In contrast, there seems to be little evidence for attributing different life-styles to homosexual male special clinic patients on the one hand and to non-patient members of that minority group on the other.

Of course, none of this can be shown to detract from a powerful

and methodologically desirable requirement for a sampling procedure which would ensure appropriate representation of the homosexual male who lives in a 'one to one' relationship of fidelity and of sexual continence which his male consort, as well as of the member of that minority group whose homosexuality tends seldom, if at all, to entail overt sexual activity. However, short of contact through homophile groups, there would appear at the present time, to be no other avenue of likely contact open or in any way available to the researcher. Nevertheless, it is a point perhaps worth making that since such individuals are equally less likely to be representatively distributed (in the overall sense) in other sites and locations previously proposed and employed as recruiting 'stations' their absence would not in the past appear to have been considered to have constituted significant loss.

In the light of the foregoing discussion, there exists a manifest need for special attention to project-design, if only to ensure avoidance of such ambiguities as may threaten or in any way impede the investigation's declared aim and purpose; namely to evaluate comparatively homosexual male special clinic patients with:-

1) homosexual male non-attenders (and having no previous history of such attendance or of a sexually acquired infection) and
2) heterosexual male special clinic patients,

..... this in observance of the process entailed in the study's central hypothesis;

HYPOTHESIS*

That unlike heterosexual male special clinic patients, (who have previously been shown to differ significantly from non-special clinic male control subjects on well-defined attitudinal,

*This composite hypothesis will, in fact, be successively restated as individual hyposthesis within the context of the subject-matter of the particular sextions which follow.

behavioural and other variables - a finding which will be retested in this present study) homosexual male special clinic patients will manifest no such evidence of difference, when compared to a representative sample of homosexual males having no history of special clinic attendance or of infection from a sexually transmitted disease. Furthermore, that in consequence of this finding, the special clinic will be indicated as a satisfactory locus for the recruitment of homosexual males for the purpose of such minority group research.

Summary

Major dimensions of change relating to improved facilities and staffing in special clinics and similar treatment centres are reviewed.

The implications of such change in terms of research requirements and possibilities are also commented upon.

Male homosexuals within the overall clinic population are identified as a likely group for profitable study. Attention is drawn to opportunities and advantages inherent in and like objections to systematic study of this most interesting minority group.

Recruitment of homosexual subjects at special clinics and similar treatment centres, is proposed. Opportunities and advantages inherent, as well as likely objections to such a systemic study of this most interesting group are also reviewed.

DEFINITIONS AND THEIR PROBLEMS

Under any circumstances, the advancement of a definition of homosexuality which can be shown to satisfy the criteria of "necessity" and "sufficiency", is an essential pre-requisite to the kind of study which was here proposed. Previously reported attempts at just such a definition have encountered difficulties which are not easily overcome.

Freund (1974) has defined homosexuality as "..... the sustained erotic preference of same persons where there is a free choice of partner as to sex and other attributes which may co-determine erotic attractiveness". Similarly, Freund has defined the concepts of heterosexuality and bisexuality in terms of "erotic preference". For Freund, the term "sex" is used to denote, "..... male type or female type of externally visible somatic features (body shape) particularly the type of external genitalia ..... and ....(is).... not a preference for the type of sexual behaviour of a potential partner or for the type of one's own preferred sexual behaviour." Freund therefore claims that "sustained erotic preference" is the key. Actual behaviour is for him, an unreliable predictor: i.e. "homosexual interaction, even if occurring regularly, is not by itself a very reliable indicator of homosexuality".

More recently, Phanjoo and Whitlow, (1978) have noted a tendency in Britain to confuse homosexuality with the practice of sodomy (anal intercourse). Phanjoo and Whitlow, (1979) are in fact, at 'pains' to enumerate some of the difficulties which stem from this confusion between homosexual behaviour and homosexuality, defining the latter term as an internal state of the individual which is largely independent of actual behaviour and which remains stable throughout his life.

Feldman(1973) has also attempted to overcome the problem of definition by referring to homosexual behaviour as "homosexual activity or fantasy directed toward orgasm with a partner of the same sex, which is persistently recurrent and not merely a substitute for a preferred behaviour, that is - heterosexual behaviour made difficult of obtainment by the immediate environment".

By contrast, Bieber, (1967) regards sexual behaviour as a

necessary component within his definition. He defines homosexuality as "..... an adaptation characterised by sexual behaviour between members of the same sex." Even so, Bieber, (1967) is clearly aware of the inherent problems which beset such a definition. Indeed, he himself poses the question - "What does sexual behaviour include"? Masturbation by pre-adolescent and adolescent boys is discounted. Such behaviour, although overtly sexual, is classified as being "onanistic ..... transpiring among males and not between any two".

Other equally widely divergent attempts to solve such theoretical problems as would appear to frustrate an acceptable definition, have been postulated by Kinsey et al (1948) and by Marmor, (1965).

Kinsey relies solely upon self-reported behaviour by means of a seven point scale, the purpose of which is to determine hetero-sexual/homosexual balance. By way of example, a respondent who returns a score of zero, is one who has had neither homosexual inclination nor experience. At the opposite pole, a respondent returning a score of six or seven would be exclusively homosexual in terms of sexual preference and practice. The classification 'bisexual' is assigned by Kinsey et al (1948) to the respondent whose score approximates to the midpoint.

For Marmor, (1965) consciousness of preferential homosexual desire is the criterion. Accordingly, only such persons as are homosexual psychodynamically are so classified. (It is worth commenting at this point, upon a potential difficulty of rating actual awareness of sexual preference as the essential component, where one is seeking to classify the homosexual prostitute, who may well be motivated solely by a desire for monetary gain.)

Feldman and McCulloch (1971), in their attempt to classify homosexuals into "types", have divided them into primary homosexuals

(those who have never shown the slightest predisposition in favour of heterosexuality) and secondary homosexuals, (those whose sexual history does indicate or include heterosexual interest or behaviour).

In the light of the many besetting problems which seriously militate against the achievement of a necessary and sufficient definition and classification of homosexuality and homosexual types, any such further attempt must be undertaken with caution and all necessary qualification. Nonetheless, a working definition is an obvious and necessary pre-requisite for the purposes of this particular study in which it is clearly necessary to distinguish satisfactorily members of the two principal research groups, namely homosexual and heterosexual males. Accordingly, such an attempted definition is given as follows:-

> "Homosexuality, (as the term and classification refers to actual subjects who participated in the study undertaken and reported in this theses), entails evidence of an erotic preference which has been manifested in a pattern of sexual behaviour to the point of penetration, with a person of the same sex. Conversely, where evidence has been apparent of a clear and exclusive preference and selection of a person of the opposite sex, the classification "heterosexual" is appropriate. The classification "bisexual", is applied to such persons who, at various times had manifested a clear preference for sexual activity to thepoint of penetration with same-sexed and opposite-sexed persons, in situations or over a period of time where both sexes would have been equally available".
> The criterion of "penetration" is employed in the interests of clarity of distinction between the two populations, as they presented at special clinics and were classified by clinics' staff. It is, of course, recognized that genito-oral sexual activity between males and females and between males only occurs and in this latter group, might accordingly satisfy the "sufficiency" criterion entailed in the definition. At the same time, it may be pointed out that such a definition does in contrast, fail to meet the "necessity" criterion. On the other hand, inclusion of the term "penetration", can be seen to satisfy the demands which are made in the interests of sufficiency, although clearly there are widely divergent points of view as to whether it is an activity which is necessarily entailed in a homosexual identity. All that can be added regarding this study is that throughout its

entire life no patient who admitted genito-oral sexual contact only, was identified as being a homosexual contact. Similarly, no homosexual control subject admitted to or any way referred to participation in genito-oral activity only, with their sexual partners.

Summary

The need to meet necessity and sufficiency criteria in an adequate account of homosexual behaviour and of a homosexual life-style is made explicit. Particular problems which frustrate and which therefore militate against the achievement of such a desired end are referred to with some detailed reference to the appropriate literature.

A working definition specifically related to a study of male homosexuality within a special clinic population is proposed.

AETIOLOGY OF HOMOSEXUALITY

Much of the available documented evidence concerning even a detailed elaboration of causal factors would in all probability, be unacceptable at the present time to most branches of science, principally on the grounds of its fragmentary/controlled nature of composition. Nonetheless, a review of the major contributions to the relevant literature is of particular consequence to the aims of the study here to be reported and for the following reasons.

Firstly, such a recognition of past belief and opinion is so much more than an interesting statement of historical fact. Rather does it possess a unique capacity to inform about past beliefs and opinions, whilst simultaneously providing an admittedly rough but none the less useful index of evolving sexual attitudes from which they emanated. Secondly, they combine to emphasize the present and future necessity of a multi-disciplinary approach involving the sciences of physiology, endocrinology, psychiatry and psychology and others beside. Thirdly, an elaboration of major aetiological considerations provides the soundest possible base for the formulation of testable hypotheses.

Toward the end of the eighteenth and at the beginning of the nineteenth century, homosexuality was pronounced to be a form of insanity with masturbation its principal causal factor, (Tissot, 1764; Rush, 1830). In fact, it was the 'nature/nurture' controversy which characterized the first really serious attempt to promulgate a genuine and worthwhile aetiology. Ellis, (1901), who had formerly supported the idea that homosexuality was acquired, became just one of many notable figures of his day to reject the 'acquired' thesis in favour of a genetic explanation.

In the event, this particular development seems at the time.

to have afforded both relief and comfort to hard-pressed medical opinion. Such an acceptance was partly due to the fact that the nurture thesis had harboured certain grave disadvantages and anomalies; namely, that if homosexuality was acquired, it would - theoretically at least - be reversible and treatable. Similarly, the legal profession had good reason to accede to this change in the then current thinking. As an 'acquired vice', homosexuality could not be held to be exempted from legal sanction. In reality, such a state of affairs would not have presented undue difficulty had its practice been confined to the lower strata of society. However, it was not then, any more than it is today, a mere function of class or social status. Nonetheless, if professionally and therefore officially, it could be judged to be 'inborn' and ipso facto, irreversible and untreatable, the sufferer could hardly be castigated or in any way blamed for his consequent behaviour.

Finally, the church with its historically-derived authority and power to influence, or to effect change in public opinion, gratefully endorsed the conclusion that homosexuality rightly belonged and could safely be assigned to that most inaccessible and therefore safest/of all categories immunity* "Act of God".

Genetic Causation: Many of the early accounts which embraced genetic theories of causality were invoked by default, in the absence of tenable alternative theories. However, serious studies providing evidence as to the likely importance of heredity gradually began to emerge. One of the earliest of such studies was reported by Lange, (1931). Investigating a series of twins with criminal records, Lange found some history of homosexual behaviour in two monozygotic twin pairs. Both members of one pair were homosexual, as was one member of the

other pair, who also had sustained brain damage. Lange's publication was swiftly followed by the publication of comparable evidence, this time undertaken and reported by Sanders, (1934) who alleged concordance in five of, in all, seven male monozygotic twin pairs. Not many years later, Lang, (1940) propounded the view that some male homosexuals appeared to be "..... male sex intergrades which are genetically female but (which) have lost all morphological sex characteristics except their chromosomal formula". Lang, (1940) concluded that homosexuality was due to an imbalance between autosomes and the feminising X chromosomes and that some homosexuals, although being phenotypical males, were genotypically female.

Strong evidence against Lange's theory has since been produced notably by Pare (1956) who reported a normal male chromosomal pattern in his study of fifty male homosexuals. However, such findings have by no means excluded a genetic aetiology for homosexuality and the study of homosexual monozygotic twin series continued to gather momentum.

Habel, (1950) reported concordance in three of five monozygotic twin pairs and in none of five dyzygotic pairs. In the particular study referred to here, it happened that the homosexual index twins had been drawn from a German prison population, where choice of a male sexual partner could arguably have been dertermined by the ansence of an available alternative. Even so, a predominant interest and value of such studies resides in the level of additional interest and emphasis laid on the distinction between genuine and pseudo homosexuality.

One of the largest and best known of all twin studies was that reported by Kallman, (1952) who recorded complete concordance for

homosexuality in thirty-seven monozygotic twin pairs, compared to a twelve per cent rate among twenty-six dyzygotic twin pairs. Although it is generally agreed that Kallmann's sampling technique is open to serious question, a point which he subsequently acknowledged, Rainer et al (1960), it clearly proved to be a noteworthy exercise and one which once again lays due emphasis upon the many problems which may beset all such investigation into the origins of homosexual behaviour.

Another well-documented study to which reference will here be made, is that published by Heston and Shields, (1968) who analysed data derived from the Maudsley Hospital Twin Register 1959-61. Concordant homosexuality was reported in two out of five monozygotic pairs and in one out of seven dyzygotic pairs. Heston and Shields, (1968) further reported upon a family of fourteen which contained among its members three pairs of monozygotic twins. In two pairs, all four twins were homosexual, whereas both twins of the remaining pair were apparently heterosexual.

Money, (1962) has suggested that the tendency for monozygotic twins to be more alike than dyzygotic twins in regard to homosexuality is more likely to be related to problems of sexual identification which predispose to homosexuality, rather than to genetic factors. However, the Heston and Shields', (1968) study refutes this suggestion by referring to the absence of any evidence which shows monozygotic twins per se to be especially prone to homosexuality. Nonetheless, the relative contribution of genetic and environmental factors has produced no small measure of controversy.

There have been several reports of monozygotic twins discordant for homosexuality (Sanders, 1934; Lang, (1940); Rainer et al, 1960; Klintworth, 1962; Parker, 1964). Davidson et al, (1971), reporting

on a male monozygotic twin pair who were discordant for homosexuality concluded that "the difference in their overt sexual orientation ..... (was) ..... almost entirely a consequence of differential environmental influence". However, Davidson et al, (1971) themselves, refer to a point made by Rainer et al (1960); namely that the occurrence of such cases does not invalidate the genetic hypothesis since they can be explained in terms of incomplete penetrance, or even differential cytoplasmic inheritance.

Zuger, (1976) has argued impressively that "the exceptional occurrence of monozygotic twins, discordant for homosexuality does not ..... detract from the impressive degree of reported concordance". Zuger points to the possibility that " ..... factors other than genetic may be operating pre or paranatally ..... (and this) ..... does not support a familial environmental causation .....".

Whilst there is no evidence to indicate that monozygotic per se predisposes toward homosexuality, it seems reasonable to at least allow for the possibility of an inherent predisposition (Pare, 1965), an hypothesis which will doubtless continue to receive further attention.

Hormonal Theories: It seems reasonable to conclude that endocrine abnormalities evident in homosexuals, have added considerable weight in favour of a constitutional factor in the pathogenesis of homosexuality. Current technology, sensitive enough to measure accurately minute concertrations of sex hormones in body fluids, have highlighted this most interesting and potentially productive area of enquiry. However, as with the findings on monozygotic twin concordance, the evidence is, as yet, far from being conclusive. Whilst it is the case that a number of studies have positively related sex hormones to sexual orientation, (Margolese, 1970; Kolodny et al, 1971; Evans,.1972; Margolese and Janiger, 1973;

Doerr et al, 1975; Starka et al, 1975), there are almost as many studies which have concluded that the relationship is a negative rather than a positive one. (Tourney and Hatfield, 1972; Birk et al, 1973; Barlow et al, 1974; Pillard et al, 1974: Tourney et al, 1975).

Friedman et al, (1976) have reported upon a pair of male monozygotic twins whose sexual orientation differed. Results contained in the study show that despite differences in their psychological development and personality structure, blood levels of testosterone and oestradiol were equivalent in both individuals.

In only three other reported similar investigations to date, Rainer et al, (1960) likewise found no difference, as also did Mesnikoff et al, (1963). Similarly, Klintworth, (1962) has observed normal levels of testosterone and oestradiol in a homosexual male. However, Klintworth, (1962) did not measure steroid metabolities in his heterosexual twin. Undoubtedly more sensitively controlled studies require to be carried out before results can be offered with reasonable confidence as providing conclusive evidence either way.

A related investigation of considerable interest and importance has originated out of animal research originally undertaken by Pfeiffer, (1936) and subsequently developed and extended by Harris and Levine, (1965) and Goy, (1968). Their combined studies would appear to indicate how at certain critical periods of foetal development, central nervous system mammals are masculinised by circulating androgens. Failure of, or interference with this mechanism,can result in the masculinisation of a genetic female, or in failure to masculinise a genetic male.

Money and Ehrhardt, (1968) have noted that human females who have been exposed to androgens in utero and are born with hermaphrodite,

are also likely to be aggressive and tomboyish. However, Money and Ehrhardt, (1968) stress the point that this pattern of behaviour should not be directly associated with lesbianism or transexualism. Indeed, such studies as have been reported concerning the effect of androgens adninistered at critical periods, would seem to have little to do with the direction of sexual drive at all. Even in case histories where patients and normal subjects have had sex hormones administered to them, it has been noted that whilst power and potency of the drive may be increased, its direction does almost invariably remain unchanged, (Money and Ehrhardt, 1968).

Other Physiological Factors More than thirty years ago, Silverman and Rosanoff, (1945) reported their finding on the association between homosexuality and EEG abnormality. This investigation involved fifty-five homosexual prison inmates within the age range 17-43 years (mean age 25.9). Of this number, three subjects (5%) had normal EEGs and twenty-four were anomalous, i.e. Grade* II and Grade III. Abnormal EEGs (Grade IV) were recorded on twenty-eight subjects (51%). Of this number, more than two in three subjects were shown to have organic cerebral impairment, with a slightly less extreme subject-ratio manifesting psychotic or psychopathic characteristics. Half of the twenty-eight subjects were graded as border-line and the remaining fourteen were graded as normal. Of this latter group, eleven subjects produced an "overbreathing" response, i.e. slow EEG activity in response to hyperventilation. From these results Silverman and Rosanoff, (1945) concluded that a "pathologically functioning brain" might be a contributory factor to the aetiology of homosexuality.

*Grade I normal with no slowing during overbreathing
Grade II some slowing apparent during overbreathing
Grade III marked degree of cerebral immaturity present
Grade IV definite localised abnormalities present

Recently, Papatheophilou et al (1975) have taken up the question relating to the twenty-four (44%) anomalous subjects to which Silverman and Rosanoff, (1945) had referred as subjects displaying cerebral immaturity. Papatheophilou et al (1975) analysed the EEG records of thirty male homosexuals and thirty heterosexual control subjects matched for age (mean 26.2), social class and I.Q. EEG records were graded in accordance with the classification given. Papatheophilou et al, (1975) reported a significantly higher level of cerebral immaturity among the homosexual population, (63%) by comparison with that reported for heterosexual control subjects (27%). Homosexual behaviour - so the authors maintain - is by no means uncommon in adolescence and may well be regarded as a phase of quite normal development. The authors suggest therefore, that a degree of cerebral immaturity may be considered as being predisposing to homosexuality. Papatheophilou et al (1975) further suggest that such findings may well point to "a retardation or even failure of psychosexual development, with increased susceptibility to sexual trauma and seduction".

In the context of such hypotheses as Papatheophilou et al, (1975) have postulated, the findings of a study reported by Kuethe, (1975) assume particular interest and significance. Kuethe designed his study in such a way as to permit an objective investigation of the "man-woman schemata" employed by a group of one hundred and forty equally proportioned (sexually) ten to eleven year old children. These he compared on the basis of schemata-patterns pervasive in sexually mature populations. Subjects' task was the free placement of male and female figures cut from felt on a flannelled board. Kuethe's principal hypothesis predicted that the schemata employed in the arrangement of the figures would be similar between children and homosexuals when these two groups were compared with sexually

mature males and females. The prediction was based upon the assumption that " ..... when certainschemata lack potency, there are cognitive consequences which are independent of whether the schemata failed to acquire such potency for pathological reasons (homosexuality), or because the individual although normal, had not yet reached the developmental stage when the schemata acquire potency, viz., childhood". In fact, the author suggests that children may be considered to be homosexual, i.e., inadequately sensitised by virtue of their currently normal state of psycho-sexual, physical and endocrinological immaturity. Kuethe, (1975) claims that his results demonstrate a substantial difference between the child and homosexual populations on the one hand and the sexually mature population on the other. More specifically, he maintain that this difference is indicative of the way in which subjects routinely employ specific schemata. The principal and very particular difference was (according to Kuethe) apparent in the lower frequency with which the children and the homosexuals employed in hisstudy both appeared to give special emphasis to the man-woman relationship. Kuethe, (1975) suggests that his results may be interpreted as showing how certain schemata such as are pervasive in mature hetero-sexual population possess less potency for children than for homosexuals. Accordingly, he concludes that whereas for most of the children such schemata will develop with maturation, for the homosexual such a maturational process has simply not taken place with anything like the same potency as might ordinarily be pre-dicted for heterosexuals, or that other competing schemata have come to predominate. One might just observe as a final comment on Kuethe's conclusions, that such a submission could hardly be judged to be in line with the explanations he offers concerning

homosexual subjects' readiness to 'pair' male with male and female with female, viz:- that " ..... this particular schemata is too obvious for the homosexual, who rejects it in favour of more socially acceptable schemata".

Experiential Factors: The question has inevitably arisen as to whether analysis of the behavioural concomitants of genetic and/or experiential causality can throw further light by directing its focus upon the latter. Historically, the nature-nurture argument has postulated a dichotomous and mutually exclusive aetiology. However, a more productive trend has been in the direction of testable hypotheses which avoid the inflexibility of polarization i.e., whilst the genetic input may well predispose toward a homosexual preference and life-style, to be expressed behaviourally in the form of a particular concentration of personality traits, a sufficiently sensitizing environment might nonetheless constitute an essential pre-requisite to its actual expression. By way of example, one might refer to the factor of human intelligence which clearly is influenced by genetic input in the development of potential ability for intelligent behaviour. An alternative (albeit rather simplistic) means of expressing the same point, is to assert that in response to motivation and adaptability to the environment, intelligence is very much a function of inherited factors and characteristics; e.g., number, type, metabolism, conductivity of a particular type of brain-cell which constitute an essential foundation upon which potential for further conditionability, selectivity, combination and "transfer of training" is inevitably set. It is of course, overwhelmingly the case that its first contact with the real world is experienced within the context of home and the 'nuclear' family.

Understandably therefore, study of parental authority as a factor involved in its subsequent growth and development, has certainly not been neglected as constituting a potential factor of aetiological significance in the study of male homosexuality. However, since it is arguably the case that the most relevant influence of such experiential factors is more appropriately reviewed within the context of maturation, learning and subsequent growth and development of personality, their status and significance will be afforded detailed treatment in the following section.

Summary: The historical development and perspectives of recorded attempts to identify major causal factors in male homosexuality, are reviewed. The nature-nurture dichotomy is particularly emphasized as representing the broad dimensions of a debate which has generated considerable research interest and activity. Because of their unique potential for controlled study, twin studies have provided an acceptable methodological basis for fruitful enquiry. Some studies of this sort are known to have supported a thesis of discordance for homosexuality among monozygotic twins. There is however, an impressive record of support in favour of concordance. The argument which postulates a constitutional factor in the pathogenesis of homosexuality, has also found support from evidence of the occurrence of abnormalities. This evidence is reviewed together with support deriving from other physiological factors.

Historically, a dichotomous and mutually exclusive approach to the status of experiential factors in the aetiology of homosexuality has, at last appeared to encourage the growth of rival interpretations and explanations. Such an inflexible approach is increasingly being acknowledged to be sterile and counter-productive. More

recent attempts to postulate hypotheses which can avoid polarization of this sort have laid emphasis upon the likely effect of interaction between heredity and experiential input variables, e.g., the nature and quality of family - and particularly of parental relationships have stimulated much interest and generated productive research activity.

HOMOSEXUALITY AND PERSONALITY DEVELOPMENT

It would seem reasonable to assert that that which is most representative of the individual - and which differentiates him from other individuals - is encapsulated within the concept of personality.

In the first place, it is precisely at this point that the complex interaction of heredity and environment finds expression in an ordered and congruent way. Second, it is through personality that mediated behavioural adjustment may be observed and measured. Thirdly, the study of personality has already yielded a common vocabulary which is routinely employed to describe the individual (or group of individuals) in accordance with previously defined and well established criteria. Such criteria are the essence of the necessary theoretical formulations, constructs and descriptive dimensions of personality theory. Fourth, such a vehicle for the necessary common description and analysis of behaviour is at the heart of specific, testable propositions. Indeed, it is precisely this latter facility which can convert a given theory from a mere "after the fact" rationalization into "before the fact"predictiveness.

It is at this point worth restating the aim of this incursion into the study of personality development. The aetiology of homosexuality has been shown inextricably to be bound up with an hereditary input as well as with the modifying influence of environment in interaction with such behavioural potential. Since it is the case that psychologic theory relies heavily upon inference and may be quantified only indirectly, via the behavioural component, it seems reasonable to assume that causal relationships will be most evident at this focal point of maximum accessibility for objective

measurement.

Such an analysis will hopefully account, at least in part, for the divergence that is wellknown to exist between rival theories concerning the origins and development of a homosexual preference and lifestyle.

One possible approach is arguably inherent in the recognition of an undeniably wide variety of conflicting conclusions, such as theoretical conceptualizations of personality structure and personality dynamics have tended to produce. It is a fact of history that such differences have tended to dichotomize between major rival interpretations and explanations. At the same time, they can clearly be shown to possess a well-defined common vocabulary which is descriptive of those motivational forces and general emotional and cognitive processes whereby behaviour is organised and integrated.

The Psycho-analytic Approach:- Psycho-analytic theory seeks to explain male homosexuality in terms of the Freudian elaboration of the Oedipus complex (Freud, 1905). The theory maintains that prior to the onset of the "phallic" period, the boy loves his mother and tends to identify with his father. As sexual drives develop and mature, the boy's love for his mother may tend to assume an incestuous nature. In situations where such an event does actually occur, the father is most likely to be perceived by the child as a rival for the mother's love. Such a state of affairs is known to result in the child's failure to negotiate and to resolve the phallic stage of psycho-sexual development, as well as to cause him to internalise particular characteristics of the mother as part of himself, (Altman, 1971, 1973). Freud therefore, believed that the individual's homosexual relationships symbolised a form of defence by regression to a fixation point in his libidinal

development. Accordingly, homosexuality has been regarded as a regression to the narcissistic phase in a desperate attempt to recover and to convert the 'mother child' relationship into a permanent state. Freud, (1905) further maintained a likelihood of homosexual preference and lifestyle ensuing from other fixation points in individual development, e.g. fixation at the oral stage, thus emphasizing the anxiety reaction which the homosexual experiences and which is occasioned by fear of the loss of the breast. Fixation at the anal stage does, according to Freud, emphasise his need for release and relief. Taken together, these are the libidinal precursors of castration anxiety, itself arising from fear of retaliation for harbouring castration wishes toward the father. Freud (1905) claimed that the over-valuation of the penis causes such an individual to avoid those persons who are lacking in this attribute - i.e. females. Thereafter, sexual responses, attitudes and behaviour tend to determine all future interpersonal relationships and are themselves, likely to be influenced by all the other dynamic interactional processes which are operant in human relationships (Bieber, 1976). Homosexuality is therefore induced and under such latter circumstances, the female (passive) role is likely to be the more commonly proffered. Moreover, the adhesive tie between mother and son may continue to promote intensely rivalrous feelings on the part of the son toward his father. Where the father successfully achieves fulfilment of the paternal role in such a manner as to encourage a masculine identification, this sexually-determined competition is most likely to be countered and neutralised. However, where the father is inclined to be weak, detached and remote, frustration caused by paternal need, will tend to promote increased and pathological

dependency on the mother. In consequence, the child is said to experience difficulty in identifying with his father whilst not daring to love his mother, or for that matter, any other female. Psycho-analytic theory concludes that such childhood fears of his mother at this stage, may well cause him subsequently to renounce all women and in ensuing homosexual activity, be more likely to favour the male (active) role.

In summary therefore, over-attachment to an exploitive mother and intense hostility toward a sexually destructive father is, according to psycho-analytic theory, the classic outcome of a morbid resolution of the Oedipus complex. Moreover, since the Oedipal male homosexual is frequently beset by feelings of deep shame and guilt, he is likely to experience difficulty in maintaining interpersonal relations and in consequence, is portrayed as being characteristically dissatisfied, withdrawn and lonely.

Whilst it is the case that the major postulates and ramifications of psycho-analytic theory are Freudian in origin, more recent aetiological formulations of male homosexuality tend to manifest subtle but important modifications from those enunciated by Freud. Reference has, for example been made by Miller, (1971) and by Hoffman, (1973) to differences which allegedly exist between what they refer to as Oedipal and non-Oedipal male homosexuals. Accordingly, the Oedipal male homosexual is more likely to try to change himself, with or without professional help. Moreover, he is concerned not to be open about his homosexuality (Warren, 1974).

In contrast to Oedipal male homosexuals, non-Oedipal male homosexuals would appear unlikely to experience feelings of shame and guilt and may well attempt to lay emphasis upon their homosexual

status, (Hoffman, 1968; Humphreys, 1972). Similarly, it has been claimed for such individuals that they may appear more likely to seek to convert the heterosexual to a homosexual lifestyle (Karen, 1971).

Other alleged differences have been reported by Masters and Johnson (1970) who claim that whereas the Oedipal homosexual favours a more conventionally heterosexual mode of dress and behaviour, non-Oedipal homosexuals are much less likely to conform to such a life-style.

Peretti et al, (1976) have summarised the typical Oedipal male homosexual as being:

(a) less likely to have exclusively homosexual relations;

(b) less likely to have such a high frequency of homosexual sex as non-Oedipal homosexual males;

(c) less likely to have experienced all of the more common non-sexual practices;

(d) less likely to have developed a strong degree of commitment for the homosexual partner.

Peretti et al, (1976) have also reported significant differences between Oedipal and non-Oedipal homosexual males on the criteria of self-image and emotional stability. By comparison with non-Oedipal homosexuals, Oedipal homosexuals are reported as displaying more negative self-images, negative self-worth and negative self-confidence, as well as manifesting much lower levels of self-acceptance. They appear to experience more emotional problems and in particular, to experience a greater sense of shame and guilt, withdrawal and depression. A markedly lower success rate in sexual activity and commitment to their homosexual partner has also been reported for Oedipal homosexuals.

A further important distinction which can be shown to distance Freud from more recent supporters of the psycho-enalytic theory of

male homosexuality, refers to his lack of emphasis upon what others have argued to be an important factor, viz., parental psycho-pathology. It is, of course true that Freud had earlier described the intense erotic attachment to the mother and the inadequacy of the father, theoretical conceptions which were undoubtedly orientated to child psychology and specifically set within the context of Freud's libido theory. However, parental psycho-pathology, as it relates to the successive maturational phases, was not regarded by Freud as being a factor having major influence.

Recent years have witnessed the growth of a truly voluminous literature, doubtless inspired originally by Freud's pioneering work. Throughout this period, the significance of the parent-child relationship as an aetiological factor in male homosexuality has been powerfully reinstated.

Certainly it would, in general terms, be difficult to over-emphasise the potency of such a powerfully formative relationship throughout successive phases of development, from infancy through to adulthood. By means of its unrelenting influence upon social learning and early attitude development, the parent-child relationship may be rightly regarded as contributing significantly to the nature and quality of psycho-social development and adjustment. It possesses the power to influence the strength of peer-group association and community participation, via a capacity to convert successive stages of change into genuine growth and development. Little wonder therefore, that in their search for aetiological factors, whether of personality development or of homosexual development <u>per se</u>, theorists and practitioners alike have directed the focus of their interest and attention onto the influence of parent/child relationships. Moreover, there would seem to be

no shortage of available evidence in support of such an analysis of personality development in homosexual males, for had not Freud, as early as 1916, described the mothers of homosexuals as being "excessively loving?" a view which as has been previously shown, was inherent in his own theoretical formulations. In the event, this particular characteristic of the female parent, has been continually emphasized. However, it is important to recognise that such later contributors as Terman and Miles, (1936), Fenichel, (1949) and Bieber et al (1962) have gone considerably further than ever Freud was prepared to do in emphasizing its erotic component. Indeed, their contention that such a mother may frequently be perceived to covertly stimulate a sexual arousal in her son, even to the point of preference to the father, has really very little to do with Freud.

A further dimension of the abnormal mother/son relationship, which has more recently been described, refers to the allegedly relentless influence of emasculatory behaviour on the part of the mother who seeks to dissuade her son or actually prevents him from participating in masculine activities (Bieber et al, 1962). Bieber et al (1962) refer to such mothers as being "..... overly close, overly intimate, possessive, dominating, over-protective and demasculinising. ..... (who) ..... openly prefers son to husband."

Several investigations into aetiological influence upon the personality of male homosexuals have reported upon the presence of an ineffective, passive or hostile father. Once again, it was Freud, (1916) who first drew attention to the inherent potential of the father's role in the development of male homosexuality. Nevertheless, it is important to note that he went no further

than to describe them as being "retiring or absent altogether". However, Stekel (1930) has specifically referred to "weak" fathers, whilst Terman and Miles, (1936) have claimed to have observed that fathers of homosexuals typically tend to be autocratic, lacking in sympathy and frequently absent from the home.

In a more recent study, Thompson et al, (1973) investigated the parent/child relationship and the sexual identity of male and female homosexuals as compared with matched heterosexual controls. In his study, female homosexuals reported more negative relationships in childhood with their fathers and appeared to be distanced from both parents and from people in general when compared to control subjects. Male homosexuals were shown to differ from their heterosexual counterparts by virtue of their close-binding, intimate mothers and hostile, detached fathers. Thompson et al, (1973) further reported that male homosexuals displayed a more feminine pattern of childhood development and were also found to be less masculine than were heterosexual control subjects when results of a masculinity-femininity test were compared.

Similar findings have been reported by Stephen, (1973) in his investigation into parental relationships and early social experiences of male homosexuals. However, Robertson, (1972) referring to the results of his investigation into parent/child relationships and homosexuality, made the point that whilst the child's relationship to both parents is individually important, it is the differing nature and pattern of relationships with male and female parents that appears to be significant for the development of heterosexuality/homosexuality. Indeed, Robertson insists, on the basis of the findings reported in his study, that the nature of the relationship between child and mother does not in itself,

appear to be of any overriding importance.

Bene, (1965) in a well-documented study of both male and female homosexuality, found no evidence of irregular mother/child relationship. Indeed, Bene clearly regarded the father as being the most significant figure for homosexuals of both sexes. (Nonetheless, the high prevalence of an absent father so frequently reported by homosexuals, gives rise to doubt concerning this contention).

Bieber et al, (1962) have referred to fathers as being "..... detached ..... unaffectionate .....(and) ..... hostile .... to the son" - a presumed consequence of rivalry for the mother's love. Bieber et al, (1962) in fact, labelled this characteristic family pattern, the "triangle system" and support in favour of his hypothesis has been proffered by Benda (1963), Brown (1963), Edwards (1963), O'Connor (1964), Whitener and Nikelly (1964), Evans (1969) and Snortun et al (1969).

Other findings concerning the importance of the role of parents of homosexuals to subsequent personality development and lifestyle, have been reported by Apperson and McAdoo (1968) who noted that whereas fathers were overtly concerned about their sons' feelings, mothers tended to display more permissive and over-indulgent attitudes toward their sons.

Although there is considerable evidence of support for the parental-influence thesis, it has by no means gone unchallenged. In a comprehensive study of male homosexuality, Siegelman, (1974) has undertaken an equally wide-ranging investigation of the parental background of a group of male homosexuals, comparing it with that reported for a control group of male heterosexuals. Siegelman's comparative analysis of biographical, demographic,

personality and masculinity/femininity data obtained on instruments of known reliability and validity casts considerable doubt on the most prevalent assumption; viz., that negative parental behaviour - especially of the mother - plays a critical role in the development of homosexuality. For sub-samples low on neuroticism, (as measured by the Neuroticism Scale Questionnaire (NSQ)), (Sheier and Cattell 1961), Siegelman reported no significant difference in family relations, although the total sub-sample favoured a description of both the male and the female parent which portrayed them as being less loving and more rejecting.

In the light of such a voluminous literature claiming a meaningful association between such family bonds and the behavioural phenomenon of homosexuality, it is important to present the counter-case which concludes that " ..... disturbed parental relations are neither necessary nor sufficient conditions for homosexuality to emerge" (Hooker, 1969). Siegelman (1974) has further drawn particular attention to "serious inadequacies" in methodological and sampling procedures in the vast majority of studies alleging a significant relationship. In particular he alleges:-

1) A disproportionate emphasis upon clinical and criminal samples.

2) distortion due to the inadequate size of sample employed. (less than fifty subjects in four out of every five such studies).

3) a tendency to ignore and apparently to disdain instruments of assessment possessing proven psychometric properties of objectivity, reliability and validity.

In addition to hypotheses (which will be formally stated in the appropriate section; see Section "Statement of Hypotheses") concerning the influence of parent/child relationships upon personality development and subsequent behaviour of male homosexuals, other indirect influences have been proposed and critically examined.

These include marital discord between parents, parental sex preferences and reaction toward effeminacy. In a wide ranging series of studies (Bakewin & Bakewin, 1953; Green and Money,1964; Zuger, 1966, 1969, 1970, 1974 , such differences have consistently failed to emerge, as also any significant findings relating to ordinal position of the affected male (Siegelman, 1973; Zuger, 1974).

Similarly, significant differences have failed to show up in studies concerned with the relationship between homosexuality and other potentially relevant factors such as parental age, complications of pregnancy, birthweight and such early medical conditions as indirect inguinal hernia, enuresis and undescended testicle (Murdoch et al, 1970; Abe and Moran, 1969; Zuger, 1974; Pasamanack and Lillienfield, 1955; Natality Statistics Analysis, United States, 1962; Rabe and Holmes, 1965).

The Social Learning 'Behaviourist' Approach:- By far the most serious challenge to the psycho-analytic theory of personality development and to its conceptualisations concerning the developmental processes which can predetermine homosexual behaviour, have come from the behaviourist proponents of the 'social learning theory'.

The central objection of social learning devotees to the psycho-analytic doctrine, is essentially one of approach. Proponents of behaviour theory regard the very basis on which psycho-analysis is founded as being overly reliant upon anecdotal and philosophical material to the detriment of data of an experimental and scientific origin and nature. In consequence, they accuse its supporters of reversing accepted scientific methodology by attempting to draw conclusions, deduce facts and establish laws from the process of treatment itself, rather than from carefully controlled and painstaking experiment. Any attempt therefore, to set up testable

hypotheses is consistently open to the charge of chronic logical circularity. Only by a procedure which permits testable deductions, so behaviourists maintain, can theory and practice be satisfactorily and confidently developed.

Through the successive contributions of its principal proponents, (Thurston, 1935; Mowrer, 1950; Dollard and Miller, 1950; Bandura and Walters, 1963; Skinner, 1938, 1953, 1968; Eysenck, 1952, 1960) the social learning theory of personality and its own consequential psychotherapy, has achieved considerable status. The very fact that many who have made major contributions toward its development would be more accurately described as learning theorists rather than personality theorists, underlies the 'behaviourists' most basic tenet; that human personality develops as it is similarly effectively modified by the relentless application of the principles of learning. The key to human personality, according to its enthusiastic proponents, therefore lies in adaptation to the contingencies of one's own very unique environment. Differences between personalities are best understood, described and - where desired - so modified in terms of the conditions of learning to which the individual has been exposed.

In contrast to psycho-analytic theory, behaviour theory is concerned with observable phenomena such as can be described and quantified. Its proponents regard sexuality as being of no greater importance than is any other human attribute or activity. They argue that the frequent involvement of sex in human conflicts is not really due to its greater importance at all, but simply because it is more frequently under attack and in consequence, is therefore likely to be inhibited than are any other primary drives. Sexual intercourse can accordingly be described as a very specific expression of emotional, perceptual and

cognitive activity. Moreover, because there exist powerful reinforcements for heterosexual behaviour, it is predictable that most individuals will tend to develop a preference for heterosexual behaviour. Any exception to this pattern, viz:- the development of a preference for homosexual behaviour, must be regarded as clear evidence of deviance from the norm. Consequently, such sexual deviance is just another behavioural manifestation for scientific observation and interpretation. Whereas proponents of the psychoanalytic approach seek to modify behaviour indirectly by focussing upon thought and feelings, which have mainly been historically determined, the behaviour therapist will seek to affect cognitive and emotional activity through the modification of the behavioural act. Thus the behaviourist approach concludes that the only form of effective psychotherapy represents a process of re-education or re-learning, and that such efforts should, wherever feasible, be based upon learning models such as have been developed in the experimental laboratory.

There is undeniably much support for the contention that the behaviourists' approach to human personality reduces to the minimum, sterile argument over certain key terms well known in psycho-analytic theory. Furthermore, behaviourism embodies what is, for many, the further attraction of regarding theories as sets of rules, which are employed only when there is a preference on the grounds of utility over other sets of rules. Its methodological sophistication is principally responsible for its relative explicitness and formal adequacy as a theory. Indeed, stimulus-response, (s-r) theory - as one of its 'branchline' developments known to personality psychologists - has come to typify,more than any other, an experimental, objective approach to human behaviour.

It is important to analyse the differences that exist between such rival theories and the ground from which they derive, since there

are likely to be major implications for personality description and analysis. Furthermore, if behaviourists complain against adherents of the classical theory on the grounds of an alleged reversal of accepted scientific methodology entailing a process which is logically 'circular', it seems reasonable to attempt to elicit at least the cardinal tenets of the behaviourists explanation of human behaviour. Within the context of this particular study, such a requirement is central to a study of homosexual behaviour, since if there does actually exist objective behavioural determinants which can be identified and measured, we need to know what they are and how access may be obtained to them for empirical testing. Indeed, the question is the more pertinent in the light of serious allegations which have been levelled against the behaviourists' theoretical formulations concerning personality development. These may be summarized as follows:-

1. It is built upon overly simplistic, naive and at times, altogether irrelevant premisses. Consequently, S-R theory as it is known to personality psychologists, fails to provide an adequate understanding of human behaviour and in reality, embodies little more than a slavish caricature of what is entailed in the experimental method of the physical sciences.
2. It has, in inevitable consequence, acquired the bulk of its experimental evidence from studies of simple rather than complex behaviour.
3. Its results have been achieved from work undertaken on species which are phylogenetically far removed from human beings and which in consequence, are fundamentally different in many crucial respects. Adherents of the psycho-analytic tradition and pursuasion would be at pains to point out that Morris's "pertinent observation ... on tenspine

sticklebacks" (Morris, 1952) which is quoted by Freund, (1974) really has no justifiable placein any serious discussion on male homosexuality and that his further reference to Beach's (Beach, 1941: 1944) experimental studies employing male rats are hardly to be regarded as being more relevant. Indeed Miller has rather sceptically suggested that S-R theory might be the more appropriately labelled, "hyphen theory" since in reality, the real isse of controversy is more about the nature of the connection between S and R than it is about the status of S and R in their own right.

The crucial questions which require to be answered may therefore be stated as follows:-

1. How are the actual structures of human personality laid down and how do they relate to and affect patterns of ensuing behaviour?
2. To what extent can this effect be systematised to the point of formulating a tenable and reliable theory of motivation?

The problems which are raised by the first of these two questions have caused many behaviourists to retain an essentially psycho-analytic explanation of personality development. Others would argue that it is not an either/or matter and that whilst the psycho-analytic explanation of personality development was first postulated by the proponents of that theory, they certainly do not possess a "divine right" to nurture it as being exclusively their own.

In contrast to both theses, Hans Eysenck has employed a particularly tough-minded disdain for that particular kind of preconception and conviction such as is rooted in psycho-analytic theory. By binding an original synthesis of clinical insight together with a highly sophisticated

psychometric procedure (Eysenck 1947, 1952; Eysenck andEysenck, 1964; Eysenck and Eysenck, 1968, 1968b), Eysenck has developed and refined a theory of personality which as has been previously shown, has reinforced the validity of the behaviourists' approach to the treatment of psychiatric illnesses and to the understanding of patterns of deviant behaviour. Having first contended that the persistence of any form of neurotic behaviour is really attributable to a process of instrumental conditioning, Eysenck has developed a thesis which aims to show how certain personality characteristics are directly related to the conditioning process. Individuals, he claims, differ in the speed with which conditioned responses are acquired and differ in the strength to which such responses are acquired, as well as in their resistance to extinction.

Eysenck has successfully related such differences to his two " ..... very clearly marked and outstandingly important dimensions ..... Extraversion (E) - Introversion and Neuroticism (N)." Although, in no way denying the existence and importance of additional factors, Eysenck maintains that the E and the N factors contribute more to the description of personality than any other set of factors outside the cognitive field. Congruent with this latter statement, is his work on a third dimension - that of Psychoticism (P), which Eysenck found to be not entirely independent from N. but to correlate moderately with it. Indeed, this P factor is a personality variable which has been found to determine differential performance, both in its own right, as well as in conjunction with E and N.

Eysenck's theory is based upon the statistical technique of factor analysis (Appendix 4) - a quantitative technique, which he has explored by means of a bold and original attempt to link theoretical and experimental psychology in a clinical pursuit. In a series of

experimental investigations, Eysenck has concluded that introverts manifest greater cortical arousal, a characteristic which, in turn, results in lowered sensory thresholds and better and quicker formation of conditional responses. The essential features of neuroticism, says Eysenck, are apparent in the individual who is over-emotional, autonomically labile and overly susceptible to stimuli which produce anxiety. Accordingly, he regards neuroticism as the principal determinant of the neuroses generally. The type of neuroticism which may develop is, according to Eysenck, determined by the degree of introversion/extroversion present: e.g. hysterics would be extroverted and dysthymics, introverted. The neurotic introvert will, in a stress situation, tend to suffer from neurotic depression and anxiety state. In a similar environment, the neurotic extrovert will tend to overreact childishly and impulsively. By comparison, extroverts will be shown to possess markedly higher sensory thresholds and will be less easy to condition.

It may well seem to follow - especially to those who regard homosexuality as a maladaptive form of behaviour - that homosexuals will tend to cluster in the direction of the introversion bi-polar alternative. Such a conclusion would certainly be consonant with Eysenck's expectations that constitutional neurotics who are also highly introverted will more quickly acquire maladaptive symptoms. In fact, Eysenck (1971) has shown that high P and N scorers display a distinctly pathological pattern of sexual reactions. Both are characterised by strong sexual drives (N more than P). However, whereas it would seem to be usual for the high P scorer to 'act out' his "..... libidinous, promiscuous and perverse desires", the high N scorer is much less likely to do so. Rather would it appear to be a more common tendency for his anxieties and guilt

feelings to prevent him consummating his desires. By sharp contrast, although high E has also been reported by Eysenck, (1972) to be characterised by promiscuous behaviour, it has also been found to correlate positively with 'lack of nervousness'. Indeed, the high E scorer presents a picture of the 'happy philanderer'.

Eysenck concludes that sexual attitudes tend to coalesce around the two main and relatively independent factors of sexual pathology and sexual libido. Both factors denote the presence of continual pathology to a varying degree and indicate a pattern of libidinal strength which may vary from little to great. High N scorers are likely to suffer from sexual pathology, whereas high P scorers are much less prone to pathology but are particularly high on libido. In contrast, high E scorers are higher on libido than are introverts and are less pathological. Accordingly, it might be supposed that those high N scorers who are also homosexuals, will tend to be those individuals in whom negative reactions of conditioned revulsion will outweigh positively reinforcing factors, such as sexual gratification. The desire for social acceptance by the homosexual within a minority subculture may well be a 'flash point' for conflict, since it possesses both negative and positive elements of reinforcement. In such an individual, the outcome will typically be resolved in one of three ways, viz:-

(1) Negative forces may predominate and a heterosexual adjustment may be a feasible outcome;

(2) Negative forces may predominate, but only for a period during which time positive aspects will be suppressed. In such an individual, a heterosexual role may well produce negative reactions to heterosexuality in the form of an increased sense of failure, dissatisfaction and frustration.

In such cases, it is likely that heterosexuality will be abandoned altogether, with its attendant positive reinforcement of relief and pleasure;

(3) Negative and positive forces will continue to compete in order to achieve ascendancy. In such a case an individual may well practise homosexuality under the guise of an apparently heterosexual life-style.

High P scorers who are also homosexual, will in terms of the theory, tend toward a life-style which is open and unconcealing. This particular hypothesis will perceive the homosexual as being likely to attempt to convert others to his sexual life-style. Accordingly, such an individual will typically become immersed in homosexual mannerisms and argot and will derive considerable confidence from the strength of the minority group.

The second question of crucial importance to the status of the behaviourists' approach to personality concerns the formulation of a tenable and reliable theory of motiviation. Basically of course, such a theory is implicit in the key concept of 'reinforcement'. More recently, Bancroft (1970a) has proposed a model for behaviour-shaping which may be represented along a continuum, the poles of which reflect opposites. Such a model is by no means confined solely to patterns of sexual development.

Bancroft (1970a) first refers to the manner in which behaviour-shaping factors tend either to inhibit, (negative) or to enhance (positive) the development of behavioural traits. He refers to such factors as 'push' and 'pull' factors.

In the case of the growth and development of homosexuality, push factors would refer to those forces which pressure the subject away from heterosexuality; i.e. that are negative to heterosexuality.

Conversely, pull factors are those which positively favour homosexuality as the preferred life-style.

The 'Push' Factors:- These involve anxiety about the heterosexual role which, in turn, stems from:-

1. Learnt inhibition about heterosexual contacts.. Such inhibitions and fears stem from taboos which prohibit any form of discussion or enquiry on sexual topics and which represent heterosexual controls as being improper and dirty. The absence of factual knowledge may well predispose to distortions and fears about unrealistic disease and injury to physical and mental health, thus retarding and preventing normal heterosexual development.
2. Incestuous feelings about the mother. Reference has previously been made to this oedipal situation which is induced either by a mother who convertly encourages, but overtly discourages such incestuous feelings or where the threat of the father's reprisals induces "castration anxiety".
3. Lack of confidence in one's sexual potency with its attendant fear of failure in heterosexual situations. This may relate to the apparent smallness of the penis and the dread of ridicule.
4. Lack of confidence in one's masculinity or an impaired gender identity. Fear of rejection by members of the opposite sex.

The 'Pull' Factors:-

1. Strength of sex drive. The desire for sexual contact with another person. Homosexual choice is just one of the alternatives available.
2. Need for security and warmth. Such a need for a relation-

ship may be fulfilled by an older male, especially where the father-son relationship has been unsatisfactory. This may, in time, lead to the development of a homosexual relationship.

3. Self-esteem. A conscious desire to be the object of sexual stimulation and desire can in itself, be positively reinforcing. If one male is praised and made the object of approval and desire by another male, such desires or pleasures at being so desired, may well develop an erotic component.

4. Eroticism of a threatening object. Bancroft (1970a) points to the fact that ecologists such as Lorenz (1966) have described how male primates lower in the social hierarchy, have been observed to adopt a sexually inviting posture in order to appease a hostile superior. Such a development of homosexual behaviour may well relate to fear of the older male, which may, in turn, have originated from an unhappy relationship with a hostile and detached father.

5. Material gain, which is likely to accrue in particular to the male who permits homosexual relationships with an affluent partner. This may be regarded as yet another 'pull' factor, Bancroft (1970a).

Bancroft points out that it is far from clear as to why in some cases the above factors, although present in a given individual to a considerable extent, do not predispose toward homosexual behaviour. Clearly such a pattern of sexually deviant behaviour is perhaps in a more subtle and complex way, powerfully and positively reinforcing to the point of overriding powerful counter forces, such as social, ethical and cultural constraints.

The importance of such factors of reinforcement can and frequently do take upon themselves a function similar to the phenomenon of higher-order conditioning in the classical mould. Cooper, (1963) reports a case of a client who characteristically experienced heightened sexual arousal from the feel of silken material. The ensuing behavioural response eventually took the form of transvestite behaviour which itself appeared to fulfil a sexual function. One day, whilst the client was in a state of acute anxiety, he allegedly discovered that transvestite behaviour had become identified with the reduction of emotional distress. Thereafter, a wide range of stressful stimuli did apparently elicit transvestite behaviour. Bond and Hutchison, (1960) have reported similar sequences in which mounting tension is abruptly reduced by the execution of sexually-deviant behaviour.

Clinical data such as these serve adequately to demonstrate the complexity of reinforcing factors in which persistent sexual deviance is likely maintained not only by sexual-reinforcers - a pull factor for such sexually-deviant behaviour, but also by a push factor in an aversion-reducing function.

Summary The inferential nature of psychological assessment and description is made explicit and is recognized as:-

a. indicating and illustrating the inaccessability in any direct sense of the underlying dynamics of personality and

b. for its historically-derived tendency to attract and to invite widely differing theoretical accounts.

The two major 'schools' of personality theory, viz., the Psycho-analytic and the Behaviourist approach, are identified and the implications for the study of male homosexuality are reviewed. Attention is particularly focused upon the theoretical conceptualisations

which relate specifically to psycho-social development and adjustment. An extensive and detailed review of the psycho-analytic view and account of personality development is provided, together with a review of published evidence in support of its explanation of the behavioural phenomenon of male homosexuality in terms of a morbid resolution of the Freudian elaboration of the oedipal complex. Alleged differences between Oedipal and non-Oedipal male homosexuals, together with their implications for homosexual behaviour and life-style are also critically reviewed. Evidence both for and against the "parental-influence" thesis is cited, together with such studies' limitations in the form of methodological and sampling inadequacies. Other potentially relevant factors involving parental relationships, role and status within the nuclear family etc., are discussed.

The most serious challenge to the psycho-analytic theory and account of personality development is shown to reside in the formidable conceptualizations inherent within the behaviourist-oriented social learning approach. The Behaviourists' heavy reliance upon learning theory and upon the experimental, objective approach to the developmental account of human behaviour is noted and critically reviewed. Specific areas of central importance to the elaboration of theory in terms of its credibility and overall relevance are identified and analysed. In particular, these relate to key questions and their attempted answers concerning:-

1. The structural development of human personality and its ensuing impact upon the learning process and ultimately upon behaviour and
2. the processes whereby particular patterns of learned behaviour are motivated and shaped through the impact and influence of positive and negative reinforcers. The implications of such behaviourist-orientated

explanations for throwing light upon the way whereby male homosexuality may flourish and become firmly established in overt behaviour, are also reviewed.

OTHER RELEVANT STUDIES AND THEIR IMPLICATIONS

The phenomenon of overt human sexual relationships between members of the same sex has continued to evoke powerful, emotive reactions and thereby, to sustain controversy. The fact that public reaction - both for and against - is not commonly apparent until some mobilizing and catalyzing event brings it to the point of expression, may in this instance be regarded as an indication of the strength of feelings involved, rather than of indifference. Inhibitory influences exerted through socially 'inherited' sexual mores, have contributed significantly to the persistence of such feelings.

By contrast, any evidence of a systematic search in pursuit of a clearer understanding of the phenomenon of homosexuality, e.g., through applied research has, until fairly recently, been almost totally absent. Only in latter years have age-old prejudices, beliefs and opinions been openly challenged first instance anecdotially - to be followed by studies of homosexuality designed to yield 'hard' data. The purpose of this particular section is to review the major contributions in the form of published reports, as well as to assess the extent to which they agree to differ in their conclusions.

A basic question relates to the universality of homosexuality and more especially, to the nature of similarity or difference between homosexuals which is the consequence of cross-cultural, as well as of intra-social influence. Whitam, (1977) and others (Zuger and Taylor, 1969; Green, 1974, 1976 and 1979) claim to have established the existence of an identifiable link between extensive and persisting cross-gender behaviour in childhood and adult homosexuality. In a later study, Whitam (1980) has endeavoured to show whether childhood

indicators of adult homosexuality are uniquely characteristic of those societies in which such studies have been undertaken or whether there are grounds for a more general application to societies having different family and social structures. Accordingly, Whitham (1980) obtained data on all the major indicators from groups of homosexuals in different and distinct societies; the USA, (the society in which almost all cross-cultural studies have been carried out) Guatemala, a heavily Indian, Spanish-speaking people and Brazil, a non-Indian society with significant urbanization and industrialization. Whitham (1980) concluded that,

1. similar behavioural indicators were apparent in all three societies and
2. tended to occur at approximately the same rate.

Although Whitam (1980) did not infer universality among childhood experience in homosexual subcultures, he clearly regarded his data as pointing to just such a possibility.

Whitam's theoretical position is in conflict with that which was earlier propounded by Spanier, (1976) who claims to have identified two main sources of error in the recall of early cross-gender play expectations, independant of relationships with parents; i.e., "faulty recall", (unintentional false reporting due to poor memory, or changing perception of past reality) and "falsified accounts",(intentional false reporting due to fear of being honest with the interviewer, together with a desire to present a false image for ego-enhancement). A third likely source of error has been hypothesized by Ross et al, (1978) who suggest that homosexuals, being well aware of stereotypes commonly assigned to them, may internalize them with the intention of providing a more fulfilling self-perception. Ross et al, (1978) have further

hypothesized that in societies where there is less rigid differentation between sex roles in terms of both legal and societal attitudes toward equality of the sexes, there will be evidence of far less rigid stereotyping of homosexual behaviour as being masculine or feminine. In a study of homosexual males undertaken in societies representing opposite extremes of sex-role differentiation and equality, Ross (1980) has concluded that sex-role rigidity and attitudes toward homosexuality may play an important part in differences in childhood recall.

Weinberg and Williams, (1974) in their study designed to reflect the problems which homosexuals commonly experience and the adaptations which they frequently have to make, have compared ethnographies in three societies, namely the United States, the Netherlands and Denmark. Weinberg and Williams clearly indicate their view that many of the problems which homosexuals face, are rooted in culturally-determined national and social attitudes. Although negative evaluation of homosexuals is a well-known and well-documented characteristic of all three societies, Weinberg and Williams, (1974) report that the principal distinguishing feature between on the one hand New York and San Francisco and on the other, Amsterdam and Copenhagen, is that of law and law enforcement. This culturally determined, rigid stereotype which is well-reflected in American institutional discrimination against homosexuals, is considerably less in evidence in the two European societies involved where homosexuality is comparatively more readily and openly tolerated.

Schofield, (1965) in an early and extensive "in-depth" study of homosexuality in the UK, has focussed upon the likely importance of intra-social influence and their effect upon the homosexual population. However, in contrast to Hauser (1962), who listed no less than 41

homosexual types, Schofield relied upon, "a simple objective classification .....," in dividing homosexuals into four groups according to the social consequences and implications of their sexual behaviour. Schofield's groups were comprised of convicted homosexuals who were serving sentences (H/C), convicted paedophiliacs who likewise were serving a prison sentence (P/C),homosexual patients who were receiving psychiatric treatment, either as an in-patient or an out-patient basis, (H/P) and a group of homosexuals who possessed no history of criminal conviction and who were not receiving treatment for a psychiatric disorder, (H/O). In the interests of facilitating validity in comparability of differentiating characteristics of the variant groups, Schofield (1965) further obtained data from two non-homosexual groups; i.e., non-homosexual hospitalized and non-hospitalized psychiatric patients, (N/P) and a groun of non-homosexual, non-conviction, normal patients controls (N/C). Each of the above mentioned groups contained fifty subjects which provided an overall sample of three hundred and fifty males.

Information was obtained under the following groupings:

(1) Family Background, e.g., relationships with parents, early and home influences and

(2) Social Behaviour, e.g., education and type of school attended; present income, relationships with employer and criminal history where relevant.

(3) Sexual Activity, e.g., early sex activity and experience, later incidence and frequency, the nature of emotional involvements, subjects attitudes toward homosexuality, the effects of homosexuality upon a) occupational and working relationships and b) on communal integration.

The essence of Schofield's conclusions are more evident in the attempt to develop his alleged "theory of homosexuality", (which, in

reality, seems to be little more than a descriptive account of the effects of homosexuality and their consequences). Schofield apparently regards homosexuality per se as a condition having only minor effects upon personality development. Rather does he emphasize the stressful consequences which he claims can lead to "character deterioration". Indeed, according to Schofield, it is those homosexuals who have yielded to such pressure who are most prone to criminal conviction and to the need for psychiatric intervention. Such failure in social integration, he contrasts with the comparatively satisfactory levels of social integration achieved by homosexuals who by adaptation and satisfactory adjustment to their homosexuality, are seldom to be found in prison or in attendance at psychiatric clinics and other treatment centres.

In their study previously referred to, Weinberg and Williams (1974) similarly reported varying levels of psychological adjustment among a relatively large homosexual sample, (1117 Americans, 1077 Dutch and 303 Danish homosexuals). Weinberg and Williams (1974) found that irrespective of their country of origin, homosexuals tended to score lower than did heterosexual non special clinic control subjects on "happiness and faith in others". Moreover, the authors reported a positive correlation between low self-appraisal and psychological maladjustment. Other identified problem areas relating to a sense of rejection and of having been discriminated against, were commonly reported by those homosexuals who also scored low in social status rating and social involvement. By contrast, homosexuals in the higher income and higher social status cohort appeared to be closer to heterosexuals of the same class, but were - according to the authors of the study - more worried about possible exposure of their homosexual preference and life-style.

A major criticism which has been levelled against a considerable number of studies which have purported to investigate the behavioural phenomenon of homosexuality is that of bias in sampling techniques which have frequently been employed. Gonsiorek (1977) has reviewed a number of studies which have employed homosexual psychiatric patients and/or homosexual prisoners and which have attempted to generalise the implications claimed for their findings to homosexuals generally. Weis and Dain (1979) are also at pains to point out that even when psychiatric patients and prisoners are omitted from such studies, a basic sampling issue may well remain and for the following reasons:-

1) Homosexuals are to a large extent, ".....an invisible minority"; i.e. they cannot be reliably identified through the normal processes of observation since in ordinary circumstances, they tend not to reveal themselves and

2) No clear dichotomy (or even trichotomy if one includes bisexuals) exists, but rather a continuum between two extremes, (Tripp, 1975: Morin, 1977).

Weis and Dain (1979) therefore argue that researchers must take this inability into consideration by describing homosexuals in terms of a broad range of sexual behaviours, e.g. sexual interest, extensiveness of sexual experience, numbers of sexual partners and the nature of their sexual involvement with them. Weis and Dain (1979) further maintain that descriptive criteria should also be routinely employed, including standard demographic variables; i.e. age, ethnicity, educational and occupational history, religion, accomodation, marital status. Full use of variables such as these as data gathering criteria is also recommended by Bell (1974) who further claims that there are advantages in sampling from such well-known congregating places as gay bars, homophile organisations and indeed, any other likely source whereby to maximize the variety of life-styles to be represented. Bell (1974)

further recommends a greater degree of attention to ".... within - group differences than has been true in the past".

Bearing in mind the strong prejudice which is alleged to exist within American society against homosexuality to which previous reference has been made, (Weinberg and Williams, 1974), Bell (1974) has suggested a systematic approach to the study of attitudes toward homosexuality. Levitt and Klassen, (1974) reporting on attitudes prevalent among a sample of 3,018 American adults, found that 78% considered homosexual behaviour to be always wrong and believed that homosexual males should be debarred from certain professions. Smith (1971) reported that persons with powerful negative attitudes toward homosexuality tend themselves to be status-conscious, authoritarian and sexually rigid. Dunbar et al, (1973) positively correlated such negative and punitive attitudes with high levels of personal sex-guilt, whilst MacDonald and Games (1974) correlated negative attitudes to homosexuality with authoritarianism, intolerance of ambiguity and cognitive rigidity.

Following upon Alfred C. Kinsey and his associates' massive investigation of the sexual behaviour of American men and women, which began in the 1930s and continued into the 1950s, there is recent evidence of interest and research commitment to studies concerned with the phenomenon of homosexuality: this may well have been inspired by Kinsey's finding that a large number of American men and women had been involved in homosexual activity throughout adolescence and sometimes into adulthood. The Weinberg and Williams (1974) study, previously referred to, does in fact provide just one such example. However, others have emerged which very clearly indicate that recommend-ations made by Bell (1974) have in fact, been well and truly taken to heart.

Certain such recommendations require special mention, not only because of the scope and scale of resulting undertakings, but also because of testable hypotheses which such detailed investigations and analyses have generated.

In 1975, Saghir and Robins reported the results of their comprehensive study of male and female homosexuality, (Saquir and Robins, 1975). In accordance with Bell's recommendation, (Bell, 1974) three quarters of the entire homosexual sample were recruited through homophile groups in Chicago and SanFrancisco. The remaining quarter were referred by friends, or were recruited at gay bars situated within the same locality. A control group of heterosexual subjects were simultaneously recruited by letter or by telephone.

The principle criterion for inclusion in the homosexual sample was evidence of overt homosexuality, extending beyond the 18th year of life. Individuals with a history of a) hospitalisation for a psychiatric illness or b) confinement in a Penitentiary or Federal Prison were excluded, as were all non-white homosexuals. Similar criteria applied to the process of heterosexual control-subject selection.

A structured interview was employed throughout and was designed so as to provide data on 'key' areas relating to psychosexual interest, development and functioning including the reported evolution and maturation of a homosexual or heterosexual orientation, subsequent sexual behaviour,* preference and pathology; the nature of family relationships and of social status, role and interaction. Saghir and Robins (1975) identified a cross-gender syndrome of effeminacy in sixty-six per cent of the entire male homosexual sample and one in three of all male homosexuals and three members of the heterosexual

*Reference will here be made only to results obtained for homosexual male and heterosexual male non special clinic control subjects.

control group, had allegedly experienced the desire to change sex in the pre-adolescent stage. Some seventy-eight percent of subjects reported the termination of this desire before the onset of adolescece (14-19 years). Ninety percent of homosexual males and twenty-nine percent of heterosexual males reported a desire for homosexual romantic attachments, prior to adolescence. This desire was eventually translated into actual experience by all homosexual males interviewed, as well as by a minority of heterosexual males.

Self-masturbation was the earliest sexual activity to be reported by both homosexual and heterosexual males alike, although frequency in practice was greater among homosexuals than among heterosexuals. Of subjects between the ages of 20-29 years, 97% of homosexuals reported continuance of this sexual practice, compared to 69% of heterosexuals. Co-masturbation was reported by 93% of homosexual and 23% of heterosexual subjects respectively.

Anal intercourse and fellatio were the most commonly reported practices involving a sexual partner. Ninety-three percent of homosexuals (there was no reported incidence among heterosexuals) had experienced anal intercourse at some time in their lives and 99% of homosexual subjects (73% of heterosexuals) had engaged in oral-genital activity.

Casual - transient solitary or repeated "sexual encounters" were commonly experienced by both homosexual and heterosexual control subjects.

Over 97% of homosexuals interviewed reported casual - transient sexual encounters with more than seven different partners over a period of the previous four months. Among heterosexual males interviewed, 57% reported the occurrence of casual - transient sexual relationships

involving intercourse and 30% of heterosexuals reported more than seven such relationships over a four month period. A large minority of homosexual males (18%) and a similar percentage of heterosexual control subjects, (17%) had experienced intercourse on between one and three occasions only. A further 40% of homosexuals and 48% of heterosexual control subjects claimed to have had intercourse more than once a week. The remaining respective populations (32% and 35%) alleged the experience of intercourse on between one and three times per week.

Saghir and Robins (1975) defined a "liaison" and referred to it as being, "a sexual or non-sexual relationship with one person lasting over one year, accompanied by intense emotional attachment". Similar proportions of homosexual and heterosexual males - more than 2 in 3, experienced such liaisons. However, considerably more homosexuals than heterosexuals reported a sexual component to such relationships ($p = < 0.001$). Considerably more homosexual males reported experience of "affairs", (the majority lasting up to 3 years) than did heterosexual control subjects ($p = < 0.001$). Indeed, Saghir and Robins (1975) report that homosexual relationships were not uncommonly long-lasting. However, infidelity between partners was even more frequently reported. No significant difference emerged between homosexuals and heterosexual control subjects on the reported incidence of one or more stable relationships, 53% homosexuals, 66% heterosexuals. 'Cruising' and sexually promiscuous behaviour were commonly reported by the vast majority of homosexual interviewees.

All research subjects were invited to provide a rating on such self-perceived variables, as appropriately masculine, feminine or neither, sensitivity, avoidance of competitiveness

experience of inner tension, poor self-confidence, low self-esteem, desire to be alone, sociability and concern for the opinions of others.

Differences between the two principal research groups were highly significant ($p = <0.001$) and predictable, i.e. homosexuals being more feminine, more sensitive, more sociable, less competitive, lower in self-confidence and esteem etc.

The reported incidence of need for psychiatric interventions was more than four times greater among homosexual males, with depressive disorders being most frequently experienced. Incidence of attempted suicide was also considerably greater among homosexual males (7% compared to 0%). One in five homosexuals admitted to excessive drinking behaviour, compared to approximately one in ten of all heterosexual control subjects.

Significant differences ($p = <0.05$) were reported between the two principal research groups on the variable of psychoactive drug misuse (39% homosexuals, 20% heterosexuals). Marihuana, amphetamine and hallucinogenic type drugs were the psychoactive substances most frequently misused.

In spite of a painstaking interrogation of subjects, Saghir and Robins (1975) were unable to find evidence of a link between parental death and divorce on the one hand and adult psychiatrc disorders on the other, in either of the major research groups. Parental discord was allegedly higher in homosexuals' homes (52%) than it appeared to be within the homes of heterosexual control subjects, (17%). The parents of heterosexuals were reportedly fairer in matters pertaining to family discipline (60%) than were the parents of homosexual control subjects (36%). No differences emerged on the variables of "parental attitude toward sex".

The mothers of homosexuals were stated to be "more possessive" (41%) and unduly involved in decision-making within the home, (58%)

than were the mothers of heterosexual control subjects (maternal possessiveness, 23%; decision-making, 20%).

Saghir and Robins (1975) report only poor identification with fathers among homosexual subjects and two out of three of all homosexual males identified primarily with the mothers. This compared with one in three of all heterosexuals.

Maternal age at the birth of homosexual and of heterosexual subjects was comparable, as were percentages of only children and of subjects with brothers only, or with sisters only. Approximately one in two of the homosexual subjects whose sexual preference and life-style was known to their family (46%) were allegedly understanding and compassionate.

Of the 61% of homosexual subjects who admitted to having been arrested for a suspected offence, considerably more than half such arrests had been for reasons of their homosexuality. One in five heterosexual control subjects had a history of criminal arrest, although in all cases, for offences other than of a sexual nature.

Thus it can be said of the Saghir and Robins (1975) study, that it entailed a scientifically credible approach, both in the scope of enquiry and in its explicit recognition of the need for control. In so doing, it effectively countered earlier criticisms and set a pattern for things to come.

It had in fact been the case that in the late 1960s, the National Institute for Mental Health (NIMH), under the Directorship of Dr. Stanley Molles, established the NIMH Task Force on homosexuality in order to carry through a comprehensive study of the development and management of homosexuality. This study, which was undertaken in fact by Bell and Weinberg (1978) set out a number of well-defined aims which the authors have conveniently summarized as follows:

(1) To identify the variety of sexual dimensions and to accurately place subjects on them.

(2) To investigate the nature of relationships between homosexuals' life-styles and their social and psychological adjustment.

(3) To compare differences and similarities between white and black homosexuals.

(4) To determine the number of valid interpretations of the term, homosexual.

(5) To present general portraits of homosexual types and thereby to show homosexuality to be more than a sexual dimension.

The study site chosen was that of the San Francisco Bay area, consisting of six counties, some 3,788 square miles of territory and with a population of four million people. Research subjects were recruited by means of a massive television, radio and press campaign and with the active co-operation of various homophile groups and organisations in the Bay area. Principal sites of contact with potential subjects were gay bars, gay baths and similar known meeting and congregating places. Yet others, received mailed invitations to participate from confidential lists of names and addresses supplied by homophile organisations. The investigation encompassed female as well as male homosexuality.

The chosen instrument for data collection, evaluation and assessment was a structured "face to face" interview schedule of 175 pages in length and containing some 528 questions. Subjects were invited to classify themselves, using the seven point Kinsey

self-rating scale on a) sexual behaviour and

b) sexual feelings.

Dimensions of sexual experience were carefully examined and these included sexual overtness, level of sexual activity, the nature of sexual partnerships, of sex-appeal and focus of sexual interest, the nature of sexual techniques commonly employed and of sexual problems commonly encountered.

Social adjustment - determined by the nature of relationships at work - interest in and affiliation to political parties, of religious involvement, of the quality of friendships, of marriage, as well as of social difficulties commonly experienced, were also painstakingly investigated.

A detailed study of psychological adjustment or malfunctioning was undertaken with special emphasis being placed upon the level of happiness and of self-acceptance experienced, as well as upon the degree of worry, of depression, of paranoia and of suicidal tendancies reported.

It is not possible here to do more than to attempt to summarize results obtained by Bell and Weinberg (1978). Their investigation into the dimensions of sexual experience have indicated that of the 579 white male homosexuals and 111 black male homosexuals who successfully negotiated all stages of the interview, nearly halfof the former and two thirds of the latter group had experienced a sexual relationship with another male at least twice weekly. Nearly all interviewees had had experience of 'cruising' activities within the past year and approximately four out of ten subjects had 'cruised' on average, up to twice weekly. All homosexual respondents were apt to report a large number (in fact, hundreds) of sexual partners over the course of

their lives, but a tendency for subjects to select partners of similar ethnic origin was also noted. A variety of sexual techniques employed was reported for almost all homosexual subjects interviewed, with fellatio being that most frequently chosen by members of both races.

The most commonly reported sexual problems were:

(1) insufficiency of sexual partners and

(2) infrequency of sexual contact.

Approximately two-thirds of all homosexual subjects had contracted a venereal disease on at least one occasion in the past. Homosexuality as a state or condition was accepted by most subjects interviwed, although one in four of all interviewees expressed a desire for change.

In terms of social adjustment, Bell & Weinberg (1978) point to evidence of greater job stability among white than among black homosexuals. More blacks described themselves as being "conventionally religious" and professed to have attended church more frequently. On the whole, the fact of their homosexuality left their religious feeling unaffected.

The majority of all homosexuals spent more than half of their leisure time alone. The most preferred activity was "going to the 'movies'", the least preferred being concerned with sporting interests.

The most pressing social difficulty was clearly that associated with law breaking and ensuing arrest. Approximately half of all white homosexuals had been "picked up" by the police on at least one occasion for offences other than traffic offences. A lesser proportion - approximately one in three white and one in ten black homosexuals had been arrested in connection with their homosexuality.

On the several criteria of psychological adjustment employed in the study, black homosexuals manifested observable differences from

white homosexuals. For example, black homosexuals reported less happiness than five years previously, were more likely to have attempted suicide and were less likely to have sought professional help. However, no differences were reported on the criteria of general health, psychosomatic disorders or in the reporting of depressive symptoms and similar disorders.

A comparison study with heterosexual subjects was also carried out, this latter group having been drawn from San Francisco's general population, using probability sampling techniques with quotas (a procedure developed by the National Opinion Research Centre, (Sudman, 1967)).

The particular point of such a comparison group in this study was to provide a 'baseline' and to ensure comparability in terms of the major demographic characteristics. Heterosexual subjects did not differ from homosexuals in age, educational or occupational status. However, heterosexuals were manifestly more likely to be employed as engineers, factory foremen, contractors etc., whereas homosexuals tended to be in office, personnel and financial undertaking employment.

In terms of performance comparatively on distinguishing social and personality variables, Bell and Weinberg (1978) reported evidence of loneliness and poorer self-acceptance among homosexuals. The incidence of depression and of ideational suicide was greater among the latter group.

In terms of the original aims of the study undertaken by Bell and Weinberg (1978) there is considerable evidence of their success in the undertaking to identify and to describe a variety of sexual dimensions upon which subjects can be placed. The attempt to investigate relationships existing between homosexual life-styles in terms of their social and psychological sequelae and to compare differences between homosexuals of

different ethnic origin is also productive and illuminating.

It is less clear from this study as to how homosexuality has been shown to be so much more than a focus upon the overtly sexual dimension, or as to how the aim to provide general portraits of homosexual types has been adequately fulfilled. It is none-the-less a study of pioneering proportions which certainly justifies Bell and Weinberg's (1978) own conclusion; viz. that "The present investigation ..... amply demonstrates that relatively few homosexual men and women conform to the hideous stereotype most people have of them".

Reference has previously been made to the Siegelman study (Siegelman, 1972a) and to his conclusions in regard to the influence of parental attitudes, life-styles (dominence, submissiveness etc.) in the behavioural development of homosexuality. In that same study, Siegelman paid special attention to differences between homosexuals and heterosexual males as well as between homosexual sub-samples. He reported his 'findings' that homosexuals were significantly different from heterosexuals ($p=<0.001$) on the Gough (1952) Femininity Scale (Fe) and that there was a significant correlation ($p=<0.001$) between Fe and the Sheier and Cattell neuroticism factor, (Scheier and Cattell, 1961). Siegelman was left with the alternative possibilities, either that femininity was a major component of neuroticism as measured by the Neuroticism Scale Questionnaire, (NSQ) or that the NSQ was in fact more sensitive to femininity than it was to neuroticism.

Up until the mid-seventies, (with the exception of Schofield's work, (Schofield, 1965)) all of the major studies on homosexuality had been undertaken in countries other than Britain - mostly, as is apparent from much of the preceding part of this section, in the USA.

Siegelman therefore, decided to replicate the USA investigation (Siegelman, 1972a) in Britain, (Siegelman, 1978). A total number of 84 homosexual males and 62 heterosexual male non special clinic control subjects, were recruited for participation in the study. Recruitment of homosexuals was undertaken through two main sources; viz. advertisement (in the New Statesman and The Spectator) and by letter to the Albany Trust, (an organisation which supports tolerance and freedom of psychosexual expression). Members of the heterosexual group were, in fact, undergraduate and graduate students at Stevenage College, Herts.

Completed questionnaires were received from all parts of Britain but the majority were from the London area.

Comparison of differences on demographic variables between homosexuals and heterosexuals, e.g. age, socio-economic status, education of subject and of parents, history of therapeutic intervention, revealed no significant differences. Neither were the two samples different in responses indicating their tendency to give socially desirable responses as measured by the Social Desirability Scale (SDS) - (Crowne and Marlowe, 1960). Other scales used for the purpose of facilitating comparative analysis between the principal research groups as well as between homosexual sub-groups, were as follows:

(1) The Scheier and Cattell, (1961) Neuroticism Scale Questionnaire (NSQ) including the four component scales of tender mindedness, (I) Depression (F), Submissiveness (E), Anxiety (Anx) and Total Neuroticism (Scheier and Cattell 1961).

(2) The Alienation and Trust Measures (Struening and Richardson, 1965).

(3) Scales of Goal-Directedness, Self Acceptance and Sense of Guilt (Dignan, 1965).

(4) Dependency Test (Conry, 1964).

(5) Nurturance Scale (Harvey et al, 1966) Neuroticism Measure (Neur) (McGuire, 1966).

All the above measures of adjustment are, in the opinion of Siegelman, "psychometrically sound". Findings for the total homosexual heterosexual sample were as follows:

(1) Homosexuals scored significantly higher on tender-mindedness, submissiveness, anxiety, total neuroticism, sense of self, dependency and nurturance. No significant differences were found for depression, alienation, trust, goal directedness, self-acceptance and neuroticism.

Siegelman makes two major points on the basis of the findings summarized above.

(1) British and USA homosexual samples manifest a high degree of similarity and do not appear to be anything like as seriously distrubed as, for example, Bieber et al, (1962), Gershman, (1966) and Socarides, (1968) and others have claimed.

(2) He agrees with Hooker, (1957) and Zucker and Manosevitz, (1966) that a multi-factorial analysis of adjustment is desirable when comparatively evaluating homosexuality and heterosexuality.

Apart from their intrinsic value and of the light which they focus on particular populations, such studies as those which have here been reviewed in this section, are of immense value because of their capacity to generate testable hypotheses for future studies such as that which is here reported.

Summary Recent trends and developments in research into psycho-social aspects of homosexuality are introduced by reference to the dearth of systematically applied research in the whole area of male homosexuality. An encouraging increase in the publication of reports of this latter type is both noted and welcomed. Questions relating to the universality of homosexuality are introduced and critically discussed, with particular reference being made to alleged cross-cultural and intra-social influences. Similarities in and differences between culturally-determined difficulties experienced by homosexual males are discussed in the light of studies which have been designed so as to emphasize and comparatively evaluate them. Studies which have been designed so as to provide comparative data from well-defined homosexual and non-homosexual male groups on such variables as family background, patterns of social and criminal behaviour, personality traits and characteristics, are also discussed in some detail. Criticisms which have been made of such studies on grounds principally of biased sampling procedures, of invalid generalisation of research findings, are also referred to. Studies which have attempted to overcome such methodological shortcomings by sampling at a variety of well-known places where homosexuals are known to congregate are also reviewed. These latter studies are shown to represent the major and most exhaustive up-to-date investigations of male homosexuality so far to be undertaken and reported. They are shown to provide important new data on alleged sexual activity, on personality and psychopathology, on family and social functioning and on social and psychological adjustment and to be of immense value to the formation and development of important hypotheses for testing in studies such as the one which is herein reported.

HOMOSEXUALITY AND SEXUALLY TRANSMITTED DISEASES

The fact that the study which is herein reported, is focused upon the special clinic as a recruitment site, gives priority status to a review of "homosexuality and sexually transmitted diseases".

Until recent years, there has been a dearth of reliable data, relating to the prevalence of sexually transmitted diseases among homosexuals. Public attitudes of strong disapproval and not infrequently of downright hostility, have tended to discourage the homosexual from disclosing the source of his infection, even to the physician. Nor is it always possible for the attending physician to actually identify the homosexual patient. Whilst sexual orientation may occasionally be indicated by mannerisms and other minor peculiarities, such chance features or characteristics are very unreliable predictors. Many homosexuals are thoroughly masculine in their appearance and general behaviour to a point that the clinician requires considerable experience to recognise the signs of inversion. Furthermore, even though the site of infection may seemingly point to the probability of homosexual contact, this also can be very misleading.

Clearly, there are very important epidemiological reasons why homosexuals attending the special clinic for treatment should be identified. In the first place, it may well be that they are covertly searching for help and counsel. Second, any active tendency toward sexually promiscuous behaviour further underlines the importance of encouraging their consorts and contacts to also attend the special clinic routinely in the interests of disease prevention.

Since Wolfenden reported in 1957, there has been evidence of a widespread modification of public attitudes. The tacit acceptance of the 1967 Homosexual Law Reform Act is but one indication of greater public awareness and tolerance of the homosexual life-style. For one thing, homosexuality is now a topic for more open comment and discussion. Consequently, the homosexual currently

runs less risk of for example, losing his employment in the event of his sexual preference and life-style becoming known.

Attitudes prevalent among members of the medical profession have also modified and this, taken together with changes in the law relating to homosexuality, has fostered a more temperate and conciliatory atmosphere in which homosexuals are apparently more ready to seek treatment and to disclose their sexual orientation and preference.

However, it must not be thought that the long battle against alien and unconstructive attitudes is all but won. Nor is homosexual attendance at special clinics markedly less traumatic than has always been the case. Even so, there are clear and unmistakable signs of gradual improvement.

One of the first persons to emphasise the significance of homosexual activity in the spread of sexually transmitted diseases was Harkness (1948). He referred specifically to experience with cases of anorectal gonorrhoea in St. Peter's Hospital, London, as well as in his own practice. Harkness also referred to the fact that more than one in three male homosexuals who were suffering from gonococcal proctitis had positive serological tests for syphilis.

In the fifties, transmission of venereal diseases by homosexual contact was being increasingly reported, (Jefferiss, 1956; Fluker, 1976). Jefferiss, (1956) showed that out of 1,000 consecutive patients with early syphilis and gonorrhoea, 8.4% admitted to infection by homosexual contact. This study also drew attention to the number of cases of a sexually transmitted disease among homosexual men seen at St. Mary's Hospital, London. Some six years later in 1961, eighty-one (72%) of one hundred and thirteen male cases of early infectious syphilis were positively identified as having resulted from homosexual

contact (Jefferiss, 1956). Jefferiss, (1956) further drew attention to the fact that in the first quarter of 1955, 281 (14%) out of a total of 1,997 new male cases admitted homosexual contact. A breakdown of these new cases showed that it included 31 cases of early syphilis (62% of all early syphilis cases) and 89 cases of gonorrhoea (15% of all gonorrhoea cases).

Corresponding figures for early syphilis in other London clinics were reported at St. Thomas' Hospital, 32% (Nicol, 1960); St. Paul's Hospital, 79% (Mascall, 1961); West London Hospital, 14% (King, 1962); St. Mary's Hospital, 68% (Woodcock, 1971). Waugh (1972) reported on a prospective study of all patients attending the out-patients department of a West London Hospital with acquired syphilis in the period January, 1970 to December, 1971. Over the two year period, a total of 3,400 new male homosexual patients were seen. Of this number, 1,337 had gonorrhoea - 630 in the urethra and 707 in the rectum. Early syphilis was diagnosed in 190 cases. Of this latter number, 172 described themselves as being exclusively homosexual. Twenty per cent were active homosexuals, 36% were usually passive and 43% alternated between the active and passive role.

In 1973, the British Co-operative Clinic Group (1973) reported on a study of homosexual infections with primary and secondary syphilis and gonorrhoea. The work encompassed 176 clinics in England, Scotland and Wales. Primary syphilis was believed to have been homosexually acquired in 42.4% of cases. The lowest reported incidence involved in the study (9.5% - 13.5%) was found to relate to English clinics situated in towns with a population of 50,000 or less, also in Wales and in Scotland. The highest (62.1%) was reported by five clinics

operating in the west-end of London. The active/passive homosexual ratio for syphilis was less than 1:1 in all three countries - the average being 0.98:1. This apparent discrepancy was thought to include the contraction of infection by passive partners whilst visiting other countries abroad. The incidence of homosexuals with gonococcal infections ranged from 3.1 to 5.6% in England (excluding London), Wales and Scotland. In London, the incidence of gonococcal infection ranged from 19.9% in the west-end of London to 7.7% in fifteen other clinics. The study concluded that the incidence of both diseases reported among homosexuals was likely to be an underestimate.

Fluker (1976) published the findings of a ten year survey of homosexually-acquired infection among males seen at Charing Cross Hospital (West London Branch) between 1962 and 1971. In 1962, the total number of male cases had been 3,369 - including 105 homosexuals, (3.1%). By 1968, the total number of cases seen had increased to 6,100 and the homosexual cases in this number to 999, (16.4%). Fluker drew particular attention to the "explosive increase" in the total number of male cases from 1968 to 1971, when it had reached a total of 11,174 males - including 1,773 homosexuals, (15.9%). It is interesting to note that by comparison with male heterosexual cases, which approximately doubled in the period 1961-1968, homosexual cases increased more than nine times (from 105 to 999) over a similar period of time. From 1968-1971, during which period of time heterosexual cases almost doubled yet again (from 6,100 to 11,174), the increase in homosexual patients no more than kept pace with this increase (from 999 to 1,773). However, one could hardly have anticipated a similar increase commensurate to that recorded for the 1961-68

period, even allowing for the legalising of homosexual relations between consenting adults in 1967.

Fluker (1976) showed in his study that the proportions of active and passive infections were 45.1% and 54.9% respectively. The recorded number of early syphilis cases rose from 5 (11.1% of total male cases) in 1961, to 100 (85.5% of total male cases) in 1968. The figure remained remarkably constant over the next three year period and in 1971, stood at 98.(84.5% of total male cases). In 1961, 68 cases of gonorrhoea among homosexual males were recorded (6.9% of total male cases). By 1968, this figure had risen to 447 (26% of total male cases) and had increased yet further by 1971 to 619 homosexual cases (28.8% of total male cases). Fluker (1976) was careful to point out that Charing Cross Hospital is not typical of the country as a whole and therefore provides little reliable evidence to suggest that the homosexual population was increasing disproportionately to the whole.

In a study undertaken at St. Bartholomew's Hospital, London during a period January, 1972 to March, 1974, Thin and Smith (1976) reported that out of 5,302 male cases recorded, 483 (9.1%) disclosed themselves to be homosexual. This figure is of even greater interest when it is compared with 1.2% of 638 male cases in 1954 and 5% of 813 cases in 1959 (Nicol, 1960). Thin and Smith, (1976) reported that primary syphilis was diagnosed in fifteen patients, of whom 11 declared themselves to be homosexual. Of 451 male patients who were found to have gonorrhoea, 110 declared themselves to be homosexual. Thin and Smith (1976) further reported that a high proportion of the homosexual patient group were of Irish, Spanish or were of North American origin, with a correspondingly low proportion of European

males (excluding U.K., Spain and Eire) of Asian, African and of West Indian males.

Similar studies have also been carried out in other areas of the United Kingdom. The changing pattern of male homosexual registrations in the Department of Venereology, Newcastle General Hospital, has been reported upon by Bavidge (1976). The principal features of clinic attendance referred to were as follows:-

1) the total number of male cases during a period to 1974 inclusive;

2) the proportion of male homosexual registrations among this number;

3) the ratio of male homosexual gonorrhoea patients to all other male gonorrhoea patients.

In 1964, total male registrations were 1,863, of which 44 (2.36%) were homosexual. In 1968, the figures rose to 2,135 and 74 (3.47%) respectively. By 1971, a further increase had taken place, thus bringing total male registrations for the year to 2,855, of which 79 (2.42%) were homosexual. In 1974, (the last year included in the survey) male registrations totalled 3,565. Of this number, 159 patients (4.43%) disclosed their sexual orientation as being homosexual. The ratio of male homosexual gonorrhoea patients to all patients remained steady throughout the entire period of the survey: in 1964 it was 7.87, in 1968 it rose slightly to 10.2, by 1971 it returned to 7.91 and in 1974, it stood at 8.93%.

Scrutiny of other reported statistics relating specifically to Edinburgh and Glasgow special clinic attendance would seem to corroborate Fluker's point about regional differences.

McMillan and Robertson (1977) have shown that, out of a total

number of 23,441 male patients seen in an Edinburgh special clinic over a 7 year period 1970-76, 345 (1.5%) admitted homosexual contact. A yearly breakdown of these figures is even more revealing:

1970 - 13 patients	1973 - 36 patients
1971 - 38 patients	1974 - 45 patients
1972 - 61 patients	1975 - 74 patients
	1976 - 78 patients

McMillan and Robertson (1977) further showed that the incidence of early syphilis among homosexuals for the period under review was 34% of the total (37 homosexual cases out of a total of 110 cases). In 1970, there were 3 cases of early syphilis - all relating to heterosexual patients. In 1971, 2 out of a total of 17 early syphilis cases were homosexuals. In 1972, there were 6 homosexual patients among a total of 14 cases. The overall incidence increased slightly to 17 cases in 1973, although only one case was recorded as being homosexual. In 1974 and 1975, 3 cases (out of a total of 15) and 4 cases (out of a total of 14) declared themselves to be homosexual. Throughout the final year of the study, viz: 1976, the ratio of homosexuals to heterosexuals was reversed, there being more homosexual than heterosexual patients with early syphilis i.e., 21 out of a total of 30 cases overall. Gonorrhoea, homosexually acquired accounted for 167 of the 4,132 such cases recorded over the seven year period - in fact, 4% of the total number.

Statistics relating to similar features of male patients attending Glasgow special clinics are available for the four year period 1974-77, (Greater Glasgow Health Board Report of the Department of Sexually Transmitted Diseases, 1974, 1975, 1976 and 1977).

In 1974, a total number of 7,415 male cases were recorded of which 109 declared themselves to be homosexual. Of 12 early syphilis cases, all were reported as being heterosexual, whilst of the 1,253 recorded cases of gonorrhoea in Glasgow special clinics 40 males were homosexual patients.

In 1975, there was a reduction in the overall male cases recorded - 6,831, although the homosexual component increased to 175. Out of a total of 28 early syphilis cases, 10 were homosexual and of the 1,051 cases of gonorrhoea, 59 were homosexual patients.

The year 1976, produced 7,234 cases overall, some 212 of this number being homosexual patients. Of 32 early syphilis cases and 1,120 gonorrhoea cases, 16 and 106 respectively were reported as being practising homosexuals.

Throughout the last of the four years, e.g. 1977, a total number of 7,849 male cases were registered - 320 of whom stated that they were homosexual. The number of recorded early syphilis cases for 1977 was 51, 16 of this number being recorded as homosexual, whilst of 1,303 patients with gonorrhoea, 106 were known homosexual patients.

It is worth noting that, whereas the number of recorded male patients attending special clinics in Glasgow has remained fairly static, the number of declared homosexual cases has increased by 300% in 4 years. It is also worthy of note that in the last year for which separate figures are available for both Edinburgh (1976) and Glasgow, (1977) the incidence of homosexual cases was greater in Glasgow by a ratio of 3:1. This particular finding is all the more surprising in that Edinburgh is generally regarded as being, in many ways, the more cosmopolitan of the two cities, with its special social, cultural and historical features including an annual Festival of the

Arts which, in turn, attracts tourists from all over the world.

One of the most interesting and striking characteristics of the vast majority of studies reporting incidence figures for male homosexuals attending special clinics in the United Kingdom generally, is the relatively small influence exerted by immigrant populations upon actual prevalence.

SUMMARY AND CONCLUDING COMMENTS

The principal purpose and value of this brief review of male homosexuality within the special clinic, has been to enumerate those identifiable and quantifiable characteristics of such a population as may distinguish "within-group", as well as "across-group" differences. It is perhaps worthwhile restating a principal aim of this study, namely to evaluate the suitability of the special clinic for research into male homosexuality per se. Previously reported differences between heterosexual special clinic attenders and non special clinic control subjects have been noted and these also directly relate to the postulation of hypotheses concerning family and domestic, educational and occupational, social, sexual, personality and other behavioural criteria. Knowledge of sexually acquired disease, of their symptoms and of the availability and expressed need for information/education concerning their prevention, provide the subject-matter for other hypotheses for testing.

Finally, attention has been focused upon the question as to how homosexuality should be regarded. In 1975, the American Psychiatric Association removed "homosexuality" from its list of "Psychiatric Diseases". Peddar and Goldberg, (1970) have reported the results of their study which sought to investigate levels of psychiatric disturbance among special clinic patients in general and among homosexual special clinic attenders in particular. The

low incidence of probable psychiatric illness from among homosexuals participating in their study, (8% of probable cases), accords with their opinion that homosexuals are not overtly disturbed and manifest only a very low indication of desire for change. Such a study as this provides the basis for the postulation of hypotheses directly concerned with incidence of psychiatric illness and with expressed desire for change.

"Within-group" criteria for comparative analysis are focused most sharply upon the 'active'/'passive' classification of preferred or practised homosexual behaviour. Appropriate hypotheses relating to these "within-group" variables as a valid basis for comparison will be formally stated in the appropriate section.

MALE HOMOSEXUALITY: A STUDY OF PSYCHOLOGICAL CHARACTERISTICS AND OF SOCIAL AND FAMILY BACKGROUND

The study which forms the subject-matter of this thesis was, in fact, part of a wider investigation into personality, family dynamics and social background of male and female patients attending special clinics within the Glasgow area. The latter study was carried out jointly by the Department of Genito-Urinary Medicine, Greater Glasgow Health Board (GGHB) and the Department of Social Administration of the University of Glasgow, over the three year period 1974-1977. The study of male homosexuality which is here reported, commenced in 197 and all field work operations were successfully concluded by the end of 1979.

The special clinics within which the study was carried out are all within the administrative area of authority of the GGHB which in turn, is the largest of fifteen such Health Boards newly created in Scotland. This new administrative structure was brought into existence by the National Health Service (Scotland) Act, 1972 and has been administratively effective since early in 1974. Judged solely by the criterion of size of geographical area served, the GGHB would certainly be regarded as one of Scotland's smaller Authorities. However, in terms of population density and size (1,082,000) as well as of numbers of districts served, (five), it is by far the largest Health Board in Scotland, being approximately half as large again as its nearest rival Lothian (755,000) in the east, which also contains Edinburgh, Scotland's capital city.

The catchment area of the GGHB is stated to be approximately 212 square miles of mainly urban **conurbation.** Based upon population statistics, (overall population of Scotland, 5,264,000; 48% males, 52% females), it is estimated that 145,000 male persons residing within the GGHB's area of administrative authority would fall

between the lower and upper age limit for this particular study (viz: proportion of total male population within 16-35 year old age cohort = 28%). If the GGHB's annual figures for special clinic attendance are averaged over the period 1976-1979, it is apparent that approximately 7,450 male patients overall, received treatment at a Glasgow special clinic for a sexually transmitted disease. Clinicians experienced within the speciality have estimated that between ninety and ninety-five per cent of all male patients attending annually might be expected to fall within the study's lower and upper age limits. Accordingly, it is evident that based upon such figures and estimates as these, special clinic patients might be expected to approximate to a 4.5 percentage (or almost one in twenty) of the GGHB areas overall male population who are within the prescribed age-range limits.

The homosexual male component of this averaged annual total male special clinic attendance (for 1976-1977) was in fact 266, which in turn represents a 3.5 percentage of overall male attenders within each of the two years in question. There are no known reliable statistics which might facilitate an accurate estimate of the overall number of homosexual males within the total Scottish male population. Scottish Minorities' office-bearers of the Edinburgh and Glasgow branches, with other interested parties, are known to have offered their own "informed estimate" of between one and three per cent. Taking the mid-point, i.e. two per cent, such a figure would if accurate, indicate a total number of about 10,400 homosexuals (overall) in Scotland with approximately 2,900 within the prescribed age-range, actually resident within the catchment area served by the GGHB. With an overall sample of 359 male homosexuals participating in the study which is here

reported, it is possible to make a tentative projection of sample ratio - proportionate to the overall population of homosexuals from which it was drawn - i.e. 12.5%. It should be clearly stated however, that even accepting the accuracy of the 2% estimate referred to above, (which is by no means certain), the figure would require to be further adjusted, proportionate to:

(a) the number of homosexual males who were simply passing through Glasgow and who simply happened to seek treatment at a Glasgow special clinic and

(b) the number (about 17%) of special clinic patients and non special clinic control subjects who were recruited outwith the administrative area of the GGHB.

METHOD AND PROCEDURE

It was manifestly apparent very early in its life, that the success of the main project would be heavily dependent upon the level of co-operation forthcoming from the special clinic population. It is a fact well-known to special clinics' staff, that the presence of psychological trauma is experienced by a significant number of patients attending for treatment. Indeed, such trauma is known to be a variable of considerable importance in influencing default rates among all special clinic patients. Considerable care was therefore exercised in order to ensure that the project should in no way, exacerbate this previously known phenomenon. Happily, it can be reported that no increase in such default rates was in evidence throughout the entire life-span of fieldwork activities.

The Sample:- initial recruitment: Senior office-bearers of the Scottish Minorities Groups were located and contacted very early in the life of the project with a view to securing their interest and co-operation in the proposed study. Such consent and readiness to co-operate was clearly of great consequence since these

minorities groups at least appeared to afford a unique opportunity for access to the main 'reservoir' of homosexual males resident within the Glasgow area. In the interests of generating an acceptably representative sample of homosexual males, other sources, i.e. informally constituted minorities groups were also 'tapped'. Willingness to co-operate with and participate in the study was almost invariably expressed by all such groups contacted. Similarly, the researcher was almost invariably accorded an open invitation to attend all regularly constituted meetings, as well as to be present at any special gatherings in order to collect the required data.

The recruitment of homosexual and of heterosexual males attending special clinics within the Glasgow area was known to be a practical possibility, since both populations had previously provided subjects for research and these had, with few exceptions, demonstrated an ability to complete the necessary research documents, (Wells & Schofield, 1972; Bindemann **et al, 1976)**

Special clinic patient subjects - homosexuals and heterosexuals - were invariably recruited immediately following their first consultation and treatment session. These potential subjects were, in the first instance, informed of the study's existence and were then told in fairly general terms that it represented an attempt to acquire accurate data about the special clinic patient population - homosexual and heterosexual - within the Glasgow area. In order to convince potential respondents that there was a genuine need to acquire accurate descriptive data relating to personality characteristics, family and social background etc., the following explanation was put forward. Firstly it was required as a means of identifying and of understanding patients' needs which may relate to, but are in many ways distinct from, the obvious requirement for

the treatment of physical infection where present. Second, it was required in response to a need for a sensitively directed service to patients which was clearly disassociated from harmful connotations of discrimination or of disapproval. Thirdly, it was required as an effective challenge to misconceived and harmful stereotyping of patients which are known to alienate and to divide.

Complete assurances as to the confidentiality of all data so obtained were given. Indeed, special care was taken to inspire full confidence in this assurance, since it is known that the Glasgow area contains a population which is representative of widely differing intelligence levels and of ability to comprehend. For this reason also, special care and attention were devoted to making all potential subjects aware of the research aims in language which was easily comprehended by them.

Adequate reference has already been made to previous research findings relating to heterosexual male special clinic patients which have reflected their atypical scores on major personality parameters. Accordingly, a heterosexual male non special clinic control group was also recruited as a means of providing the necessary verification of such reported results as have been previously referred to.

Classifying and Grouping of Subjects: The classification "homosexual" was - for reasons previously given - assigned to all male subjects who claimed to have experienced anal intercourse with another consenting male. The classification "heterosexual" was assigned to all subjects who had explicitly denied such (current or previous) sexual (erotic) activity to the point of penetration.

The classification, homosexual special clinic patient was assigned to all homosexual male subjects who were currently receiving, or who had in the past received, treatment at a special clinic for a sexually acquired infection. The classification "homosexual

control subject" was assigned to all homosexual males who up the time of their participation in the study, had no history of attendance at a special clinic or of infection from a sexually transmitted disease and who were wholly free from likely symptoms of such infection. The classification "heterosexual (Group 1)" was assigned to heterosexual males who were currently attending, or who had in the past attended a special clinic for the treatment of a sexually transmitted disease. The classification "heterosexual (Group 2)" was assigned to heterosexual males who up to the time of their participation in the study, had no history of attendance at a special clinic or of infection from a sexually transmitted disease.

Summary of essential dimensions: It is evident from the foregoing criteria for inclusion in the study, that all homosexual male subjects were recruited at special clinics serving the GGHBs area of administrative authority, or at minorities group getherings either at Glasgow or at Edinburgh. Heterosexual male subjects were recruited either at special clinics or at other recreational and social centres within the GGHB's administrative area and to which the researcher had obtained permission for access. Eligibility on the basis of age was set to apply between the ages 16 and 35 years.

Instruments of assessment employed in the study: The method and procedure entailed in the collection of data turned upon two well documented research strategies.

(1) The self-report questionnaire or inventory and

(2) A Research Interview.

The Self-Report Questionnaire or Inventory: The first of the two strategies referred to above might be more aptly described as a 'battery' of short questionnaires (Appendix 3a). All such questionnaires were specifically constructed as a means toward the

fulfilment of the study's precise aim which has been described previously.

Questionnaire 1 was devised and constructed as the principal instrument for demographic data collection, as well as for the acquisition of relevant information relating to the pre/extramarital sexual activity, the prevalence of alcohol drinking and cigarette smoking and of experience of, or involvement with psychoactive drugs and substances.

Questionnaire 2 was a "semantic differential-type scale", (Osgood et al, 1957).and followed the method of scale construction previously described by Bindemann,(1974), In order to generate a wide and varied item 'pool', a number of relevant sources were tapped, including published material and clinicians' impressions of patients. However, the main contributors to this process were adolescents and young adults - heterosexuals and homosexuals - who agreed to co-operate and who were invited to draw upon personal experiences. Participants were instructed to write down a description of themselves in terms of words and short phrases, e.g., happy, easy-going, often a failure, shy etc. From this process, there ensued a hard 'core' of items and these were included, together with some of the more unusual contributions, which served the purpose of buffer items. Item-reduction was in the main, largely an intuitive process. In its final form, Questionnaire 2 contained 30 such items, which were arranged together with their polar alternatives, e.g. "happy-sad", "shy-bold" etc. on a five point scale and on which, subjects were invited to respond to the 'actual self' response-criterion, i.e."The kind of person I am".

A similar process for gathering expressed beliefs, opinions etc. was adopted for the purpose of creating Questionnaires 3 and 4. Questionnaire 3 composed 30 statements in the form of such stated beliefs and opinions. These were assigned to a Likert-type scale, ranging from "strongly agree" to "strongly disagree".

Questionnaire 4 was so designed as to provide for a "True-False" forced response scale, concerning subjects' reactions to 30 statements.

The final scales to be specifically constructed for deployment in the study which is here reported, i.e. Questionnaires 5a and 5b, were of the 'self-anchoring' type, originally described by Kilpatrick and Cantril, (1960). The procedure involved in this latter scale is wholly ideographic and is designed so as to provide a unique measure of the individual's relative position in life between two extremes, viz., "ideal way of life" and "most unsatisfactory way of life". By means of a ten point 'ladder' type scale, each subject is afforded an adequate opportunity to indicate his personal preference in agreement with that point which most accurately represents his self-perceived level of satisfaction with currently experienced way of life. Questionnaire 5b differs from 5a in that it is concerned with and facilitates such self-perception, but of estimated position on an identical scale, projecting forward to a response criterion, " in five years time".

In addition to those questionnaires referred to above - all of which were constructed specifically for the purpose of this study - other well-validated 'pencil and paper' self-report scales were also employed

throughout. One such example is the Psychoticism, Extraversion, Neuroticism (PEN) Inventory, (Eysenck and Eysenck, 1968) which is a refinement of the Eysenck Personality Inventory (EPI), (Eysenck and Eysenck, 1964). The PEN Inventory facilitates an objective measurement of the Psychoticism (P) dimension, in addition to that relating to Neuroticism (N) and Extraversion (E) parameters. The Institute for Ability Testing (IPAT) Self Analysis Scale (Cattell and Scheier, 1963) was employed throughout as the most efficient and productive means of objectively scaling anxiety levels among subjects and the General Health Questionnaire (GHQ), (Goldberg, 1970) provided a well-validated self-report method for accurately assessing present levels of psychiatric morbidity in subjects. The Test of Social Insight (Cassals, 1959a) completed the 'battery' of instruments for self-assessment employed throughout the study. A detailed account of all such inventories referred to above is provided in Appendix

The average time taken for completion of all questionnaires and inventories attempted at the initial session of actual participation, i.e., the 'battery' of specially constructed questionnaires and scales, together with the PEN, the IPAT Anxiety Scale and the GHQ, was approximately one hour and thirty minutes.* Great care was taken to ensure the safe return of all questionnaires or inventories originally handed out and under no circumstances were subjects allowed to remove or to take research documents away from the site of their actual recruitment as research subjects.

The writer's previous research experience of data collection on especially sensitive aspects of sexual interest and behaviour resulted in a preference for the "face to face" interview as the

*The Test of Social Insight was invariably completed in a separate and additional session lasting approximately twenty minutes.

most acceptable and effective tool for such date collection. Moreover, in order to enhance validity in its comparative function, as well as a means of reducing those elements of bias with which the personal interview has been known to be associated, arrangements were made for subjects to attend for interview as soon as possible after, (and in some cases on the same day as) questionnaire completion. Special clinic patients were invariably invited to attend for interview immediately following their next clinic appointment. This stage of the enquiry was explained and described to them as constituting an attempt to further assess existing levels of knowledge, of beliefs and of opinions about sexually transmitted diseases, as well as providing an opportunity for evaluating discrepancies if any, between what is actually known and what is in fact desired by way of health education. The timing of this request for subjects' continued participation was regarded as being of considerable importance and it was invariably made at the end of the original session of subject - participation when completed questionnaires, inventories etc., were being gathered in. Thus, it was made manifestly apparent that such a request was in no way connected with particular responses to any items contained in research documents already completed.

Where feasible, questionnaire completion and interviews involving subjects contacted at Minorities group gatherings, were completed over a single session. This practice was not always convenient however,and where a further appointment was in fact required for the purpose of interview, subjects were requested to refrain from any form of discussion about questionnaire-content with any person or persons who had not as yet participated in the study but was likely to do so. The research interview took approximately forty minutes for heterosexual subjects and fifty minutes for homosexuals to complete successfully.

Following interview completion, subjects were invariably requested to attend for the further session in order to complete the Test of Social Insight. As is apparent in the appropriate table of results, considerably fewer subjects were willing to attempt this final session and an even smaller minority of subjects successfully completed it.

Other noteworthy methodological factors: It is clearly evident from the numerical size of the control group involved in the study, (as well as from the selection procedure outlined previously) that no attempt was made to employ a "matched pair" method for statistical evaluation and comparison. Whilst the advantages of such a sampling procedure are readily acknowledged, it would in this instance, have considerably reduced overall sample size which in turn, would have seriously curtailed the study's predictive capacity. Nonetheless, special clinic patient/non-patient control subject parity was regarded as constituting a highly desirable if not qualifying criterion and all feasible attempts were made to ensure a valid basis for the necessary comparative analysis. The level of success achieved toward this end is clearly apparent in the results of comparative analysis of data relating to subjects' age, occupational status, type of living accomodation etc, ie. Chi square value, NS in all instances.

Computer analysis of data: All data obtained by means of the method and procedures outlined above were prepared for computer storage, retrieval and analysis in accordance with appropriate programmes available in the Statistical Package for the Social Sciences, (SPSS).

INITIAL POSTULATION OF HYPOTHESES

One essential requirement toward the fulfilment of which the early sections of this thesis have been directed, concerns provision of an adequate historical account of the manner in which research into male homosexuality has evolved in recent times. Indeed, the relentless influence of history with its capacity to modify current opinion and belief, as well as to influence prejudice and misunderstanding, would be difficult to overstate in this particular area of human interest and activity.

A further purpose which the foregoing sections have sought to fulfil concerns the related need to postulate firm grounds for relevant and testable hypotheses. The need for such hypotheses - founded upon criteria whereby to evaluate comparatively, homosexuals possessing a history of special clinic attendance for treatment, with homosexuals possessing no such history - is quite explicit in a study such as this where a declared aim is to test the feasibility and value of a proposed locus for subject recruitment, viz. the special clinic. It must nonetheless, at all times remain clearly evident that the point of search for such a tenable and satisfactory recruitment site should be a means to an end, that end being to facilitate valid studies of male homosexuality as a behavioural phenomenon. This calls for comparative analysis of data relating to well-defined variables of homosexual and heterosexual life-styles, attitudes, personality etc. Accordingly, hypotheses which are identified and enumerated in this present section and which will be formally stated in the following section, provide a reliable and comparable basis for intragroup, (viz. special clinic/ non clinic homosexuals) as well as for intergroup analysis comparatiely. At risk of labouring the point, it is again emphasized that all such

hypotheses will be shown, for the most part, to have been generated by the foregoing literature review as being hypotheses which:

(1) are of greatest relevance to the type of investigation which has been attempted and which is herewith described

and (2) are consistent with a research methodology which deploys self-report and subject interrogation as the sole method of data-collection.

Accordingly, such hypotheses will be introduced under the following headings: Family and Domestic

Educational and Occupational

Sexual

Social and Psychological, i.e. Personality

Psychiatric

Other behavioural.

The declared purpose of this and of the following section is therefore to identify accurately:

(1) Appropriate relevant variables for comparative analysis under the above-stated headings.

(2) Documented research evidence relating to the postulation of specific hypotheses.

(3) The anticipated direction of predicition, i.e. difference/ no difference.

FAMILY AND DOMESTIC

The rationale for the postulation of such hypotheses can be seen to follow from the foregoing review of the literature; Mean-age of subjects' parents at the time of subjects birth; That essential degree of unanimity in research findings which would ensure the nature of prediction and hence of hypotheses on this particular topic is not at all evident in the literature. Murdoch et al (1970) have reported significant differences between the mean-ages of mothers

of homosexual sons and mothers of heterosexual sons, whereas Saqhir and Robins (1974) have indicated that maternal age at the time of birth of homosexual and heterosexual subjects were entirely comparable.

By whom subjects were raised; ie. whether raised by their natural parents or by foster-parents, or whether raised in an institution or 'home'. Such hypothesized differences between homosexuals and heterosexuals have also been postulated by Murdoch et al (1970) who have reported a greater incidence of natural parent/child relationships among heterosexuals. However, there is again evidence of grounds for controversy in that in a subsequent published study undertaken by Zugar, (1974) no such differences as these reported by Murdoch et al (1970) were found to apply.

Variation in numbers of and ordinal differences between siblings; Schofield (1965) reported his findings of comparability in such variations between male homosexuals and heterosexuals. Findings such as these were later deployed as the basis for a similar prediction by Siegelman (1974) and by Zugar (1974), a finding which was subsequently confirmed in their respective studies and again the following year by Saqhir and Robins (1975).

Patterns of parental behaviour; Reported differences in patterns of parental behaviour which have been shown to be evident within the family homes of male homosexuals have been described by Bieber et al (1962). Bieber et al (1962) referred to mothers of homosexuals as ".... dominating, overprotective and demasculinizing ...." and to their fathers as " ..... detached ... (and) ... unaffectionate". In contrast, Apperson and McAdoo (1968) have reported their observed tendancy for mothers of homosexuals to display permissive and overly indulgent behaviour toward their sons.

whilst Schofield (1965) had earlier reported his finding that homosexuals themselves considered their mothers to display overly protective behaviour and attitudes toward them. Such reported patterns of parental behaviour is well summarized in the central tenet of psychoanalytic theory concerning male homosexuality, to which reference has previously been made; viz. evidence of an ".... over-attachment to an exploitive mother, in company not infrequently, with evidence of hostility toward a remote and frequently absenting father", (Ferman and Miles, 1936; Fenichel, 1949).

Bieber et al (1962) and Thompson et al (1973) have accordingly, deployed this central premise as the basis for their predictions that mothers of homosexual sons will display significantly greater levels of: Authoritarian attitudes, together with evidence of

Indulgent and overly affectionate behaviour toward their sons. These authors have further predicted a tendency for such mothers to be continuously present within the family home.

Converse patterns of such behaviour are hypothesized for male parents of homosexual sons, i.e:

Anti-authoritarian and permissive attitudes

Unaffectionate and 'distant' behaviour and

Prolonged absence from the family home.

Such hypotheses as those embodied above, find support in the work of Saghir and Robins (1975) referred to previously, who also found mothers of homosexuals to be more possessive and unduly involved in decision-making and fathers to manifest poor identification with their homosexual sons. Significantly higher incidence of this latter form of deprivation in early childhood had earlier been reported by Schofield (1965). It is apparent from the review of the literature

that there is little. if any evidence, of differences between homosexuals and heterosexuals on the following variables:

Incidence of parental death (either or both parents) and

Favourable/unfavourable attitude toward family home, although Saghir and Robins (1975) have reported evidence of a higher incidence of parental discord in homosexual homes than was allegedly the case for heterosexual control subjects.

On the basis of Pare's thesis (Pare, 1965) of an"inherent predisposition" toward homosexuality, it may be hypothesized that, significant differences between homosexuals and heterosexuals will emerge in reported historical evidence of homosexual proneness within the family. If it be the case - as this thesis is at pains to test - that homosexual special clinic patients and their non-patient counterparts are essentially undifferentiated, it is firmly predicted that consistent evidence of **their similarity will emerge in relation to all** variables referred to above.

EDUCATIONAL AND OCCUPATIONAL

In their comprehensive study referred to previously, Bell and Weinberg (1978) reported comparability between homosexuals and heterosexuals on all educational and occupational variables reviewed in this study, with the exception of type of job in which subject was engaged at the time. Homosexuals manifested greater liklihood of occupying "... office, personnel and financial undertaking employment", whereas heterosexuals were more likely to be employed ".... as engineers, factory foremen, contractors etc". Reference has been made previously to Schofield's study, (Schofield, 1965) in which he was unable to distinguish homosexuals from heterosexuals on the variables of education and type of school attended. These studies apart, there would seem to exist no substantial body of

evidence indicating detailed analysis of comparison of educational variables. Several studies have however, pointed to evidence of similarity rather than difference on the variable of occupational status. In another study previously referred to, (Bindemann et al 1978) a worthwhile and meaningful analysis of a coherent grouping of educational and occupational variables has been reported as the basis for statistical analysis comparatively between discreet groups which is both applicable and relevant as a basis for similar statistical analysis comparatively in this present study, viz;

School leaving age

Attitude toward compulsory education

Evidence of further/higher education received

Evidence of "drop-out" from, or successful completion of, and

Current occupational status

and accordingly it is proposed to deploy these variables as criteria for hypotheses to be postulated in this present study, since they also encompass educational and occupational variables referred to above. In the absence of relevant and reliable evidence of incomparability between homosexuals and heterosexuals on such variables, similarity rather than difference is predicted.

The recruitment location for this study, viz. the special clinic, affords credibility and relevance to other variables for objective testing which may also be grouped under this specific heading: i.e.,

Whether offered health education

Evidence of individual effort being made to obtain health/sex knowledge

Prevalent attitude toward it

Awareness of specific sexually transmitted diseases

Awareness of principal means of contagion

Accurate knowledge of the main symptoms of syphilis and gonorrhoea

In the absence of documented evidence to indicate otherwise, (Schofield, (1965) has reported a finding of similarity rather than difference as characterizing homosexuals and heterosexuals on the variable of availability of sex education), similarities between criterion groups are predicted.

SEXUAL

Bearing in mind a principal aim of the enquiry, viz., to evaluate the credibility and status of the special clinic as a satisfactory site for the study of homosexuality, it seemed highly desirable to determine and to evaluate comparatively such patterns of homosexual behaviour as would be expected to differentiate special clinic patients from non-patients in the event of such groups being shown in fact, to represent distinctive and discreet populations. Conversely, if comparability were to emerge as the distinguishing feature between homosexual special clinic patients and non-patient control subjects as predicted, one might reasonably hypothesize similarity between the two groups of interest on the following variables;

Age of initial homosexual arousal

Age of initial heterosexual arousal (where applicable)

Age of first homosexual (anal) intercourse

Role played/preferred

Age of first heterosexual intercourse (where applicable)

Stated reactions to these experiences, i.e. 1) enjoyed/did not enjoy

2) felt guilty/experienced no such feelings of guilt

whereas differences may be anticipated, thus distinguishing the two groups of interest on status of sexual consort, i.e.,

Casual acquaintance/close friend

Status of subsequent sexual consorts

Frequency of anal and/or heterosexual intercourse

Number of sexual partners

Finally, the evidence of a higher frequency of masturbation and of co-masturbation among homosexuals, as reported by Saghir and Robins (1975) provides the ground for a prediction of incomparability between homosexual and heterosexual subjects on these variables.

Since it is manifestly evident that the research strategy employed throughout the study entails evaluation comparatively of two heterosexual samples, i.e., special clinic patients (Group 1) and non-patients (Group 2), it would seem only reasonable also to evaluate the status of heterosexual intragroup variations on similar comparative criteria referred to above, where applicable. Studies previously carried out which have reported statistical comparison of sexual behavioural differences between male heterosexual special clinic patients and non-patients, (Bindemann et al, 1978) would certainly support the prediction of earlier initial sexual arousal and of earlier initial sexual intercourse, as well as of greater frequency of sexual intercourse and of increased numbers of sexual partners among special clinic patient subjects. No such differences are predicted between heterosexual groups on status of first sexual consort, or on reported reaction to such experience. The variable of "role played" and of "desire for change" are not relevant to heterosexual intercourse.

Comparison of male homosexuals and of male heterosexuals is in many ways, central since it constitutes a principal ground for the very existence of such a study as this, i.e. to provide a

credible and acceptable recruitment site for analysis comparatively of homosexual and heterosexual subjects on a wide range of behavioural and environmental variables.

Chief among sexual variables referred to above as being most likely to distinguish male homosexuals from their heterosexual counterparts, are those relating to higher incidence of co-masturbation and greater evidence of promiscuous behaviour among homosexuals than among heterosexuals . Schofield (1965), Bell (1973), Saghir and Robins (1975) and Bell and Weinberg (1978) are in total agreement in respect of such findings.

SOCIAL AND PSYCHOLOGICAL

Such variables and hypotheses for testing are included under the same heading in line with a practice evident in several of the studies referred to previously. A further practical reason for so doing concerns the explicit relationship to psychological testing of component variables which together make up the "Test of Social Insight". This well-validated test has been included as an instrument of assessment because of its known ability to discriminate between criterion-groups on those very variables, i.e. social withdrawal, passivity, co-operativeness and aggression as well as to objectively measure social insight whereas the PEN Inventory can confidently be expected to provide group scores relating to the personality parameters of Psychoticism (P), Extraversion (E) and Neuroticism (N). The IPAT Anxiety (Self-analysis) Inventory may, with equal confidence, be expected to elicit group anxiety scores.

Two explicitly social variables will be investigated and evaluated, namely reported membership of formal groups and previous history of criminal conviction. In the light of evidence referred

to previously, the prediction would be in the direction of a higher incidence of formal groups' membership and of criminal conviction (sexually-related offences) being evident among homosexuals than heterosexuals.

In their study to which previous reference has frequently been made, Saghir and Robins (1975) reported homosexuals to be more social, less competitive and lower in self-esteem. The same authors also reported significantly higher incidence of sex-related offences. Bearing in mind the influence of cultural variations, it is worth recalling the major findings of social and psychological variables reported by Siegelman (1978) in which he attempted to replicate his USA investigation (Siegelman, 1972a) in Britain on a sample of male homosexuals and male heterosexuals. Siegelman, (1978) clearly found homosexuals to score the more highly on the factors of "tender-mindedness, submissiveness, anxiety, total neuroticism, dependency and nurturance", whilst Wells and Schofield (1972) had earlier reported their finding of higher neuroticism and lower extraversion scores among male homosexual special clinic attenders when compared with their heterosexual counterparts.

On the basis of these and other similar findings referred to previously, there are reliable grounds in support of a prediction of similarities/differences between male homosexuals and heterosexuals in:

Membership of formal groups:	higher among homosexuals
History of criminal conviction:	greater among homosexuals
Social withdrawal:	more in evidence among homosexuals
Passivity:	more in evidence among homosexuals
Co-operativeness:	more in evidence among homosexuals
Aggression:	lower among homosexuals

Psychoticism:	comparability
Extraversion:	lower among homosexuals
Neuroticism:	higher among homosexuals
Anxiety:	higher among homosexuals

As has previously been shown to be the case and for reasons which have been clearly stated, comparability between homosexual special clinic patients and homosexual control subjects is confidently predicted on all variables cited above. Results reported in a study previously referred to (Eindemann et al, 1978) would support predictions of a lower incidence of formal group membership and a higher incidence of criminal conviction, as well as of significantly higher Extraversion scores and lower Neuroticism and Anxiety scores among heterosexual special clinic patients when compared with heterosexual non-clinic subjects. It is predicted that comparability between these two criterion groups will apply to all other variables listed immediately above. Finally, it is predicted that homosexual special clinic patients will be distinguished from their heterosexual counterparts in regard to higher incidence of formal group membership and of criminal conviction, in evidence of greater social withdrawal, passivity, co-operativeness and higher neuroticism and anxiety scores. Conversely, heterosexuals will - so it is predicted - manifest higher levels of aggression. Similar differences are also likely to statistically differentiate homosexual non-patient subjects from heterosexual Group 2 subjects.

PSYCHIATRIC

Saghir and Robins (1975) have reported prevalence of the need for psychiatric intervention among male homosexuals which is allegedly four times greater than that which was found to apply to male heterosexual control subjects. Incidence of symptoms indicating psychiatric

morbidity, e.g. attempted suicide, depressive disorders, excessive alcohol drinking etc. were also found to be considerably greater among homosexuals than among heterosexuals. Similar findings have been reported of British male homosexuals, (Schofield, 1965; Siegelman, 1978) as well as of such members of minorities interviewed in the USA (Siegelman, 1972a; Weinberg and Williams, 1973; Bell and Weinberg, 1978). In their report of a study undertaken within the Glasgow Special Clinics, Bindemann et al, (1978) reported comparability of psychiatric morbidity between male heterosexual special clinic patients and a non special clinic control group. It follows therefore, that whereas there is a firm research basis for the prediction of significantly higher prevalence of psychiatric morbidity among male homosexuals when compared with male heterosexuals, there would appear to be no known valid grounds for such a prediction of intra-group differences.

OTHER BEHAVIOURAL

With the exception of findings reported by Saghir and Robins (1975) who indicated a higher incidence of psychoactive drug misuse among male homosexuals (< 0.05), other researchers have been substantially unable to distinguish homosexuals from heterosexuals on the behavioural variables of drug misuse, alcohol consumption and cigarette smoking.

In contrast to this finding and as has been indicated previously, significantly higher incidence of **drug misuse** have been reported for male heterosexual special clinic patients when compared to their non clinic attending counterparts, (Fish, Wells and Bindemann, 1973; Bindemann et al; **1976, 1978). Such findings as these serve as a firm** basis for the prediction of comparability:

1. Between homosexual sub-groups and

2. between homosexuals and heterosexuals

but that conversely, statistically significant differences will emerge between male heterosexual special clinic patients and their non clinic-attending male counterparts. It will be remembered that the introductory section argued powerfully against the notion of comparability between male homosexual and heterosexual special clinic patients, an argument which has been afforded strong support by Wells and Schofield (1972) who distinguished these two populations on major personality parameters, namely Extraversion and Neuroticism. Moreover, whereas the archetypal male heterosexual special clinic patient would appear to be clearly distinguished from his non clinic-attending counterpart, there are no such grounds for predicting similar differences between male homosexual special clinic patients and members of the homosexual non-patient group. Indeed, it is a major submission of this thesis that these two groups will, in fact, be characterized by comparability on major personality parameters as on other key variables referred to under the respective headings.

Summary

This section has been concerned to show:

1. The rationale which underlies such hypotheses as have been tentatively postulated for inclusion.

2. Their predictive value based on evidence contained within the relevant literature.

Where hypotheses have been postulated for which no previously reported evidence is available in support of the prediction of inter-group or intro-group differences, group comparability has been hypothesized.

Hypotheses, appropriately postulated under their relevant headings, will be formally stated in the following section.

STATEMENT OF HYPOTHESES TO BE TESTED

1. FAMILY AND DOMESTIC

That no statistically significant differences will emerge between:

(a) homosexual (special clinic patients and non-patient control) subjects in such areas of interest as are entailed in the following variables:

1a Age of mother at the time of subject's birth.

1b Age of father at the time of subject's birth.

2. By whom subject was raised: ie. parent(s)/other.

3. Number of siblings in family.

4. Ordinal difference between next older/younger sibling.

Parental Behaviour

Mother

5a i) Authoritarian/permissive behaviour.

ii) Overly indulgent/unaffectionate behaviour.

iii) Presence/absence within family home.

Father

5b i) Authoritarian/permissive behaviour.

ii) Overly indulgent/unaffectionate behaviour.

iii) Presence/absence within family home.

Both Parents

5c i) Parents' marital status, i.e., together/separated.

6. Subject's opinion of family home, ie. favourable/unfavourable.

7. Parents' awareness of subject's homosexuality.

STATEMENT OF HYPOTHESES (cont)

Parents living/deceased

Mother

8a i) On or before 12th birthday.

ii) After 12th birthday.

Father

8b i) On or before 12th birthday.

ii) After 12th birthday.

8c Both parents deceased.

9. History of homosexuality within family.

10. Type of living accomodation.

That no statistically significant differences will emerge between (b) heterosexual (Groups 1 & 2) subjects in such areas of interest as are entailed in 1-5b, 8,9 and 10 (above) but that significant differences will be evident in comparative analysis between such subject-groups' data relating to 5c and 6 (omitting 7 and 9 from such comparative analysis as being non-relevant).

That no statistically significant differences will emerge between (c) homosexual special clinic patients and heterosexual (Group 1) subjects in comparative analysis of variables entailed in 2-4, 8-10 but that significant differences will be evident in results reported for these groups entailed in 1a and b, 5a,b,c and 6 (omitting 7 from comparative analysis as being non-relevant).

That no statistically significant differences will emerge between (d) homosexual non-patient control and heterosexual (Group 2) subjects in comparative analysis of variables entailed in 2-4, 8-10 but that differences will be evident in results reported for those groups entailed in 1a,b,5a,b,c, and 6 (omitting 7 & 10).

2. EDUCATIONAL AND OCCUPATIONAL

That no statistically significant differences will emerge between

(a) homosexual special clinic patients and non-patient control subjects in such areas of interest as are entailed in hypotheses 1-6 (below) but that significant differences will emerge between variables entailed in hypotheses 7a and b.

1. School-leaving age.

2. Attitude toward compulsory education received.

3a Further/higher education received

b Drop-out from

4. Current occupational status.

5a Whether offered health education.

b Whether effort made to obtain health knowledge.

c Attitude toward health education/knowledge received.

6. Awareness of specific sexually transmitted diseases.

7a Awareness of principal means of contagion to disease.

b Knowledge of main symptoms.

That statistically significant differences will emerge between

(b) heterosexual (Groups 1 and 2) subjects in comparative analysis of variables entailed in 1-7b above inclusive (excepting 5a).

That statistically significant differences will emerge between

(c) homosexual special clinic patients and heterosexual (Group 1) subjects in data reported for these respective groups relating to 1-5c, but not in comparable analysis of data reported for 6-7b.

That no statistically significant differences will emerge between

(d) homosexual non-patient control and heterosexual (Group 2) subjects in comparative analysis of all variables, i.e., 1-7b.

3. SEXUAL

That no statistically significant differences will emerge between

(a) homosexual special clinic patients and non-patient control subjects in such behavioural activities, reactions etc. as are contained in hypotheses 1-5b, 8, 15a-17, 20a and b (listed below). Statistically significant differences are in fact, hypothesized as arising out of analysis comparatively of data relating to hypotheses 6, 7, 18 & 19. (Hypotheses 9-14 relate quite specifically to a history of heterosexual behaviour. However, to conclude or to in any way indicate at this stage that such hypotheses might be inappropriate to homosexual subjects would be entirely premature).

1. Age of initial homosexual arousal.
2. Age of first homosexual (anal) intercourse.
3. Status of first homosexual partner, i.e. casual/close friend etc.
4. Role played on first occasion, i.e., active/passive etc.

5a Reaction to this experience, ie., enjoyed/did not enjoy.

5b Reaction to this experience, i.e., felt guilty/did not feel guilty.

6. Frequency of homosexual intercourse (past 3 months).
7. Number of sexual partners (past 3 months).
8. Expressed desire for change.
9. Age of initial heterosexual arousal.
10. Age of first heterosexual intercourse.
11. Status of heterosexual partner, i.e., casual/close friend etc.

12a Reaction to this experience, ie., enjoyed/did not enjoy.

12b Reaction to this experience, ie., felt guilty/did not feel guilty.

13. Frequency of heterosexual intercourse (past 3 months)
14. Number of sexual partners, (past 3 months).

15a History of masturbation.

15b History of co-masturbation.

16. Age of first homosexual or heterosexual arousal.

17. Age of first homosexual or heterosexual intercourse.

18. Frequency of such intercourse (past 3 months)

19. Number of sexual partners (past 3 months).

20a Reaction to such activity, i.e., enjoyed/did not enjoy.

20b Reaction to such activity, i.e., felt guilty/did not feel guilty.

That statistically significant differences will emerge between

(b) heterosexual (Groups 1 & 2) subjects from comparative analysis of data relating to hypotheses 9, 10, 13, 14, 16-19 but that comparability will be recorded in respect of hypotheses 11, 12a,b, 20a and b (Hypotheses 1-8 not relevant).

That statistically significant differences will emerge between

(c) homosexual special clinic patients and heterosexual (Group 1) subjects in behaviour, opinions etc. entailed in hypotheses 12a, b, 13, 14, 15b, 18 and 19 (where relevant) but that no such differences can be anticipated in respect of hypotheses 9, 10, 11, 16, 17, 20a and 20b.

That statistically significant differences will be apparent between,

(d) homosexual non-patient control and heterosexual (Group 2) subjects in analysis comparatively of data as for (c) above.

4. SOCIAL AND PSYCHOLOGICAL i.e., Personality characteristics

That no statistically significant differences will emerge between

(a) homosexual special clinic patients and non-patient control subjects in any of the variables of interest, i.e., 1-11.

1. Membership of formally structured groups.

2. History of criminal conviction (excluding motoring offences).

3. Withdrawal.
4. Passivity.
5. Co-operativeness
6. Competativeness.
7. Aggression.

} As measured by "Test of Social Insight"

8. Psychoticism "P" Score
9. Extraversion "E" Score
10. Neuroticism "N" Score

} As measured by PEN Inventory

11. Anxiety Score – As measured by IPAT Self-Analysis Questionnaire

That statistically significant differences will emerge between

(b) heterosexual (Groups 1 and 2) subjects in analysis comparatively of data relating to hypotheses 1, 2, 7 and 9-11 but that comparability will characterize such analysis of data relating to hypotheses 3-6 and 8.

That statistically significant differences will distinguish

(c) homosexual special clinic patients and heterosexual (Group 1) subjects on hypotheses 1, 3-7, 9-11 but that comparability between groups will be evident concerning variables 2 and 8.

That statistically significant differences will indicate incomparability between,

(d) homosexual non-patient control and heterosexual (Group 2) subjects on hypotheses 1-7 and 9-11 but comparability on hypothesis 8.

It is also likely that additional social and personality may ensue from factor analysis of Questionnaire 2a-4 data. However, because of the heuristic nature of this part of the study, statement of hypotheses at this stage is not feasible.

6. PSYCHIATRIC ASSESSMENT

That no statistically signficant differences will emerge between

(a) homosexual special clinic patients and non-patient control subjects when comparative analysis is made of these group scores on the following variable:

1. Psychiatric Morbidity as measured by the GHQ.

That no statistically significant differences will emerge between

(b) heterosexual (Groups 1 & 2) subjects.

(c) homosexual special clinic patients and heterosexual (Group 1) subjects.

(d) homosexual non-patient control and heterosexual (Group 2 subjects) as the result of similar comparative analysis.

7. OTHER BEHAVIOURAL

That no statistically significant differences will emerge between

(a) homosexual-special clinic patients and non-patient control subjects when comparative analysis is made of these group scores on the following variables:

1. Cigarette smoking (whether regularly, occasionally, not at all)

2. Alcohol drinking (whether regularly, occasionally, not at all)

3a Psychoactive drug misuse (whether regularly, occasionally, not at all)

3b Whether offered drugs

3c Knowledge of where drugs can be obtained.

That statistically significant differences will similarly emerge between,

(b) heterosexual (Groups 1 & 2) subjects and

(c) homosexual special clinic patients and heterosexual (Group 1) subjects but not between,

(d) homosexual non-patient control and heterosexual (Group 2) subjects.

RESULTS

A total number of 617 males participated in at least one of the projects' requirements. Of this number, 359 (58%) were homosexual according to the criterion for group inclusion set out in an earlier section. The remaining 258 (42%) were considered to be heterosexual, in accordance with the appropriate criterion for their inclusion. Of the 359 homosexual subjects, 205 (57%) were special clinic patients and 154 (43%) were non-patient control subjects. Heterosexual subjects (258) were assigned Group 1 or Group 2 status, depending upon their eligibility for Group entry, i.e., 179 (69%) Group 1 and 79 (31%) Group 2. All subjects referred to above completed Questionnaire 1 (see App. 4) which may be regarded as the projects' principal instrument for data collection.

A somewhat smaller sample of essentially the same research subjects also completed Questionnaires 2a - 4, the Psychoticism, Extraversion, Neuroticism (PEN) Inventory, the IPAT "Self Analysis" Questionnaire and the General Health Questionnaire (GHQ). A total number of 542 males successfully completed these research documents in addition to Questionnaire 1. Of this number, 284 (52%) were homosexuals and 258 (48%) were heterosexuals. Homosexual participants were further subdivided into special clinic patients, 178 (63%) and non-patient control subjects, 106 (37%) whilst the number of heterosexuals participating remained unchanged, i.e., 179 (69%) and 79 (31%) for Groups 1 and 2 respectively.

Additional data - collected in this instance, by means of a structured interview - were obtained from a total number of 237 persons. Of this number, 158 (67%) and 79 (33%) were homosexuals and heterosexuals respectively. Assignment of this sample to group status

in accordance with the format referred to above, produced a homosexual component of 102 (64%) special clinic patients and 56 (36%) non-patient control subjects. The heterosexual group totalled 79 subjects of which 53 (67%) were Group 1 subjects, with the remaining 26 (33%) being assigned to Group 2.

The Test of Social Insight was completed by only a minority of the above-mentioned subjects, in fact by a total number of 75, 41 (55%) homosexual and 34 (45%) heterosexual subjects. In order to elicit maximum value from these data, no further sub-division into the respective research groups was attempted.

The reason for such reducing levels of compliance - especially as one approached the latter stages of the project's demands - was almost certainly due to an inability or unwillingness on the part of subjects to make further time available for completion. Another factor (which related almost exclusively to heterosexual Group 2 subjects) involved a reluctance to respond positively, i.e., in terms of enthusiasm for the more sensitive questions entailed in the structured interview and concerning sexual experience and activity. On the whole however, subject-compliance was a positive feature of the study throughout and with that exception referred to above, less than 40 individuals all told (distributed approximately equally between homosexuals and heterosexuals) either refused to participate in or defeaulted from the project, without having successfully completed that part of it with which they were engaged.

SUMMARY OF SAMPLE DATA

Questionnaire 1a was satisfactorily completed by all participant 617 male subjects, i.e., 359 homosexuals, (205 special clinic patients and 154 non-patient control subjects and 258 heterosexuals (179 Group 1 and 79 subjects). In addition, Questionnaires 2-4

- together with Personality and Psychiatric evaluation - were successfully negotiated by 542 of the above subjects, of which 264 were homosexual (178 special clinic patients and 106 non-patient control subjects and 258 heterosexuals (as above)). The structured interview was successfully carried out with 237 of those subjects referred to above. Of this number, 158 were homosexuals (102 special clinic patients and 56 non-patient control subjects) and 79 heterosexuals (79 and 26 Groups 1 and Groups 2 subjects respectively). **Finally, the Test of Social Insight was completed by 41 and 34 homosexuals and heterosexuals respectively.**

TABULAR PRESENTATION

In accordance with the demands entailed in the Statement of Hypotheses for data collection and analysis of results, tables have been so designed and constructed so as to facilitate easy and accurate perusal of results obtained. Tables 1 - 6 which display data relating to "Family and Domestic", "Educational and Occupational", "Sexual", "Social and Psychological", "Psychiatric" and "Other Behavioural" variables are designed to provide the following information;

Columns 1 & 2 :- Identity of the number and nature of the hypotheses which are being tested, together with actual subject-matter of those data which form the basis of hypotheses being tested.

Column 3:- The precise nature of the test employed, e.g., Chi Square, Analysis of variance and the value of "F", the students' t test etc.

Columns 4 - 11 (Columns 4 & 5 repeated four times):- Numbers of subjects, i.e., "populations" of subjects included in the particular test being deployed. (Note that sample sizes will necessarily differ in accordance with the method and nature of enquiry employed in data collection, e.g. Questionnaire 1, Questionnaires 1-4, Structured Interview etc.) Columns 4-11 also indicate the level of

confidence appropriate to statistical significance (if any) achieved between criterion groups, which are also clearly identified in table legend.

Columns 12 - 15:- (12) Source of actual question(s) employed in hypotheses testing e.g., Q1 = Questionnaire 1, I1 = Interview Schedule (part 1), I2 = Interview Schedule (part 2) etc.

(13) The appropriate item number of that particular instrument of assessment.

(14) The source of tabular display, e.g., App. 1a, App. 2b etc.

(15) The actual table number within the cited appendix which contained raw scores, percentages etc.

All results set out in accordance with the above, are displayed in the main body of the report viz., Tables 1 - 6, whilst basic data obtained by the appropriate method of enquiry, e.g., questionnaire, interview, etc. and which therefore constitute the raw material for comparative statistical evaluations on family and domestic, educational and occupational, social, sexual and other behavioural criteria, are contained in App. 1a, Tables 1 -18. Personality data and data obtained by means of questionnaires 2a - 5b concerning actual and ideal self-perception (2a, 2b) obtained by means of "strongly agree/strongly disagree", and by "true/false" scales (3 and 4) and "way of life" questionnaires (5a, 5b) - all of which were created and designed specifically for use in this present study - are presented in App. 1c Tables 1 - 16 together with Figures 1 - 10.

RESULTS (CONT'D)

Family and Domestic: Results appertaining to appropriate hypotheses are provided in Table 1.

The postulation of all such hypotheses relating to homosexual special clinic patients and non-patient control subjects predicting

comparability on all variables of interest is well justified by reported results, (see Table 1), a sole exception being that hypothesis predicting similar patterns of family history of male homosexuality. "In this single instance, there is evidence of significant difference in the form of a known higher incidence of homosexuality among the special clinic patient group". ($p < 0.05$)

It was hypothesized thatheterosexual (Groups 1 and 2) subjects would also be undifferentiated on "Family and Domestic" variables, 1 - 5b, 8 and 10, but that significant differences would result from group comparison in relation to 5c and 6 (hypothesis 7 is non-relevant). Such forecasts of heterosexual subject-differences were made in part, on the basis of an absence of known evidence up to the present time of reported differences and where appropriate, on the basis of previously reported differences between male heterosexual special clinic patients and their non-clinic subject counterparts. Hypotheses 1a and b which predicted comparability in mean age of parents at the time of subjects' birth, find no support in these data, there being evidence of difference in the direction of younger parents - both male and female - for Group 1 subjects. ($p < 0.05$) All other hypotheses of intergroup comparability, i.e., 3 - 5b, 8 and 10 are amply confirmed by reported findings. Hypotheses 5c and 6 (which predicted differences between Groups 1 and 2 subjects in parents marital status and subjects'stated opinion of family home) are in the event, unsupported.

Hypotheses of similarity/difference between homosexual special clinic patients and heterosexual (Group 1) special clinic patients, predicted similarity on variables specified in hypotheses 2 - 4b, 8 and 10 and significant differences between subject groups of interest in hypotheses 1a and b, 5a b and c, 6 and 9. Results do, in fact,

show ... with homosexual special clinic patients and heterosexual Group 1 subjects are, on the whole, characterized by similarity with exceptions relating to "mean age of mother at time of Ss birth", ($p < 0.001$) (as predicted) "history of having lost both parents by death", ($p < 0.001$) (higher incidence reported by heterosexual subjects) 'history of homosexuality in family', (p 0.001) (higher incidence reported by homosexual subjects', (as predicted) and 'type of living accomodation', ($p < 0.00$) with greater tendency in direction of independence and evidence of self-supportiveness, i.e., flats, houses, etc. among homosexual subjects).

The final intergroup comparison which was made as part of the process of testing "Social and Domestic" hypotheses, concerned homosexual and heterosexual control, i.e., non special clinic subjects. It was hypothesized that similarity rather than difference would prevail between the groups of interest on variables entailed in hypotheses 2 - 4b and 8 - 10, whereas these groups would be differentiated in a statistically significant manner in respect of variable 1a and b, 5a b and c, and 6, (hypotheses 7 and 9 being not relevant to this particular group comparison). In the event, no significant differences were reported between homosexual control subjects and heterosexual (Group 2) subjects on any of the variables entailed in "Social and Domestic" hypotheses, with the exception "history of homosexuality in the family" ($p < 0.05$)

Summary

Homosexual special clinic patients/ non-patient control subjects	All hypotheses (except No. 9) Supported
Heterosexual Grp.1/ Heterosexual Grp. 2 Ss.	Hypotheses 2 - 5b, 8 and 10 Supported
Homosexual special clinic patients/ Heterosexual Grp. 2 Ss	Hypotheses 1a, 2 - 4, 8a & b Supported 1b, 6, 9 & 10 Unsupported
Homosexual Control/ Heterosexual Grp. 2 subjects	Hypotheses 2,3,4,8 & 10 Supported 1a,1b,5a,b,c,6 & 9 Unsupported

Educational and Occupational

Table 2 sets out results relating to variables which serve as criteria for specific hypotheses.

Consistent with the contention that homosexual special clinic patients (or those possessing a history of infection by a sexually transmitted disease) and non-special clinic patients (i.e., no previous history) would be undifferentiated, all educational and occupational hypotheses anticipated similarity between these two principal research groups on variables specified on Table 2 (with the exception of results relating to variables of interest entailed in hypotheses 6, 7a and b, i and ii, viz., awareness of specific sexually transmitted diseases and principal means of contagion, in which significant differences are predicted.)

Results indicate a considerable measure of support for hypotheses but not entirely so. The hypothesis of intergroup comparability in respect of variables 2 (attitude toward compulsory education), 3a (further/higher education received) and 4 (current occupational status),are unsupported in the data, ($p = <0.05$ in all three instances) whereas the hypothesis of intergroup disparity predicted for variable 7a (awareness of principal means of STD contagion) is unsupported (NS).

Statistically significant differences were hypothesized as distinguishing heterosexual (Group 1) subjects from their Group 2 counterparts on all educational and occupational variables, with the sole exception of that relating to whether subjects had previously received sex education/information from parents or schools. The postulation of such hypotheses is amply justified in the data since in only two cases, ie., those relating to incidence of part/full-time further or higher education and 'drop-out' from such education, there is absence of confirming evidence. (NS in both cases)

Comparison between homosexual special clinic patient subjects

and heterosexual Group 1 subjects was undertaken in order to test the validity of hypotheses 1 - 5c (predicting significant differences between criterion groups) and of hypotheses 6 - 7b, (in which similarity, rather than difference, was hypothesized). As Table 2 indicates, hypotheses 1, 2, 4, 5a and b, were confirmed by findings of significant difference with levels of confidence ranging from $p<0.05$ through to $p<0.001$, as were 7a and b ii in which similarity between criterion groups is clearly evident. Hypotheses 3a and b, (difference predicted in further/higher education received as well as in 'drop-out' rates) 5c (difference predicted in attitudes toward sex education received) 6, (similarity predicted in levels of awareness of specific diseases) and 7b ii (knowledge of main symptoms of gonorrhoea) are unsupported in Table 2 of results.

It had been hypothesized that no intergroup differences would emerge in comparative analysis of results reported for homosexual control and heterosexual Group 2 subjects. In the event however, these groups did differ significantly in current occupational status ($p<0.05$) (tendency toward higher occupational categories among homosexuals), health education given by parents or at school, ($p<0.001$) (higher incidence among homosexual subjects), efforts made to obtain sex-education ($p<0.001$) (higher incidence among homosexuals) and awareness of specific diseases, i.e., gonorrhoea ($p<0.05$) and syphilis ($p<0.01$),(higher among homosexuals).

Summary

Homosexual special clinic patients/ non-patient control subjects	All hypotheses (except 3a,7a) Supported
Heterosexual Group 1/ Heterosexual Group 2	Hypotheses 1,2,5a-c,6,7b i &ii Supported 3a,b,7a Unsupported
Homosexual special clinic patients/ Heterosexual Group 1	Hypotheses 1,2,4,5a,b,7a,b ii Supported
Homo. non-patient control Ss/ Heterosexual Group 2 Subjects	Hypotheses 1-3b,5b,7a Supported 4,5a,5c,6,7b i & ii Unsupported

Sexual

Sexual data - relates to hypotheses which are in some instances specific to sexual preference, i.e., homosexual activity, (1 - 8) heterosexual activity, (9 - 14) whilst in other instances, such hypotheses relate to sexual behaviour as reported by homosexuals and/or heterosexuals (15a - 20b). Results obtained are shown in Table 3.

It is also evident from perusal of results set out in Table 3 that not all inter-group comparisons which were theoretically available for such analyses, proved feasible with sexual data. This was, in part, due to the non-relevance of certain specific hypotheses, e.g., of hypotheses involving heterosexual groups, but entailing homosexual behaviour and in other instances, was because of an insufficiency of data forthcoming, especially from heterosexual (Group 2) subjects.

In hypotheses relating to intergroup comparative analysis of sexual data and affecting homosexual subjects, differences were actually predicted on those variables which, on the basis of experience with special clinic patients, one might expect to differentiate attenders from non-attenders; i.e., "Status of sexual partner(s)", "frequency of sexual intercourse within the past three months" and "number of sexual partners" (within the same time period). It is noteworthy that, with the exception of hypotheses 5a and 20a, "reaction to first anal intercourse", and "reaction to intercourse within the past three months", (where similarity rather than difference was predicted, but where in the event, levels of confidence in differences are both $p<0.05$), hypotheses were all afforded consistent support from these data.

In those instances where actual data obtained could be shown to justify statistical comparison between heterosexual (Groups 1 & 2)

subjects, such comparative analysis was carried out and results are also reported in Table 3. As is evident from the table of results, insufficient data did in fact prevent the testing of a number of interesting hypotheses.

It is clear from the appropriate section in which hypotheses are formally stated, that with the exception of hypotheses 6,7,18 & 19 (in which a higher prevalence of sexual activity and of sexual promiscuity is predicted among homosexual special clinic patients) comparability between homosexual criterion groups is consistently predicted. The confidence entailed in such predictions is well justified in the data and as Table 3 clearly indicates, only in regard to hypotheses 3, 5a and 20b is such support unforthcoming in results reported. Results obtained for hypotheses 3 clearly indicates statistical difference between homosexual special clinic patients and non-patient control subjects in relation to the variable "status of first homosexual partner", there being clear evidence of a higher incidence of casual acquaintances as opposed to close friends reported by the former group, it is this same homosexual group which reports a higher level of enjoyment of this initial experience ($p = 0.05$) and of reported sexual activity in the past three months ($p = 0.05$).

With the exception of variables 9, 11 and 16, in which there was insufficient data for testing, all hypotheses concerning analysis comparatively of data obtained from heterosexual Group 1 and Group 2 subjects, were duly confirmed.

In contrast, similarities/differences between homosexual special clinic patients and heterosexual Group 1 subjects are much less inclined to confirm predictions entailed in hypotheses. For example, (and contrary to a prediction of similarity), there is evidence

of highly significant differences ($p=<0.001$) between criterion groups in regard to "Age of initial heterosexual arousal", "age of initial heterosexual intercourse" (earlier for heterosexuals in both cases) and "Status of heterosexual partner" higher incidence of initial sexual intercourse with casual acquaintance. Similarly, in regard to the variable of "Age of first homosexual or heterosexual intercourse" there was - contrary to prediction - significant difference ($p=<0.05$) in the direction of earlier intercourse among heterosexual subjects as also there was concerning "Reaction to recent sexual experience". Somewhat surprisingly, there is evidence of greater enjoyment and little, if any, evidence of guilt reaction ($p=<0.001$ in the case of both hypotheses). All hypotheses in which differences were predicted (viz. 12a,b,13,14,15a,b,18 & 19) were confirmed in the data, with the exception of 12a & b in which insufficiency of data prohibited testing. Insufficiency of data restricted the testing of hypotheses concerning similarities/differences between homosexual non clinic patients and heterosexual Group 2 subjects to four in all, i.e., 10,17,18 & 19. In all four cases, hypotheses were confirmed in the data.

Summary

Homosexual special clinic patients/ non-patient control subjects	Hypotheses 1,2,4,5b,6-12a & b, 15a,15b - 18,20a & b Supported Hypotheses 3,5a,18,19,20a Unsupported Insufficient data 13,14
Heterosexual Group 1/ Heterosexual Group 2	Hypotheses 10,12a & b,13,14,19-20a & 20b Supported Hypotheses Unsupported Insufficient data 9,11,16
Homosexual special clinic patient/ Heterosexual Group 1	Hypotheses 12a & b, 15a & b, 16 18,19 Supported Hypotheses 9-11,17,20a & b Insufficient data 13,14
Homo. non-patient control Ss./ Heterosexual Group 2 Subjects	Hypotheses 10,17,18 & 19 Supported Hypotheses Insufficient data 9,11,12a & b 13 14,15b,16,20a & b.

Social and Psychological

Results of comparative analysis relating to social hypotheses are displayed in Table 4. Although comparability had been confidently predicted between homosexual subjects in respect of variables 1 & 2, "Formal membership of Group" and "History of criminal conviction", statistical significance did in fact, distinguish these criterion groups on formal group membership contrary to prediction. Hypothesized incomparability between heterosexual Groups 1 & 2 subjects is confirmed in the data. However, similar hypotheses of incomparability between homosexual special clinic patients and heterosexual (Group 1) subjects and between homosexual (non-patient) subjects and heterosexual (Group 1) subjects were only partially supported in the data. History of criminal conviction between both group-pairings referred to immediately above, is in fact comparable.

Test of Social Insight data was insufficient to permit discreet group comparisons previously proposed. Statistical comparison between undifferentiated homosexual (n41) and heterosexual (n34) subjects only, was therefore feasible. Tables containing basic data obtained by the Test of Social Insight as well as by PEN and IPAT Inventories, from which results of comparative analysis are derived, are contained in App. 1b (Tables 1 -15).

Prior to the testing of hypotheses entailing comparative analysis of individual personality scores, the value of "F" as a means of assessing the validity of comparability of sample sizes, i.e., $\frac{176\ 179}{106\ \ 79}$ was computed. Only in cases where "F" does not achieve statistical significance does the computation of "t" have validity, (see App. 3b). The fact that "F" is shown to be

insignificant has facilitated further statistical analyses, the results of which are shown on Table 4.

Analysis of variance among group means for all PEN and Anxiety sub-group scores was computed. This resulted in variance being apparent at $p<0.05$ level of confidence. Analysis of variance was then computed for these same data but in this latter instance, comparison was made separately between criterion groups previously referred to, i.e., homosexual special clinic patients/non-patient control subjects, heterosexual Groups 1/2 subjects, homosexual special clinic patients/heterosexual Group 1 subjects, homosexual non-patient control/heterosexual Group 2 subjects. Results show differences to be non-significant in all four cases of comparison.

Since it was the case that variance between norm-scores for personality results in overall comparison differed significantly, compared with reported non-significance in differences achieved by analysis of variance of criterion group means, it was decided to statistically compare such criterion group mean scores for particular personality parameters, i.e, P,E,N and anxiety. Indeed, as the "Statement of hypotheses" clearly indicates, it had been hypothesized that in an analysis undertaken comparatively of scores achieved by homosexual special clinic patients and non-patient control subjects, no such statistical differences would be apparent. Results of the comparison of means achieved by these two research populations (students t) as shown in Table 4, are clearly in support of hypotheses, viz., that similarities in,rather than differences between,scores would prevail.

By contrast, statistically significant differences were hypothesized as being likely to distinguish heterosexual Group 1 subjects

from their Group 2 counterparts on E,N and Anxiety parameters. In the event, these 'populations' were undifferentiated on P, E and Anxiety scores. Results of comparative analysis of Neuroticism scores do however, provide a strong measure of support, ($p<0.001$) for the particular hypothesis concerned; viz., Table 5 Hypotheses No. 3.

As in previous hypotheses concerning P scores achieved by other criterion groups mentioned earlier in this section, similarity in scores achieved on this parameter was predicted for homosexual special clinic patients and heterosexual Group 1 subjects. However, differences are hypothesized as distinguishing these groups in a significant manner on E, N and Anxiety parameters. Results of statistical comparison shown on Table 5 indicate no support for hypotheses in this instance. Difference between the groups of interest in Psychoticism scores are highly significant, ($p=<0.001$) whereas differences between group Extraversion, Neuroticism and Anxiety scores are statistically non-significant.

The statement of hypotheses further predicts that statistically significant differences in group scores will emerge between homosexual non-patient control subjects and heterosexual Group 2 subjects in respect of E,N and Anxiety scores, but that comparability will characterise P scores. Only in comparison of N scores is a statistically significant difference ($p<0.05$) in fact apparent.

Comparative evaluation of PEN and Anxiety scores of homosexuals by preferred sexual role, i.e., active/passive, produced no statistical significance between these two criterion groups.

Summary

Social Hypotheses, i.e., hypotheses 1 & 2.

Homosexual special clinic patients/ non-patient control subjects	Hypothesis 2 only Supported

Summary (cont.)

Heterosexual Group 1/ Heterosexual Group 2	Hypotheses 1 & 2 Supported
Homosexual special clinic patients/ Heterosexual Group 1 Ss	Hypothesis 1 only Supported
Homo. non-patient control Ss./ Heterosexual Group 2 subjects	Hypothesis 1 only Supported

Analysis of Variance (F) between respective population sizes = NS

between means - all personality variables i.e., PEN and Anxiety/All Group = $p < 0.05$.

between means - all personality variables (as above)/criterion groups = NS in all cases.

Psychological Hypotheses, i.e., hypotheses 8-11
Value of t

Homosexual special clinic patients/ non-patient control subjects	Hypotheses 8-11 Supported
Heterosexual Group 1/ Heterosexual Group 2	Hypotheses 8 & 10 Supported
Homosexual special clinic patients/ Heterosexual Group 1	No support for hypotheses 8-11
Homo. non-patient control Ss./ Heterosexual Group 2 Subjects	Hypotheses 8 & 10 Supported

Results of Factor Analysis and "Way of Live" enquiry: Results which are shown in Table 4b were achieved from comparative of well defined variables etc., which, in turn, are clearly set out in App. 1b, Tables 3a-15 and Figures 1-10. The data which constitute the substantial body of App. 1b, were obtained by means of Questionnaires 2a-4, i.e., actual and ideal self-perception, (2a,2b) "strongly agree - strongly disagree" and "true - false" scales (3,4) and "way of life" questionnaires, (5a,5b) all of which were created and designed specifically for use in this present study. The data obtained by means of questionnaires 2a-4 were subjected to a correlation matrix, principal components (unrotated factor) analysis. These principal

iterations were finally rotated into terminal factors in accordance with a "varimax" format for factor analysis. A detailed account of the statistical procedure for factor analysis is provided in App. 3b

In the case of such an analysis of questionnaires 2a and b data, a three factor solution was selected in each specific instance. Of questionnaire 2a and b data, principal components analysis showed these three unrotated factors to account for the following percentages of variance.

Questionnaire 2a = 66.25% of common variance (59.6% of total variance)

Questionnaire 2b = 63.25% of common variance (60.4% of total variance)

where common variance = the percentage of total variance accounted for by eigen values which are equal to or greater than unity. The fact that substantially identical factors emerged from an independent analysis of both sets of data may be fairly regarded as a powerful and independent verification of validity and reliability.

The three terminal factors which emerged and were successively identified as:

"Personal and social functioning",

"Achievement and ability to plan the future" and

"Risk taking tendency"

are illustrated in App 1b (Tables 3a and b, 4a and b and 5a and b respectively).

A three factor solution was also chosen in respect of the data obtained by means of Questionnaire 3, i.e., the "Strongly agree - strongly disagree" scale. The unrotated factor solution of Questionnaire 3 data accounted for 83.5% of common varance (62.5% of total variance). Rotated factors were successively identified

identified as:

"Conformist - Rebellious behaviour",

"Assertive and Sexually-permissive behaviour", and

"Future-time perception", and are also pr vided in App. 1b (Tables 6a and b, 7a and b and 8a and 6 respectively).

Factor analysis of Questionnaire 4 data, i.e., the "true/false" scale resulted in selection of a two-factor solution. The factors (prior to rotation) accounted for 76% of common variance (54.6% of total variance). Terminally-rotated factors which are identified as:

"Anxious and neurotic behaviour" and

"Impulsive - pleasure seeking behaviour" are presented in App. 1b (Tables 9a and b, 10a and b respectively).

Factor scores (a process which is also given detailed treatment in App.3b) were computed for all four criterion groups and visual interpretation of these results is also given in App. 1 (Figures 1-8).

Statistical management of group performances on given factors took the following form:

1. Analysis of variance among factor-scores for all groups (all factors) resulted in a computed value of F at 6.08 ($p<0.01$). This result provided a sound base for hypothesizing major differences between groups, given a statistically viable and reliable means of identifying the source of such differences. Analysis of variance was then computed for all four pairings i.e.,

Homosexual special clinic patients/Homosexual non patient control Ss $p<0.01$

Heterosexual Group 1/Heterosexual Group 2 subjects $p<0.05$

Homosexual special clinic patients/Heterosexual Group 1 Subjects $p<0.01$

Homosexual non-patient control Ss/Heterosexual Group 2 Subjects $p<0.01$

Finally, the value of t, as a method of measuring the level of

significance between means (factor-scores) was computed for all of the above on each individual factor and results of t tests carried out are provided in Table 6.

Homosexual special clinic patients/homosexual non-patient control subjects are significantly differentiated on one factor only, namely actual self-perception of "Personal and Social Satisfaction".

Heterosexual Group 1 and Group 2 subjects do however differ significantly and consistently on actual self-perception on all three factors ($p<0.05$, $p<0.01$ and $p<0.01$ respectively). These same subjects also differ significantly in terms of ideal self-perception of future-time ($p<0.01$) and on the factor of Assertive/Permissive behaviour ($p<0.01$). Heterosexual Group 1 subjects manifest significantly higher, actual self-perceived, levels of 1) Personal and Social satisfaction ($p<0.01$) and 2) of Risk-taking behaviour ($p<0.01$) when compared with the homosexual special clinic patient group. However, in their ideal self-perceptions, these two groups are undifferentiated on Personal and Social satisfaction. They again differ, this time in their ideal self-perceived level of achievement (higher levels being desired by homosexuals) and in their ideal self-perception of risk-taking behaviour, with heterosexuals (who perceive actual risk-taking behaviour as being high) desirous for significantly lower levels of risk-taking behaviour ($p<0.001$). Heterosexuals appear to hold more rebellious and anti-authoritarian beliefs and opinions ($p<0.01$) and would, according to these data, seem to be more assertive and sexually permissive in the views which they hold ($p<0.01$). Heterosexual Group 1 subjects have factor scores which indicate markedly lower levels of Anxious and Neurotic

behaviour than do homosexual special clinic patient subjects ($p<0.001$).

Homosexual non-patient control subjects are substantially undifferentiated statistically from heterosexual Group 2 subjects, the exceptions being in actual perception of "Level of achievement and ability to plan ahead", ($p<0.05$) in which heterosexuals manifested a tendency toward the perception of a higher level of such achievement and ability to plan ahead. These two groups are statistically differentiated also on the factor of "Anxiety and neurotic behaviour" in which substantially higher scores ($p<0.001$) are again reported by members of the homosexual group.

"Way of Life" data: Results obtained by means of the "Way of Life" questionnaire which provided an objective means of distinguishing between self-perceived present and future way of life are provided in Table 16 (App. 1b) and Figure 10 (App. 1b). The heuristic nature of this particular exercise means that no hypotheses have been postulated in respect of these data. In the event, it is clear from the Table referred to above that whilst all four groups hold similar self-perceptions of "present way of life", homosexual self-perceptions entailing the projection forward over five years are depressed, comparative to the optimistic forecasts of both heterosexual groups.

Psychiatric Assessment: Table 5 sets out the results of comparative analysis between criterion groups on scores obtained by means of the General Health Questionnaire (GHQ). The scores obtained were analysed in the first instance, in accordance with the methods recommended by Peddar and Goldberg (1970). The first such recommendation requires the comparison of mean scores achieved by defined groups or sub-groups. Comparison of means between homosexual special clinic patients and non-patient control subjects indicates no significance in differences

reported, thus supporting the hypothesis postulated in the appropriate section. Similarly, comparison of means between heterosexual Groups 1 and 2 produced no significant differences. The postulated hypothesis again finds support in the data.

In contrast to results referred to above, in which similarity rather than difference characterizes criterion groups, homosexual special clinic patients and heterosexual (Group 1) subjects are significantly differentiated, ($p<0.001$) contrary to the appropriate hypothesis which predicted similarity between these two groups of interest.

Homosexual non-patient control and heterosexual Group 1 subjects are - like their special clinic and Group 1 counterparts - undifferentiated by their GHQ mean scores, a result which is again in support of the appropriate hypothesis.

The second and alternative method which is recommended for data analysis of GHQ scores is achieved by computing the percentage of "probable" psychiatric cases in each group of interest, where a "probable" case is a respondent with a score of 12 or more. Results obtained by means of this method of computation as reported in Table 6, clearly indicates that proportions of probable cases among homosexual subjects is significantly higher than proportions reported for heterosexual subjects. By comparison, their is similarity between proportions of probable cases where homosexual and heterosexual respondents are subject to intra-group comparison.

Summary

Comparison between group means

Homosexual special clinic patients/ Homosexual non-patient control subjects	Hypothesis	Supported
Heterosexual Group 1/ Heterosexual Group 2	Hypothesis	Supported

Summary (cont)

Homosexual special clinic patients/ Heterosexual Group 1	Hypothesis	Unsupported
Homosexual non-patient control Ss./ Heterosexual Group 2	Hypothesis	Supported

Other Behavioural: As a Statement of Hypotheses indicates, interest in other behavioural variables was focused upon:

1. Cigarette smoking
2. Alcohol consumption
3a. Psychoactive Drug misuse and
3b. Whether subjects had been offered drugs

No differences between homosexual special clinic patients and non-patient control groups were hypothesized and as Table 6 clearly shows, with the exception of hypothesis 1 (where differences on the variable of cigarette smoking were highly significant ($P<0.001$)) there is clear support in favour of predictions.

Studies which have been carried out and referred to previously, clearly favoured a hypothesis of no difference between Heterosexual Group 1 and 2 subjects in reported incidence of cigarette smoking and alcohol consumption. However, on the basis of evidence emerging from such previous work, significant differences between these groups was confidently predicted as distinguishing heterosexuals on "incidence of psychoactive drug misuse" and on the experience of having been offered drugs". Results reported on Table 6 show support for all such hypotheses.

The prediction made in the Statement of Hypotheses, of no difference between homosexual special clinic patients and heterosexual Group 1 subjects in reported cigarette smoking and alcohol drinking behaviour but of significant difference in incidence of psychoactive drug misuse and of having been offered drugs is, in the

main, unsupported. Differences in reported behaviour between these groups in cigarette smoking ($p<0.001$) and alcohol consumption ($p<0.05$) and similarity between them in reported incidence of drug misuse is evident in Table 6. Only on the "Offered drugs" variable are homosexual special clinic patients and heterosexual Group 1 subjects, distinguished ($p<0.05$).

The final comparison of group behaviour on the variables of interest was made between homosexual non-patient control and heterosexual Group 2 subjects. The hypothesized "no difference between groups" on all four variables is supported only in the results of comparative analysis on the two psychoactive drug misuse variables (NS in both cases). These two groups are differentiated by statistical analysis of results relating to cigarette smoking ($p<0.05$) and alcohol consumption ($p<0.05$).

Summary

Homosexual special clinic patients/ non-patient control subjects	Hypotheses 2-4 Hypothesis 1	Supported Unsupported
Heterosexual Group 1/ Heterosexual Group 2	Hypotheses 1-4	Supported
Homosexual special clinic patients/ Heterosexual Group 1 subjects	Hypothesis 4 Hypotheses 1-3	Supported Unsupported
Homosexual non-patient control Ss. Heterosexual Group 2 Subjects	Hypotheses 3-4 Hypotheses 1-2	Supported Unsupported

ABLE 1

ESULTS OF COMPARATIVE EVALUATIONS MADE BETWEEN DISCREET SUBJECT GROUPS
amily and Domestic Hypotheses

HYPOTHESIS NATURE OF VARIABLE		N	P	N	P	N	P	N	P	RAW DATA* 1	2	3	4
1 a Age of Mother at time of Ss birth	t=	158	NS	79	<0.05	155	<0.001	82	NS	I2	1	App 2b	1
b Age of Father at time of Ss birth	t=	158	NS	79	<0.05	155	NS	82	NS	I2	1		1
2 By whom subject was raised	X^2	158	NS	79	NS	155	NS	82	NS	I2	2	App 2b	2
3 No of siblings in family	X^2	158	NS	79	NS	155	NS	82	NS	I2	3	App 2b	3
4 Difference (years) between next older/younger sibling	X^2	158	NS		NS	155	NS	82	NS	I2	4	App 2b	4
MOTHER													
5 a (i) Authoritarian/permissive behaviour	X^2	158	NS	79	NS	155	NS	82	NS	I2	5	App 2b	5
a (ii) Overly indulgent/unaffectionate	X^2	158	NS	79	NS	155	NS	82	NS	I2	5	App 2b	5
a(iii) Presence/absence from home	X^2	158	NS	79	NS	155	NS	82	NS	I2	8	App 2b	5
FATHER													
5 b (i) Authoritarian/permissive behaviour	X^2	158	NS	79	NS	155	NS	82	NS	I2	6	App 2b	5
b (ii) Overly indulgent/unaffectionate	X^2	158	NS	79	NS	155	NS	82	NS	I2	6	App 2b	5
b(iii) Presence/absence from home	X^2	158	NS	79	NS	155	NS	82	NS	I2	8	App 2b	5
BOTH PARENTS													
5 c Marital status - living together/apart	X^2	359	NS	258	NS	384	NS	233	NS	Q1	22	App 1a	8
6 Subject's opinion (favourable/unfavourable) of family home	X^2	359	NS	258	NS	384	NS	233	NS	Q1	24	App 1a	8
7 Parents awareness of homosexuality	X^2	158	NS	79	-	155	-	82	-	I2	48	App 2b	8
MOTHER - living/deceased													
8 a (i) On or before 12th birthday	X^2	359	NS	258	NS	384	NS	233	NS	Q1	21	App 1a	6
a (ii) After 12th birthday	X^2	359	NS	258	NS	384	NS	233	NS	Q1	21	App 1a	6

*RAW DATA
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SIS = Social Insight Scale
I1 = Interview (Part 1)
I2 = Interview (Part 2)

ABLE 1 (Contd)

ESULTS OF COMPARATIVE EVALUATIONS MADE BETWEEN DISCREET SUBJECT GROUPS
mily and Domestic Hypotheses

HYPOTHESIS NATURE OF VARIABLE		N	P	N	P	N	P	N	P	*RAW DATA 1	2	3	4
FATHER - living/deceased													
8 b (i) On or before 12th birthday	X^2	359	<0.05	258	NS	384	NS	233	NS	Q1	18	App 1a	6
b (ii) After 12th birthday	X^2	359	NS	258	NS	384	NS	233	NS	Q1	18	App 1a	6
8 c Both parents deceased	X^2	359	NS	258	NS	384	NS	233	NS	Q1	17.20	App 1a	6
9 History of homosexuality in family	X^2	158	<0.05	79	NS	155	<0.001	82	<0.05	I2	17	App 2b	6
10 Type of living accomodation	X^2	359	NS	258	NS	384	<0.001	233	NS	Q1	31	App 1a	10

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I2 = Interview (Part 2)

ABLE 2

ESULTS OF COMPARATIVE EVALUATION MADE BETWEEN DISCREET SUBJECT GROUPS
ducational and Occupational Hypotheses

HYPOTHESIS	NATURE OF VARIABLE		N	P	N	P	N	P	N	P	RAW DATA* 1	2	3	4
1	School leaving age	X^2	359	NS	258	<0.001	384	<0.001	233	NS	Q1	4	App 1a	3
2	Attitude toward compulsory education	X^2	359	<0.05	258	<0.05	384	<0.001	233	NS	Q1	5	App 1a	4
3 a	Further/higher education received	X^2	359	<0.05	258	NS	384	NS	233	NS	Q1	6	App 1a	5
b	'Drop-out' from	X^2	359	NS	258	NS	384	NS	233	NS	Q1	849	App 1a	5
4	Current Occupational Status	X^2	359	<0.05	258	<0.05	185	<0.01	233	<0.05	Q1	10	App 1a	2
5 a	Whether offered health education	X^2	158	NS	79	NS	155	<0.001	82	<0.001	I1	61	App 2a	6
b	Whether effort made to obtain HE	X^2	158	NS	79	<0.001	155	<0.001	82	NS	I1	63	App 2a	5
c	Attitude toward health knowledge received	X^2	158	NS	79	<0.01		NS	82	<0.05	I1	68	App 2a	5
6	Awareness of specific STD's	X^2	158	NS	79	<0.001		<0.05	82	<0.001	I1	1	App 2a	2
7 a	Awareness of principal means of contagion	X^2	158	NS	79	NS		NS	82	NS	I1	8	App 2a	4
b	(i) Knowledge of man Syphilis	X^2	158	<0.001	79	<0.05		<0.001	82	<0.01	I1	9	App 2a	2
b	(ii) Symptoms Gonorrhoea	X^2	158	<0.001	79	<0.001		NS	82	<0.05	I1	9	App 2a	2

*RAW DATA

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I1 = Interview (Part 1)
I2 = Interview (Part 2)

TABLE 3

RESULTS OF COMPARATIVE EVALUATIONS MADE BETWEEN DISCREET SUBJECT-GROUPS

HYPOTHESES	NATURE OF VARIABLE	Test of P	N [1]	P	N [2]	P	N [3]	P	N [4]	P	RAW DATA* 1	2	3	4
HOMOSEXUAL ACTIVITY														
1	Age of initial homosexual arousal	X^2	158	NS	9	-	2	-	9	-	I2	7	App 2b	6a
2	Age of first anal intercourse	X^2	158	NS	9	-	9	-	9	-	I2	11	App 2b	6b
3	Status of first homosexual partner (ie casual/close friend)	X^2	158	<0.001	9	-	9	-	9	-	I1	13	App 2a	8
4	Role played on first occasion (ie active/passive)	X^2	158	NS	9	-	9	-	9	-	I2	25	App 2b	6b
5a	Reaction to this experience (ie enjoyed/did not)	X^2	158	<0.05	9	-	9	-	9	-	I1	15	App 2a	8
5b	Reaction to this experience (ie felt guilty/did not)	X^2	158	NS	9	-	9	-	9	-	I1	16	App 2a	8
6	Frequency of homosexual intercourse (past 3 months)	X^2	359	<0.001	9	-	9	-	9	-	Q1	41	App 1a	14
7	Number of sexual partners (past 3 months)	X^2	359	<0.001	9	-	9	-	9	-	Q1	42	App 1a	14
8	Expressed desire for change	X^2	158	NS	9	-	9	-	9	-	I2	56	App 2b	9

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SIS = Social Insight Scale
I1 = Interview (Part 1)
I2 = Interview (Part 2)
F/A = Factor Analysis

TABLE 3 (cont'd)

HYPOTHESES	NATURE OF VARIABLE	Test of P	N [1]	P	N [2]	P	N [3]	P	N [4]	P	RAW DATA* 1	2	3	4
HETEROSEXUAL ACTIVITY														
9	Age of initial heterosexual arousal	X^2	158	NS	9	-	155	<0.001	9	--	I2	9	App 2b	7
10	Age of first heterosexual intercourse	X^2	158	NS	258	<0.05	155	<0.001	233	NS	I2		App 2b	7
11	Status of heterosexual partner (ie casual/close friend)	X^2	158	NS	9	-	155	<0.01	9	-	I1	13	App 2a	8
12a	Reaction to experience (enjoyed/did not enjoy)	X^2	158	NS	79	NS	155	<0.001	9	-	I1	15	App 2a	8
12b	Reaction to experience (felt guilty/did not feel guilty)	X^2	158	NS	79	NS	155	<0.001	9	-	I1	16	App 2a	8
13	Frequency of intercourse (past 3 months)	X^2	9	-	258	<0.001	9	-	9	-	Q1	41	App 1a	14
14	Number of sexual partners (past 3 months)	X^2	9	-	258	<0.001	9	-	9	-	Q1	41	App 1a	14
HOMOSEXUAL AND/OR HETEROSEXUAL ACTIVITY														
15	History of masterbation	X^2	158	NS	9	-	155	NS	9	-	I2		App 2b	6a
16	History of co-masterbation	X^2	158	<0.05	9	-	9	-	9	-	I2	11	App 2b	6b
17	Age of first homosexual or heterosexual intercourse	X^2	359	NS	258	<0.05	384	<0.05	233	NS	Q1	39	App 1a	13

TABLE 3 (cont'd)

HYPOTHESES	NATURE OF VARIABLE	Test of P	N [1]	P	N [2]	P	N [3]	P	N [4]	P	RAW DATA* 1	2	3	4
18	Frequency of such intercourse (past 3 months)	X^2	359	0.001	258	0.001	384	0.001	233	0.001	Q1	40	App 1a	14
19	No of sexual partners (past 3 months)	X^2	359	0.001	258	0.001	384	0.001	233	0.001	Q1	41	App 1a	14
20a	Reaction to such activity (ie enjoyed/did not)	X^2	158	0.005	79	NS	155	0.001	9	-	I1	52	App 2a	8
20b	Reaction to such activity (ie felt guilty/did not)	X^2	158	NS	79	NS	155	0.001	9	-	I1	50	App 2a	8

* RAW DATA

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I2 = Interview (Part 2)
F/A = Factor Analysis

ABLE 4a SOCIAL AND PSYCHOLOGICAL HYPOTHESES

ESULTS OF COMPARATIVE EVALUATIONS MADE BETWEEN DISCREET SUBJECT-GROUPS

HYPOTHESES	NATURE OF VARIABLE		N	P	N	P	N	P	N	P	RAW DATA* 1	2	3	4
SOCIAL														
1	Group Membership	X^2	359	<0.01	258	<0.001	384	<0.001	185	<0.001	Q1	3	App 1a	11
2	Criminal Conviction	X^2	359	NS	258	<0.01	384	NS	185	NS	Q1	55,54	App 1a	12
PSYCHOLOGICAL														
	Analysis of Variance (PEN + An) (all groups)		N = 542				P = 0.05							
	Analysis of Variance (PEN + An)	F=	284	NS	258	NS	357	NS	185	NS	PEN		App 1b	1+2
1	Psycholism Score	t=	284	NS	258	NS	357	<0.001	185	NS	IPAT		App 1b	1+2
2	Extraversion Score	t=	284	NS	258	NS	357	NS	185	NS	"		"	
3	Newolicism Score	t=	284	NS	258	<0.001	357	NS	185	<0.05	"		"	
4	Anxiety Score	t=	284	NS	258	NS	357	NS	185	NS	"		"	
	Withdrawal	t=					NS							
	Passivity	t=					0.01	Analysis						
	Cooperativeness	t=					NS							
	Competitiveness	t=					NS	of		= NS	SIS		App 3b	15
	Aggression	t=					NS							
	Total Score	t=					0.05	Variance						

*RAW DATA

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GHQ = G H Questionniare
SIS = Social Insight Scale
I1 = Interview (Part 1)
I2 = Interview (Part 2)

TABLE 4b RESULTS OF EVALUATIONS, COMPARATIVELY BETWEEN MEANS

PERSONALITY (contd)

Questionnaires 2a-4 and Test of Special Insight Data	ANALYSIS OF VARIANCE (Value of F)			
Questionnaire 2 Factor 1 "Level of Personal and Social Functioning" Factor 2 "Level of Achievement and Ability to Plan Ahead" Factor 3 "Risk-taking"	All groups F = 6.08 (P = 0.01)			
Questionnaire 3 Factor 1 "Conformist/Rebellious" Behaviour Factor 2 "Assertive/Permissive" Behaviour Factor 3 "Perception of the Future Questionnaire 4 Factor 1 "Anxious and Neurotic" Behaviour Factor 2 "Impulsive and Pleasure-seeking" Behaviour	Comparison Groups 1	2	3	4
	(All factors)			
	F = 11.7 (P= 0.01)	F = 6.85 (P= 0.05)	F = 20.1 (P= 0.05)	F = 30.5 (P= 0.001)

TABLE 4b Personality (Contd)

RESULTS OF COMPARATIVE EVALUATIONS MADE BETWEEN DISCREET SUBJECT-GROUPS

NATURE OF VARIABLE		N	P	N	P	N	P	N	P	RAW DATA* 1	2	3	4
Questionnaire 2													
Factor 1	Level of Personal and Social Functioning t=	284	0.05	258	0.05	357	0.001	185	NS	Q2	F/A	App 1b	4a/4b
2	Level of Achievement and .... Ahead t=	284	NS	258	0.01	357	NS	185	0.05	"	"		5a/5b
3	Risk-taking Behaviour t=	284	NS	258	NS	357	0.01	185	NS	"	"		6a/6b
Questionnaire 3													
Factor 1	Conformist/Rebellious Behaviour t=	284	NS	258	NS	357	0.01	185	NS	Q3	"		10a/10b
2	Assertive/Permissive Behaviour t=	284	NS	258	0.01	357	0.01	185	NS	"	"		11a/11b
3	Future time Perception t=	284	NS	258	NS	357	NS	185	NS	"	"		12a/12b

* RAW DATA

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GHQ = G H Questionnaire
SIS = Social Insight Scale
I1 = Interview (Part 1)
I2 = Interview (Part 2)
F/A = Factor Analysis

TABLE 4b(Contd) Personality (Contd)

RESULTS OF COMPARATIVE EVALUATIONS MADE BETWEEN DISCREET SUBJECT-GROUPS

NATURE OF VARIABLE		N	P	N	P	N	P	N	P	RAW DATA* 1	2	3	4
Questionnaire 4													
Factor 1	Anxious and Neurotic Behaviour t=	284	NS	258	NS	357	0.001	185	0.001	Q4	F/A	App 1b	13a/13b
Factor 2	Impulsive and Pleasure Seeking Behaviour t=	284	NS	258	NS	357	NS	185	NS	"	"	"	14a/14b

*RAW DATA

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GHQ = G H Questionnaire
SIS = Social Insight Scale
I1 = Interview (Part 1)
I2 = Interview (Part 2)
F/A = Factor Analysis

TABLE 5

RESULTS OF COMPARATIVE EVALUATIONS MADE BETWEEN DISCREET SUBJECT-GROUPS

HYPOTHESIS	NATURE OF VARIABLE		N	P	N	P	N	P	N	P	RAW DATA* 1	2	3	4
1	Psychiatric Morbidity (1)	t=	284	NS	258	NS	357	0.001	185	NS	GHQ	-	App 1c	1
2		(2) X^2	254	NS	258	NS	357	0.01	185	0.001	GHQ	-	App 1c	2

* RAW DATA

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GHQ	= G H Questionnaire
SIS	= Social Insight Scale
I1	= Interview (Part 1)
I2	= Interview (Part 2)
F/A	= Factor Analysis

TABLE 6

RESULTS OF COMPARATIVE EVALUATIONS MADE BETWEEN DISCREET SUBJECT-GROUPS

HYPOTHESES	NATURE OF VARIABLE		N	P	N	P	N	P	N	P	RAW DATA* 1	2	3	4
1 1	Cigarette Smoking	X^2	359	0.001	258	NS	384	0.001	233	0.05	Q1	43	App 1a	15
2 2	Alcohol Consumption	X^2	359	NS	258	NS	384	0.05	233	0.05	Q1	45	App 1a	15
3 a	Psychoactive Drug	X^2	359	NS	258	0.01	384	NS	233	NS	Q1	49	App 1a	17/18
3 b	Know where drugs are available	X^2	359	NS	258	0.001	384	0.05	233	NS	Q1	50	App 1a	16

* RAW DATA

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I2 = Interview (Part 2)
F/A = Factor Analysis

DISCUSSION

The study which is now to be the subject of discussion, has focused sharply upon the male homosexual and upon the ways in which he may be shown to be comparable to, or distinguishable from, his heterosexual counterpart in society. The method which has been employed in completion of the study is of course, subordinate but crucial, nevertheless. In this particular investigation, research design has in the first instance, entailed an analysis and an evaluation comparatively of self-reported behaviour, beliefs and opinions, etc. of the male homosexual special clinic patient and of his non-clinic attending counterparts in society. Members of this latter group were recruited by permission of and with kind assistance given by office bearers of Minorities Groups in Edinburgh, Glasgow and in the West of Scotland. It is immediately evident therefore, that the validity of any comparison here made between male homosexuals and heterosexuals, will be wholly dependent upon the emergence of irrefutible support for the proposition, 'that all homosexual participants are, in reality, representative of a single population'.

The male heterosexual sample employed in this study for the purpose of comparison, was also recruited at Special Clinics, as well as at other sites and locations possessing a capability for the supply of subjects - e.g. members, clientele, etc. within previously specified criteria for selection - who were representative of the general population. It has been clearly indicated in the introductory section of this thesis, that the study of homosexuality here reported and discussed is, in reality, part of a larger enquiry embracing an overall sample, (n 866) of male and female special clinic patients and non-patients. Its purpose has also been

clearly defined and indicated, viz., to identify and to evaluate comparatively such differences as may indicate incomparability between special clinic patients and non-patient subjects. It is manifestly clear therefore, that at the time of the commencement of this study, early information concerning the hypothesized atypicality of special clinic patients was unconfirmed by data: hence, the division of male heterosexual subjects into discreet populations, i.e., a special clinic patient and non-patient group.

The level of concordance which is shown to be apparent throughout all those areas of specific interest upon which the study has concentrated as the basis for analysis comparatively of data reported for homosexual groups, i.e., Family and Domestic, Occupational and Educational, Sexual, Social and Psychological, Psychiatric and Other Behavioural, is impressively high and sustained throughout. On Family and Domestic variables, (twenty-two in all), disparity occurs in two only, viz., "Subjects who had lost the male parent by death on or before the 12th birthday", and "history of homosexuality within the family". It is evident from the results of this study, that a significant proportion of homosexuals with a history of special clinic attendance, were deprived of the male parent in childhood. Similarly, a comparatively greater number of members representing this latter group provided evidence of a "family history of homosexual behaviour". In the case of both variables, postulated hypotheses had predicted comparability between the groups in question.

Evidence of discordance between homosexual groups is marginally more apparent in relation to "Educational and Occupational" variables. It had in fact, been hypothesized that 'attitudes toward

compulsory education' and 'evidence of further/higher education' would be characterized by comparability between homosexual special clinic and non clinic attending subjects. In the event, attitudes of dissatisfaction were more apparent, together with evidence of a lower prevalence of "further/higher education among homosexual special clinic patients". Moreover, evidence of lower occupational status among homosexual special clinic patients, contrasts with a confident prediction made for its comparability. Here it is temptimg to interpret such a result as constituting a repetition of the kind of atypicality which, on the basis of evidence previously reviewed, it is hypothesized that male heterosexual special clinic patients will be distinguished from their non-clinic patient control subject-counterparts. However, acceptance of such an interpretation would seem also to require additional supporting evidence, in the form of inter-group disparity, for example, in "School-leaving age" as well as in the "incidence rates of 'drop-out' from further/higher education". In the event, no such supporting evidence has emerged from reported data concerning either variables.

Health education variables (5a-6) do not distinguish the groups of interest, i.e., homosexual special clinic patients and non-patient subjects and the evidence which is apparent of inter-group comparability is entirely consonant with predictions entailed in the particular relevant hypotheses postulated. The prediction of likely intergroup differences in respect of variables 6, 7a, bi and bii, i.e., "awareness of specific sexually transmitted diseases", "awareness of the principal means of contagion" and of "knowledge of main symptoms", are confidently predicted as being most likely to clearly distinguish a special clinic population

from non-clinic control subjects. Rather surprisingly however, such confidence is only partially justified by the evidence of highly significant differences in levels of knowledge of the main symptoms of syphilis and gonorrhoea. Indeed, it seems clear that Health Education entails a subtler and more complicated process than is perhaps commonly acknowledged, the more especially since education is by very definition, as much to do with the elaboration of criteria for making value judgements as it is to do with their subject-matter. Facts so identified and acknowledged in the process of information-transmission, are the indispensable 'building bricks' of any educational pursuit. However, it is equally a matter of empirical observation that they are most reliably bonded by consonant belief and opinion, as forming a foundation upon which culturally. socially and morally determined attitude judgements are firmly set. It is precisely the existence of such attitudes, be they favourable or unfavourable, which most assuredly bestow meaning to the concepts of 'acceptable' and of 'unacceptable' behaviour.

A policy whereby community health specialists are regulaly invited to attend S.M.G. gatherings to inform on medical and behavioural aspects of the prevention of sexually transmitted diseases is clearly apparent from these data. Yet, of the special clinic patient subjects (of whom four out of five could accurately specify at least one major symptoms of gonorrhoea and syphilis respectively), less than five per cent indicated their willingness to regularly attend treatment centres for routine health checks. It is also worthy of note that less than two in five of homosexual non-clinic attending subjects (who presumably had received equal exposure to the subject-matter of lectures, etc.) were able

to accurately identify a major symptom of gonorrhoea and syphilis. It would therefore, appear to be the case that for members of the homosexual group, knowledge of symptoms is most effectively reinforced by first-hand experience of such diseases.

The "one population" thesis relating to homosexual subjects, is consistently confirmed by the very high level of support for hypotheses relating to "Sexual" and to "Other Behavioural" variables and most emphatically of all, by evidence of the uniformity and strength of support for a conclusion that in personality, as on the basis of evidence of psychiatric morbidity, the two groups are so clearly comparable. Evidence of comparability between the two homosexual research groups is further available in the form of results obtained by means of the factor analysis of Questionnaires 2a-4 data. With the sole exception of factor scores reported on the factor of "personal and social functioning", (which indicates self-perceived, less satisfactory functioning on the part of special clinic patients, all other factor-scores, e.g. regarding "achievement and ability of plan the future", "risk-taking" behaviour, "rebellious/conformist" behaviour, "impulsive/pleasure-seeking" behaviour, unerringly indicate similarity rather than difference. This independant, multivariate approach, whereby research questionnaires and their composite items, were specifically devised and constructed for a precise purpose within this study, in accordance with the methodology previously reported, (Bindemann, 1975) enabled subjects themselves to determine factor-homogeneity by the nature of their self-perceived and reported responses. Similarly, subjects were entirely free to specify their self-perceived estimate of location

on such factors, as the computation of factor scores for criterion groups clearly shows. This contribution to the study, which is original, yet which is shown by the application of a well-tried and accepted statistical method to be reliable, has furnished an impressive, independant means of verification which would be difficult to refute.

Thus far, it seems reasonable therefore to conclude that the attempt to evaluate these two groups on a wider variety of highly relevant variables has been successfully achieved. Moreover, the results of this study now renders it possible to point to an irrefutable body of reliable evidence in support of the conclusion in this study, i.e., that whereas male homosexuals attending a special clinic are likely to be more sexually promiscuous and more knowledgeable about sexually transmitted diseases (that is to say, that there are behavioural differences which are, in any event entirely predictable) that male homosexuals are nevertheless, shown essentially to constitute, one population. Moreover, such evidence of a well sustained and impressively high level of comparability is, in itself, an important finding in that it opens up possibilities for much greater contact for the precise purpose of achieving knowledge and understanding of minority group behaviour, belief and opinion which in the past, has all too frequently, been considered to be inaccessible. Furthermore, it achieves this goal without incurring the damaging charge of bias in subject selection; e.g. the deployment of samples obtained from sources which are known to be characterised by evidence of psychiatric morbidity, or of criminal conviction etc.

It seems equally clear from the body of data which is available to this study, that heterosexual male special clinic patients do differ in certain important respectsfrom heterosexual non-clinic

attending subjects. There is, for example, evidence to indicate a marked tendency for members of the former group to leave school earlier, to display more rebellious attitudes toward compulsory education, to be less likely to engage in further/higher educational pursuits and to be employed in occupations which are of lower occupational and social status. Predictably, special clinic patients display evidence of more permissive and sexually promiscuous attitudes, although evidence of highly promiscuous behaviour among heterosexual males who are attending special clinics, is by no means characteristic of all the group and according to these data, is in fact, confined to a minority of its members.

Studies, to which previous reference has been made, e.g., Fish, Wells, Bindemann (1973) and Bindemann et al, (1976) have reported in favour of personality differences between heterosexual male special clinic patients and non-clinic attending subjects, in the direction of higher "E" and lower "N" scores among the former of these two groups. Such previously reported findings of statistically significant difference is, in fact, unconfirmed throughout this study in personality data which is reported for Group 1 and Group 2 heterosexual participants. However, it is worthy of note that the emergent trends are entirely consistent with trends which are evident in previous data.

In confirmation of reported behavioural differences between male heterosexuals, (Groups 1 and 2 subjects), there is confirming evidence of attitudinal and behavioural variance, as shown by factor-scores relating to "personal and social functioning", "level of achievement and ability to plan the future", in "risk-taking" and in "assertive and sexually permissive behaviour". The value

of the factor-analytical approach as an independent means of subject assessment is also evident in factor-scores reported for heterosexuals on the factor of "anxious and neurotic behaviour". Placement on this factor, indicated by factor-scores reported for heterosexual subjects, is entirely consistent with and indeed, appears almost to 'mirror' results of personality assessment achieved by means of the well-validated, PEN Inventory.

It will be apparent from the foregoing paragraphs of this discussion section, that a straightforward comparison between homosexual and heterosexual males who participated in the study, posed something in the nature of a problem. This was due to the hypothesis (and in fact to its confirmation which this study has provided) relating to a previously reported finding, viz., that heterosexual male special clinic patients are quite atypical of heterosexual males who possess no previous history of attendance at a special clinic. Indeed, it was precisely because of the probability of confirmation of this prediction, that analysis comparatively between homosexual and heterosexual male special clinic patients and between homosexual and heterosexual males, with no previous history of special clinic attendance or of a sexually transmitted disease, was considered to be desirable and therefore carried out.

Such analysis of data by means of comparison of the two research groups involved in the study, reflects a genuine attempt to focus directly upon the whole point and purpose of this and of all similar research undertakings; namely, to seek to identify and where possible, to postulate and to test valid hypotheses which can be shown to account for behavioural and attitudinal differences between male homosexuals and heterosexuals. Taking

into account all the circumstances which have combined to influence the design of the study which is here reported, together with the methods of interrogation and data-collection employed throughout, two alternative possibilities for discussion of results relating specifically to similarities and differences between homosexual and heterosexual males, are available; viz., that which confines comparison to the discreet groups - four in all - i.e. between homosexual and heterosexual special clinic patients and between homosexual and heterosexual non-patient subjects, or that which (within the context of the study) adopts a more global approach, by comparing homosexual males with their heterosexual male counterparts, whilst at the same time, exercising great care to document such discrepancies as would appear to distinguish homosexual and heterosexual special clinic patients, or homosexual and heterosexual non-clinic subjects. In fact, it is the latter of these alternative formats for the discussion of results which is preferred and for the following reasons:

1. It affords a considerably larger sample size for all necessary comparisons and thereby enhances the study's predictive value.
2. It is most likely to provide for optimal use of available data (on condition that such discrepancies as may exist between special clinic patients and non-patient subjects are carefully noted and taken fully into account).
3. It is entirely consistent with the main purpose of this and of all such studies; i.e., to obtain a fuller understanding of behavioural and attitudinal phenomena of male homosexuality.

It is strikingly clear from data displayed in table 1, that with few exceptions, homosexuals are indistinguishable from heterosexuals on "family and domestic" variables. The reason for the discrepancy in "age of female parents at the time of subjects' birth", is not immediately clear. In these data, mothers of homosexual subjects were older comparatively, at the time of their sons' birth, than were the mothers of heterosexual subjects at the time of their sons' birth although, as has previously been reported - principally by Siegelman, (1973) Zuger,(1974) and others - no really adequate or satisfactory account has been proferred in order to show how (if at all), they may relate specifically to an ensuing homosexual life-style. Moreover, it is clear that the findings of this study are in good agreement with those previously reported by Abe & Moran, (1969), Murdoch, (1970), Moran, (1974) and others, in that family characteristics, i.e., "number of siblings" and differences in years, i.e., "next oldest/next youngest sibling", are comparable. However, there is a notable absence of supporting evidence in these data for the proposition earlier reported by Bieber,(1962), Brown, (1963), Evans, (1969) and by Saghir and Robins, (1975) that female parents of homosexual subjects are incomparable to those of heterosexual subjects in prevailing patterns of authoritarianism or in permissive behaviour in their management of home and family. It should perhaps be noted however, that the data does reveal an undeniable tendency for a higher incidence of decision-taking and authoritarian behaviour by the female parent of homosexuals.

Differences between homosexual and heterosexual special clinic patients, in "type of living accommodation" reported,

is suggestive of a tendency toward greater independance (maybe toward social isolation) among homosexuals, than is demonstrated within commensurate data obtained from heterosexuals, i.e., significantly higher incidence of owner-occupied properties. Just why this should be the case is again not immediately clear. It may simply do no more than provide further confirmation of a widely reported finding, viz., that among male heterosexuals generally, a higher incidence of sexually transmitted diseases is more characteristic of occupational categories 3,4 and 5, whereas homosexuality would appear to be a behavioural and attitudinal phenomenon which is present in all occupational classes. Given the fact that the number of sexually active homosexual partners are so disporportionately fewer in number, there is more likely to be - as indeed this study would appear to demonstrate - a higher incidence of sexual promiscuity among homosexuals and therefore of risk of exposure to sexually transmitted diseases.

Evidence of a history of homosexuality within the family is significantly greaterin families of both homosexual groups, i.e., special clinic and non-clinic patients, when compared with their heterosexual-subject counterparts. This is in itself, an interesting finding, although once again the reason(s) which might account for such differences, are unclear. An hereditary basis would certainly raise expectations of major personality differences between homosexuals and heterosexuals. However, such evidence is notably absent from reported results. This leaves an alternative explanation, that such evidence of a higher incidence of homosexuality within the families of homosexuals

is acquired through learning, either directly and by actual contact with homosexuals, or indirectly through association with, or by influence of predisposing family traits, attitudes, patterns of behaviour etc. However, as results ensuing from the testing of "family and domestic" hypotheses makes clear, homosexuals and heterosexuals are characterised by similarity, rather than by difference in such matters.

Something more in the nature of a trend is evident in results reported in table 2, i.e., "Educational and Occupational" variables. Comparison between homosexual and heterosexual special clinic patients on the variables of 'school-leaving age' and in 'attitude toward compulsory education' is characterised by differences which are statistically significant, with heterosexual subjects being distinguished by earlier school-leaving and by less favourable attitudes toward compulsory education. However, in the overall picture, i.e., that which includes data obtained from members of the other two homosexual and heterosexual groups, it is clear that similarity rather than difference, may well be the predisposing characteristic, since it is the heterosexual special clinic patient group which is clearly atypical of all other subjects in respect of results obtained and relating to these variables.

There is really very little by way of a basis for distinction between homosexuals and heterosexuals in application to any particular social class, as relected in data concerning the variables of 'occupational status' and 'type of living accommodation' reported.

The evidence which emerges of greater familiarity and involvement with health education among homosexuals - especially with regard to sexual experience and practice - reflects the

tendency for minorities group organisations to acknowledge and to attempt to combat the homosexuals' greater risk of exposure to venereal and other sexually transmitted diseases, through the provision of relevant information in the form of lectures and discussions, delivered and supervised by specialists in Community Medicine.

Comparison of homosexuals and of heterosexuals on variables relating directly to sexual practice and behaviour is adversely affected by the relatively high incidence of non-compliance with this part of the project's requirement which is evident among the heterosexual non clinic-attending population and in consequence, is limited. Nor is it easy to determine how such reticence may readily be overcome. Fruitful and productive discussion of likely differences on sexual variables is, with few exceptions therefore limited to comparison between homosexual subjects and heterosexual special clinic patients.

On the basis of evidence eminating from these data, it would certainly appear to be the case that co-masturbation is much more firmly established as a sexual practice among homosexuals than it is among heterosexuals. Some would argue with seemingly sound logic that such practice is de facto, a homosexual's practice. However, the case for regarding sexual penetration as the behavioural criterion for homosexual practice has previously been argued and no further reference need be made to such a preference here. Sufficient is it to observe that such findings as are here reported, are comparable to those reported by Saghir and Robins, (1975) to which detailed reference has previously been made concerning the practice of masturbation.

Interpretation of data relating to reactions of 'enjoyment of sexual behaviour' or expressions concerning the presence or

absence of associated 'guilt feelings' among homosexuals or heterosexuals in response to their first experience of sexual intercourse, is confounded by evidence to indicate that a minority of homosexual subjects did, in the very first instance, experience heterosexual intercourse. It is clear that failure to enjoy sexual activity and as a consequence of it, to experience feelings of guilt, is more commonly associated with homosexual behaviour and is more frequently reported by homosexual special clinic patients. Whether or not such a finding as this evokes surprise, it does at any rate seem clear that contravention of conventional sexual moves, together with ensuing participation - either ideationally or actually - in minority sexual practices, may still give rise to conflict as the basis for such an experienced sense of dissatisfaction and guilt.

A further cause of such negative reactions may be held to be associated with evidence which indicates higher levels of sexual promiscuity among homosexuals than among heterosexuals whereby homosexuals run considerably greater risk to infection by a sexually transmitted disease. Such a state of affairs is, in itself, entirely predictable and is unerringly consistent with evidence arising from studies to which reference has previously been made. Indeed, the reasons for such a behavioural phenomenon may be seen to have a parallel in heterosexual behaviour. Among heterosexuals, it is the highly promiscuous female special clinic patient who is generally regarded as constituting a 'reservoir' for such diseases. Infection is spread by the promiscuous heterosexual male in his casual sexual 'encounters' and is contracted by his sexual partners who, not infrequently happen to be other highly promiscuous females. Since, according to all the available evidence it would seen to be the case that such

promiscuous behaviour is typically confined to a minority of all sexually active members of the heterosexual population, the risks of contagion are similarly confined and are therefore more amenable to regulation and control. Moreover, although there appears to exist no reliable body of evidence to indicate that male contraception is widely practised, clearly, effective encouragement of such a precaution would further reduce the risks of contagion and therefore the incidence of the disease yet further. In contrast, the typical sexually active homosexual is regularly exposed to greater risk of contagion, if only because of the fact that the incidence of sexually transmitted diseases is known to be so disproportionately greater among sexually active homosexuals. Moreover, although it is by no means unknown for the homosexual to experience an enduring relationship of sexual fidelity to only one partner, such a state of affairs is the exception rather than the rule. It is clearly the case that the sexual and social conventions and constraints of everyday western society tend to militate most powerfully against such culturally unorthodox practices of homosexual co-habitation. In consequence, pressures of considerable force tend to be exerted against those whose sexual preference and life-style might desire such permanent and sexually-continent lifestyles. It would therefore seem reasonable to postulate such a state of affairs as being a factor of significance in the considerably higher levels of promiscuous behaviour among homosexuals, where a casual sexual relationship constitutes the sole reason for contact. Similarly, future meetings arranged by the parties concerned are likely therefore to be motivated solely by sexual interest and for sexual purposes.

It is, of course, by no means uncommon for similarly

sexually motivated casual contacts to occur between consenting male and female heterosexuals. However, on the evidence of these data, it would seem reasonable to conclude that even among a special clinic patient population (where one might expect to find a disporportionately greater number of such individuals) entirely sexually motivated casual contacts are a feature of only the minority of heterosexuals. Accordingly, the results of this investigation clearly indicate a markedly higher incidence of casual sexual contacts among homosexuals than among heterosexuals. Furthermore, the level of significance of the difference is highly distinguishing, whether the comparison is made between all homosexuals and all heterosexuals or is rather confined to an analysis of the difference between the special clinic patient members of the principal research groups. Analysis of those data which refer to actual numbers of sexual partners point unerringly to a similar conclusion. The ratio of heterosexual special clinic patient subjects who stated that they had had recent sex with more than one sexual partner, (within the past three months) is approximately one in three. This compares with nine out of ten of all homosexual special clinic patient subjects who have stated that they had experienced a homosexual relationship within the past three months. The results of a comparison of data relating to homosexual and heterosexual non-patient groups, manifest good grounds for a prediction of even greater disparity between homosexual and heterosexual subjects on this variable, a finding which is totally in accord with expectations.

Differences in terms of distinguishing criteria for "social integration" are also far from being clear and

unambiguous. Although there exists prima face evidence of a highly significant difference between homosexuals and heterosexuals on the specific variable of formal group membership, attention must again be drawn to the fact that a high proportion of homosexual special clinic patient subjects and all members of the homosexual non-patient subject group, were members of the Scottish Minorities Group.

On the specific variable of "history of criminal conviction(s)", more than one in two of all homosexuals with such a record reported the offence as being of a sexual nature, compared with less than one per cent of such offences being reported as the cause of conviction among heterosexuals.

The study of personality which facilitates comparison between male homosexuals and heterosexuals on the well-validated personality parameters of extraversion, (E), neuroticism, (N) and psychoticism, (P) as well as on the level of "free-floating anxiety" and of withdrawal, passivity, co-operativeness, competetiveness and aggression, as measured by the "Test of Social Insight", is of special interest within the context of the aims of and criteria for this particular study. This is evidently more so in light of the sparcity of evidence to emerge so far, of real difference between the two principal research groups on "family and domestic" and "educational and occupational" variables. It therefore seems reasonable to insist that if hypothesized differences of real consequence are to be empirically valid, they will be manifestly and consistently apparent within personality data.

Detailed reference has previously been made to reported results which provide a firm basis for the prediction that statistically significant differences will distinguish homosexuals

from heterosexuals on all of the above-named personality variables with the exception of psychoticism (P). Homosexuals, so it has been hypothesized, will be more socially withdrawn, passive and co-operative and at the same time, may be expected to demonstrate lower levels of competitiveness and of aggression. Male homosexuals, so it has been predicted, will manifest evidence of significantly higher neuroticism and anxiety and lower extraversion. The postulation of such hypotheses has drawn heavily upon a number of studies to which reference has previously been made, such as that reported by Wells and Schofield, (1972) who reported significantly higher neuroticism (N) and lower extraversion (E) scores among homosexual special clinic patients, when compared with similar scores reported for heterosexual special clinic attenders. Other published findings which are of consequence within the context of hypothesized personality differences, include those which have been reported by Siegelman, (1978) and Saghir and Robins, (1978). Siegelman (1978) - whose comparison was a straightforward one between male homosexuals and heterosexuals - reported the former to exhibit higher scores on the parameters of tendermindedness, submissiveness, anxiety, total neuroticism, dependance and nurturance and Saghir and Robins, (1975) showed homosexuals to be more feminine, more sociable, less competitive and lower in self-confidence and esteem. In many ways, it is the almost total absence of evidence of consistent discrimination between homosexuals and heterosexuals on such variables relating to major personality traits and for which atypicality among homosexuals had been confidently predicted, that points away from an earlier held conviction in real and sustained differences. Indeed, there would appear to be so much evidence of anomoly among

homosexuals, e.g., on the one hand, higher psychoticism, passivity and lower Social Insight scores and on the other, higher Neuroticism scores among homosexual non-patient subjects only, that it is quite impossible to lay serious claims to any emergent pattern of response. At the end of the day, the researcher can only report what is in the data. Moreover, results such as these do give rise to feelings of serious disquiet about previous claims to indications of almost unerring agreement in reporting atypicality of personality trait score among homosexuals.

The Actual Self and Ideal Self Perception Scales, together with the Likert-type and True-False Scales, which were devised and employed specifically for use in this study, after a methodology and model previously devised and described by the author (Bindemann, 1975) have proved to be a major tool in the task of describing the principal research populations under scrutiny. In their Actual Self perceptions, i.e., "the kind of person I am", of level of 'personal and social functioning', it is clear that homosexual and heterosexual special clinic patients are distinguished in favour of significantly higher factor scores than those reported for non clinic subjects. It is especially noteworthy to observe the similarity in terms of item-content, between low or unsatisfactory personal and social functioning and Eysenck's N factor and conversely, between high levels of self-perceived personal and social functioning and Eysenck's E parameter. Under such circumstances, it is particularly gratifying to observe the concordance or level of agreement which is manifestly obvious between N and E and unsatisfactory and satisfactory levels of self-perceived personal

and social satisfaction respectively.

Further confirmation of the proposition that such difference is associated with a history of special clinic attendance rather than with male homosexuality is clearly apparent from,

1. Evidence of difference between:

   a) homosexual special clinic patients and their non-clinic attending counterparts and

   b) heterosexual group 1 and group 2 subjects and

2. Evidence of comparability between homosexual and heterosexual non-clinic attending subjects.

The factor of 'conformist/rebellious behaviour' clearly distinguishes homosexuals from heterosexual special clinic patient groups. However, it is surprising to observe that in this regard, heterosexuals display more rebellious beliefs and opinions than do homosexuals. Heterosexual group 1 subjects are similarly distinguished from heterosexual group 2 subjects.

Differences in 'assertive/permissive behaviour' would, once again, appear to be much more apparently associated with a history of special clinic/non-clinic attendance than with sexual preference and life-style. Both of the special clinic-attending populations, viz., homosexuals and heterosexuals, are similarly distinguished from their non clinic attending counterparts by virtue of the presence of more assertive beliefs and opinions among the former to these two populations.

It is of interest to note that whereas homosexuals and heterosexuals were comparable on the basis of 'N' (PEN data) and of Anxiety (IPAT data) scores, these populations are clearly distinguishable on the factor of 'Anxious and Neurotic Behaviour' with higher levels being indicated for homosexual subjects.

One of the most recently reported studies of the attitudinal and behavioural phenomenon of male homosexuality of a comparable nature, viz., that undertaken and reported by Saghir and Robins, (1978) did, as we have previously noted, focus especially upon incidence of need for psychiatric intervention, upon evidence of difference in prevalence of criminal conviction and upon the phenomenon of psychoactive drug misuse.

The picture which has emerged from their study is, as we have seen, one which indicates:

a) a level of psychiatric morbidity, some four times greater among homosexuals than heterosexuals.

b) an almost 3:1 incidence ratio of greater criminal activity as indicated by reported criminal records among homosexual males and

c) a thirty-nine per cent reported prevalence of psychiatric drug misuse among homosexual males, compared to a twenty per cent incidence among their heterosexual control counterpart.

Whilst there is consistency of agreement in the data reported for this present study in trend, so far as the three variables under discussion are concerned, it is a similarity which stops far short in degree. In accordance with the prediction inherent in the particular hypothesis, there is evidence of statistically significant differences between homosexual and heterosexual special clinic patients on the variable of psychiatric morbidity, irrespective of the criterion for calculation employed. There is also evidence of similar difference between homosexual non-patient subjects and heterosexual group 2 subjects on the criterion of "comparison of probable cases", a result which is

Contrary to the prediction entailed in the relevant hypothesis. Such results generate even greater interest when they are compared with reported results obtained from the instrument, also obtained from a sample of special clinic patients, (Pedder and Goldberg, 1970). Pedder and Goldberg (1970) showed that out of a total number of 219 patients, approximately thirty per cent were probable cases, a figure which they claimed is similar to that found in general practice and medical out-patient departments. In contrast with the findings of this present study however, Pedder and Goldberg (1970) reported a substantially lower score for homosexuals, i.e., eight per cent probable cases.

The variable of criminal activity which has been subject to previous discussion within the context of 'Social and Psychological' variables has, as we have seen (and contrary to prediction), failed to distinguish the major research groups.

In keeping with the reported 'findings' of previous studies, (Bindemann, 1973; Fish, Wells, Bindemann et al, 1973; Bindemann et al, 1976) drug misuse is a known behavioural phenomenon among special clinic patients, with an incidence which is above the norm for a Glasgow domiciled general population. A similar finding is featured in the data reported for this study. However, drug misuse would not, on the basis of these results, appear to distinguish a homosexual from a heterosexual population.

It is of interest to note that when comparison is made on incidence statistics of cigarette smoking between the present study and earlier reported data (Fish, Wells, Bindemann, 1974), a slight reduction in favour of these data is in evidence. However, the high prevalence of alcohol consumption is, depressingly, a feature among all subject groups participating

in this study. Of all homosexual subjects, some ninety-six per cent claim to be alcohol drinkers, with more than seventy per cent reporting alcohol consumption as constituting a regular activity. Heterosexual subjects likewise reported a similarly high level of drinking behaviour. Less than one in ten of all heterosexual subjects professed not to drink alcohol at all.

Data obtained by means of the 'in-depth' interview reveals that one in five of all homosexual and heterosexual interviewees claimed to have been drinking at the time of their first experience of sexual intercourse..

There exists no reliable basis therefore, on which to distinguish between homosexuals and heterosexuals on the variable of alcohol drinking. One might perhaps add that such findings are well in accord with the known disporportionately high incidence of alcohol consumption and of alcoholism generally throughout the West of Scotland.

CONCLUSIONS

Contained within reported results of the comparison of data obtained from the two homosexual research groups employed throughout this study, is consistent evidence in favour of their comparability. This finding is of special interest and importance, particularly in the light of the study's declared first aim; viz, to investigate and to attempt to evaluate the status, i.e., suitability and potential of the special clinic as a future recruitment site for male homosexual/heterosexual research.

Moreover, it is a finding of considerable epidemiological significance which may well be thought to indicate that the most likely means of sexually transmitted disease control will reside in the formulation and implementation of policy at treatment centres and clinics, which will encourage and facilitate regular health checks for all who are at risk to exposure of infection by venereal and other sexually transmitted diseases.

Although the paucity of data emanating from non-clinic-attending homosexual males in this study inhibits valid comparison between homosexuals and heterosexuals in a general sense, there remains ample evidence in the form of 'hard'data to indicate a degree of comparability which has not always previously been reflected in the literature reporting discussion concerning the homosexual, comparative to his heterosexual counterpart in society. Indeed, there is a real sense in which, in the light of all the social and psychological pressures which militate against the homosexual as a member of a minority group in modern western society, such slight evidence of incomparability on major behavioural, personality variables etc., is all the more surprising. In the past therefore, we, in reality, appear to have learned more about heterosexual perceptions of and attitudes toward homosexuals,

than we have about what manner of persons homosexuals really are. It is of course, of great interest and importance to accurately identify and painstakingly assess the impact of such heterosexual perceptions and attitudes toward homosexuality and hopefully, much future research into homosexuality will succeed in directing and adjusting it's focus accordingly. Moreover, evidence of an ensuing improvement in the accuracy of our perception and hence, in our understanding, can only result in particular, in more skilled management of the homosexual special clinic patient and in facilitating greater co-operation and success among such sexually active persons in the highly desirable preventative discipline of greater health checks.

The evidence of much recent research into homosexuality - including the results of this study which have here been reported and discussed - are consistent in their tendency to weaken and discourage past polarisation and to represent the homosexual, not as an aberration or a freak, or as an immoral individual who is unworthy of trust, but rather as one possessing as much potential for variation in sexual response - ranging from sexual fidelity to one partner on the one hand, to sexual promiscuity on the other, as his heterosexual counterpart is well-known also to possess.

The individual and group benefits which will flow from greater acceptance, understanding of and respect for the homosexuals' rights and needs as a fellow human being - citizen, working colleague or whatever - in daily life can only improve and enhance the quality of life, of co-operaton and joint endeavour for all concerned.

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APPENDICES

APPENDIX 1a

Questionnaire 1 data

APPENDIX 1a TABLE 1

ASSIGNMENT OF SUBJECTS TO DISCREET GROUPS: DISTRIBUTION BY AGE AND SEX (Numbers and Percentages)

AGE COHORTS	HOMOSEXUALS					HETEROSEXUALS					ALL SUBJECTS	
	S/C Patients		Non-Patient Control Ss		Total	Group 1		Group 2		Total		
	No	%	No	%	No	No	%	No	%	No	No	%
16 - 18 years	28	13.5	25	16.5	53	24	13.5	17	21.5	41	94	15.5
19 - 21 years	54	26.5	35	22.5	89	44	24.5	23	29.0	67	156	25.5
22 - 24 years	35	17.0	29	19.0	64	34	19.0	17	21.5	51	115	18.5
25 - 27 years	34	17.0	27	17.5	61	32	18.0	10	12.5	42	103	16.5
28 - 30 years	27	13.0	18	11.5	45	26	14.5	7	9.0	33	78	12.5
31 years and over	27	13.0	20	13.0	47	19	10.5	5	6.5	24	71	11.5
TOTALS	205	100	154	100	359	179	100	79	100	258	617	100
Percentage of subjects in each group	57		43		100	69.5		30.5		100		

APPENDIX 1a TABLE 2

DISTRIBUTION OF SUBJECTS BY OCCUPATIONAL STATUS (Numbers and Percentages)

OCCUPATIONAL STATUS	HOMOSEXUALS						HETEROSEXUALS					
	S/C Patients		Non-Patient Control Ss		Total		Group 1		Group 2		Total	
	No	%	No	%	No	%	No	%	No	%	No	%
Professional	5	3.0	4	2.0	9	2.5	3	1.5	1	1.0	4	1.5
Semi-Professional	41	20.0	30	21.0	71	20.0	24	13.5	7	9.0	31	12.1
Skilled Worker	44	22.5	39	29.0	83	23.0	37	20.5	24	30.5	61	23.6
Semi-skilled Worker	30	15.0	21	10.5	51	14.0	39	22.0	14	17.5	53	20.5
Unskilled Worker	33	16.5	22	11.5	55	15.5	39	22.0	9	11.5	48	18.6
Unemployed	25	11.0	19	10.5	44	12.0	24	13.5	9	11.5	33	12.8
Full-time Student	23	10.0	16	12.5	39	11.0	12	6.5	8	10.0	20	7.8
School Pupil	4	2.0	3	2.5	7	2.0	1	0.5	7	9.0	8	3.0
	205	(100)	154	(100)	359	(100)	179	(100)	79	(100)	258	(100)

APPENDIX 1a TABLE 3

LEAVING AGE OF SUBJECTS HAVING LEFT SCHOOL (Numbers and Percentages*)

SCHOOL-LEAVING AGE	HOMOSEXUALS				HETEROSEXUALS			
	S/C Patients		Non-Patient Control Ss		Group 1		Group 2	
	No	%	No	%	No	%	No	%
15 years	71	41.0	53	41.5	96	54.0	35	44.5
16 years	41	16.5	36	17.5	36	20.0	20	25.5
17 years	43	21.5	31	19.5	15	8.5	16	20.0
18 years or over	44	21.0	31	21.5	31	17.5	8	10.0
TOTAL NUMBERS	199	(100)	151	(100)	178	(100)	79	(100)

* Percentages of total numbers of subjects who have left school

APPENDIX 1a TABLE 4

ATTITUDE TOWARDS COMPULSORY EDUCATION

	HOMOSEXUAL		HETEROSEXUAL	
	S/C Patients	Non Clinic Patients	Group 1	Group 2
Enjoyed	65	34	31	17
Did not enjoy	75	79	111	38
In between	65	41	37	24

APPENDIX 1a TABLE 5

SUBJECTS AGED OVER 16 YEARS WHO HAVE RECEIVED OR ARE RECEIVING FULL OR PART-TIME FURTHER EDUCATION: CURRENT STATUS (Number and Percentages)

CURRENT STATUS	HOMOSEXUALS				HETEROSEXUALS			
	S/C Patients		Non-Patient Control Ss		Group 1		Group 2	
	No	%	No	%	No	%	No	%
Currently receiving	74	56.0	43	52.0	57	57.5	29	62.0
Successfully completed	41	31.0	28	34.0	29	29.5	14	29.5
Have 'dropped out'	17	13.0	11	14.0	13	13.0	4	8.5
TOTAL NUMBERS	132		82		99		47	
Percentage of all subjects in sub-group	(64.5)		(53,0)		(55.5)		(59.5)	

APPENDIX 1a TABLE 6

SUBJECTS WHO HAD LOST BY DEATH ONE OR BOTH PARENTS (Number and Percentages)

One or both parents deceased		HOMOSEXUAL		HETEROSEXUAL	
		S/C Patients	Non-patient Control Ss	Group 1	Group 2
Total numbers and percentages	Mother	29 (14)	22 (14)	37 (20)	6 (7.5)
	Father	52 (25)	36 (23)	39 (21)	11 (14)
Up to 12 years:	Mother only	6 (3)	5 (3)	8 (4.5)	- (0)
	Father only	17 (8)	12 (8)	15 (8.5)	5 (6.5)
On or after 12th birthday					
	Mother only	23 (11)	17 (11)	29 (16)	6 (7.5)
	Father only	35 (17)	24 (15.5)	24 (13.5)	6 (7.5)
Number of subjects who had lost both parents		12 (6)	7 (4.5)	10 (5.5)	1 (1.25)

APPENDIX 1a TABLE 7

CURRENT MARITAL STATUS OF SUBJECTS' PARENTS* (Numbers and Percentages)

MARITAL STATUS	HOMOSEXUALS				HETEROSEXUALS			
	S/C Patients		Non-Patient Control Ss		Group 1		Group 2	
	No	%	No	%	No	%	No	%
Living together	174	85	129	84	160	89	70	88.5
Separated	14	7	9	6	14	8	6	8
Divorced	17	8	16	10	5	3	3	3.5
	205	100	154	100	179	100	79	100

* IF PARENT(S) ARE DECEASED THEIR MARITAL STATUS IS RECORDED AS APPLYING AT TIME OF DECEASE

APPENDIX 1a TABLE 8

SUMMARY OF SUBJECTS' OPINIONS ABOUT THEIR FAMILY HOME
(Percentages of Subjects' Ratings)

RATINGS	HOMOSEXUALS				HETEROSEXUALS			
	S/C Patients		Non-Patient Control Ss		Group 1		Group 2	
	No	%	No	%	No	%	No	%
A happy place	107	52	68	44	87	48.5	39	49.5
Not a happy place	33	16	34	22	38	21.5	14	17.5
In between	65	32	52	34	54	30	26	33

APPENDIX 1a TABLE 9

NUMBERS AND PERCENTAGES* OF SUBJECTS WHO ARE MARRIED/SINGLE: DETAILS OF CURRENT MARITAL STATUS (Numbers and Percentages)

MARITAL STATUS	HOMOSEXUALS				HETEROSEXUALS			
	S/C Patients		Non-Patient Control Ss		Group 1		Group 2	
	No	%	No	%	No	%	No	%
Married and living with spouse	-	-	3	-	39	57	14	-
Married and separated	6	-	3	-	13	25.5	2	-
Married but divorced	2	-	1	-	8	15.5	2	-
Married but spouse deceased	3	-	1	-	1	2	-	-
TOTAL NUMBERS	11	-	8	-	51	(100)	18	-
Numbers of married Ss expressed as a % of all Ss in each group	5.5		5		28.5		23	

* NUMBERS TOO SMALL TO CALCULATE MEANINGFUL PERCENTAGES ARE GIVEN AS RAW SCORES ONLY

APPENDIX 1a TABLE 10

SUBJECTS CURRENT LIVING ACCOMMODATION (Numbers* and Percentages)

TYPE OF DWELLING	HOMOSEXUALS				HETEROSEXUALS			
	S/C Patients		Non-Patient Control Ss		Group 1		Group 2	
	No	%	No	%	No	%	No	%
Detached Villa	15	7.5	8	5	12	7	6	7.5
Semi-detached or terraced	31	15	41	26.5	41	23	16	20.5
Main door Flat	54	16.5	37	24	20	11	13	16.5
Tenement Building	39	19	31	20	57	32	24	30.5
'High Rise' Flat	23	11	10	65	18	10	10	12.5
Hostel/Rooms/University Residence etc	40	19.5	25	18	28	15.5	10	12.5
Commune or similar	-		-		3		-	
Living in Company Relatives, Friends, etc	% 75		% 78		% 85		% 96	
Living Alone	23.5		21		14		4	

* NUMBERS ARE IN SOME INSTANCES REDUCED BECAUSE OF A FAILURE ON PART OF SMALL MINORITY TO REPLY TO THE QUESTION

APPENDIX 1a TABLE 11

NUMBERS* OF SUBJECTS WHO
i Are currently a member of an Organisation or Formal Group
ii Are currently (or have been in the past) a member of a gang

TYPE OF GROUP	HOMOSEXUALS		HETEROSEXUALS	
	S/C Patients	Non-Patient Control Ss	Group 1	Group 2
	No	No	No	No
Cultural and/or recreational	132	154	12	20
Religious	43	34	3	9
Political	60	49	15	8
Sports or athletic	39	42	31	21
Others - not defined	35	47	18	9
Total number of Ss belonging to at least one organisation	170	154	64	54
Is currently or has been a member of a gang	3	4	16	2

* Numbers in rows 1-5 exceed totals given in row 6
This is because some subjects belonged to more than one organisation

APPENDIX 1a TABLE 12

DETAILS OF CONVICTIONS IMPOSED ON SUBJECTS FOR COMMITTING A CRIMINAL OFFENCE (OTHER THAN TRAFFIC)

TYPE OF OFFENCE	HOMOSEXUALS		HETEROSEXUALS	
	S/C Patients	Non-Patient Control Ss	Group 1	Group 2
	No	No	No	No
Larceny	15	9	15	2
Breach of Peace	14	11	25	8
Drunk and Disorderly	22	19	27	6
Assault, etc	2	1	14	2
Housebreaking, breaking and entering	5	2	8	2
Vandalism	2	-	8	2
Illegal possession of drugs	4	1	2	-
Sexual, e.g. prostitution, indecent exposure, loitering, etc	30	14	1	-
Total numbers	59	39	52	14
% of all Ss in sub-groups	29	25.5	(29)	17.5
Total number of subjects convicted for more than one offence	40	19	29	9

APPENDIX 1a TABLE 13

SUBJECTS' HISTORY OF PRE/EXTRA MARITAL SEXUAL INTERCOURSE:
AGE WHEN FIRST EXPERIENCED (Numbers and Percentages)

AGE OF FIRST PRE/EXTRA MARITAL SEXUAL INTERCOURSE	HOMOSEXUALS				HETEROSEXUALS			
	S/C Patients		Non-Patient Control Ss		Group 1		Group 2	
	No	%	No	%	No	%	No	%
Under 16 years	38	18.5	28	18.0	52	29.0	7	25.0
16-18 years	88	43.0	75	43.5	76	42.5	10	36.0
19-21 years	43	21.0	27	17.5	37	20.5	5	18.0
22-24 years	25	12.0	12	8.0	12	7.0	4	14.0
25-27 years	7	3.5	7	4.5	2	1.0	1	3.5
28-30 years	4	2.0	3	2.0	-	-	1	3.5
31 years and over	-	-	2	1.5	-	-	-	-
Total numbers and % of all subjects in sub-group	205	100	154	100	179	100	28	100

APPENDIX 1a TABLE 14

SUBJECTS HISTORY OF PRE/EXTRA MARITAL SEXUAL INTERCOURSE: NUMBER OF PARTNERS AND NUMBERS OF TIMES EXPERIENCED WITHIN PAST THREE MONTHS

NUMBERS OF SEXUAL PARTNERS IN PAST THREE MONTHS	HOMOSEXUALS				HETEROSEXUALS			
	S/C Patients		Non-Patient Control Ss		Group 1		Group 2	
	Hom	Het	Hom	Het	Hom	Het	Hom	Het
None	29	--	48	--	--	--	--	56
One	16	--	10	--	--	111	--	14
Two-three	69	--	51	--	--	49	--	6
Four - eight	55	--	31	--	--	15	--	2
Nine - fifteen	30	--	9	--	--	3	--	1
More than fifteen	15	--	5	--	--	1	--	-
Pre/extra marital/hom (past three months)	176	--	106	--	--	179	--	23
Pre/extra marital altogether	205	--	154	--	--	179	--	28
FREQUENCY OF INTERCOURSE (past three months)	Hom	Het	Hom	Het	Hom	Het	Hom	Het
Not at all	29	--	48	--	--	--	--	56
One	6	--	4	--	--	4	--	3
Two - five times	21	--	20	--	--	35	--	11
Six - ten times	38	--	33	--	--	37	--	7
More than ten times	111	--	49	--	--	103	--	2

APPENDIX 1a TABLE 15

CIGARETTE-SMOKING AND ALCOHOL CONSUMPTION: INCIDENCE AND FREQUENCY (Numbers and Percentages)

FREQUENCY	CIGARETTE SMOKING							
	HOMOSEXUALS				HETEROSEXUALS			
	S/C Patients		Non-Patient Control Ss		Group 1		Group 2	
	No	%	No	%	No	%	No	%
Regularly	109	53.0	72	47.0	130	72.5	53	67.0
Occasionally	8	4.0	26	17.0	13	7.5	7	2.0
Not at all	88	43.0	57	36.0	36	20.0	19	24.0
FREQUENCY	ALCOHOL DRINKING							
Regularly	158	77.0	106	69.0	138	77.0	53	67.0
Occasionally	39	19.0	38	25.0	23	13.0	17	21.5
Not at all	8	4.0	10	6.0	18	10.0	9	11.5

APPENDIX 1a TABLE 16

SUMMARY TABLE OF DATA RELATING TO SUBJECTS WHO:
i Have been offered psychoactive drugs at least once
ii Know where drugs may be obtained (Numbers and percentages)

CATEGORIES	HOMOSEXUALS				HETEROSEXUALS			
	S/C Patients		Non-Patient Control Ss		Group 1		Group 2	
	No	%	No	%	No	%	No	%
Offered drugs	120	58.5	77	50.0	122	68.0	32	40.5
Know where obtained	69	35.5	53	34.5	86	48.0	16	20.0

APPENDIX 1a TABLE 17

DRUG MISUSE: INCIDENCE, TYPE OF DRUG, MISUSED AND FREQUENCY OF MISUSE EXPRESSED AS A PERCENTAGE OF THE PREVALENCE FIGURE FOR EACH GROUP

		HOMOSEXUALS				HETEROSEXUALS			
		No	%	No	%	No	%	No	%
Misuse of psychoactive drugs Total Numbers		58 205	28.0 (100)	41 154	26.5 (100)	63 179	35.0 (100)	15 79	19.0 (100)
TYPE OF DRUGS									
Cannabis	Occ Reg	46 12	79.5 20.5	20 13	49.0 32.0	29 14	46.0 22.0	11 3	73.0 20.0
Tranquilizers	Occ Reg	6 7	10.5 12.0	12 3	29.0 75.0	3 2	5.0 3.0	2 -	13.5 --
Pep/Speed	Occ Reg	11 -	19.0 --	7 -	17.0 --	11 1	17.5 1.5	1 -	6.5 --
Hallucanogenic	Occ Reg	31 3	53.5 5.0	20 3	49.0 7.5	27 6	43.0 9.5	4 1	26.5 6.5
Barbiturates and Hypnotics	Occ Reg	10 4	17.0 7.0	11 -	27.0 --	10 2	16.0 --	4 1	26.5 6.5
Heroin and other narcotics	Occ Reg	6 2	10.0 3.5	8 -	19.5 --	14 1	22.0 1.5	2 -	13.5 --
Solvent sniffing	Occ Reg	- -	-- --	3 -	7.5 --	12 -	19.0 --	4 -	26.5 --

APPENDIX 1a TABLE 18

DRUG MISUSE: FREQUENCY OF DRUG MISUSE WITHIN THE PAST THREE MONTHS

FREQUENCY	HOMOSEXUALS		HETEROSEXUALS	
	S/C Patients	Non-Patient Control Ss	Group 1	Group 2
	No	No	No	No
Once	-	-	3	1
Between two and five times	4	4	11	3
Between six and ten times	15	11	12	3
More than ten times	11	8	15	2
Total number of misusers in past three months	29	23	41	9
Expressed as % of all misusers	53.5	79	65	60

APPENDIX 1b

Questionnaire 2 - 5b data,
Also data from PEN, IPAT
and
"Test of Social Insight"

QUESTIONNAIRE (PEN) DATA

APPENDIX 1b TABLE 1

SCORES OBTAINED ON THE PEN INVENTORY AND THE IPAT ADULT ANXIETY SCALE: EXPERIMENTAL AND CONTROL GROUPS

		HOMOSEXUALS		HETEROSEXUALS	
		S/C Patients	Non-Patient Control Ss	S/C Patients	Non-Patient Control Ss
PSYCHOTICISM	No	178	106	179	79
	Mean	3.0	2.4	2.2	2.3
	SD	2.05	1.9	1.7	1.9
EXTRAVERSION	No	178	106	179	79
	Mean	12.6	12.3	12.8	12.8
	SD	3.3	3.4	3.5	3.2
NEUROTICISM	No	178	106	179	79
	Mean	10.3	9.55	8.8	8.8
	SD	3.65	3.7	3.5	3.4
ANXIETY	No	178	106	179	79
	Mean	6.8	6.6	6.25	6.3
	SD	2.1	2.1	2.1	3.3

APPENDIX 1b TABLE 2

STANDARDISATION DATA FOR THE PEN INVENTORY*

		Normal Sample		Psychotics		Neurotics (In-Patients)	
		Males	Females	Males	Females	Males	Females
PSYCHOTICISM	No	1,012	1,320	156	154	83	132
	Mean	2.50	2.02	4.83	4.92	4.70	4.46
	SD	2.71	2.22	3.28	3.64	3.09	3.26
EXTRAVERSION	No	1,012	1,320	156	154	83	132
	Mean	12.75	12.36	10.04	10.26	10.54	9.67
	SD	4.12	3.68	4.58	4.44	4.82	4.45
NEUROTICISM	No	1,012	1,320	156	154	83	132
	Mean	7.33	8.64	9.64	9.46	11.19	12.99
	SD	4.37	4.35	4.90	5.13	5.22	4.81

* As published by Eysenck and Eysenck (1969)

APPENDIX 1b TABLE 3a

FACTOR ONE. QUESTIONNAIRE 2

"LEVEL OF PERSONAL AND SOCIAL FUNCTIONING"

Factor Items	Factor Loadings
	Questionnaire 2
SELDOM DEPRESSED	.83
SELDOM LONELY	.80
QUITE HAPPY	.79
SELF CONFIDENT	.78
RELAXED	.75
AN INTERESTING PERSON	.67
LEADER	.67
MANY FRIENDS	.66
ENJOY MEETING PEOPLE	.56
PREFER COMPANY	.40
TRUSTING OF OTHERS	-

* Positive items only shown

APPENDIX 1b TABLE 3b

REVISED FACTOR ONE: "ACTUAL SELF"

"PERSONAL AND SOCIAL FUNCTIONING"

High	Low
Seldom depressed	Often depressed
Seldom lonely	Often lonely
Quite happy	Not very happy
Self confident	Not very self confident
Relaxed	Tense
Am an interesting person	Not a very interesting person
Leader	Follower
Have many friends	Have few friends
Enjoy meeting people	Do not enjoy meeting people
Prefer company	Prefer to be alone

APPENDIX 1b TABLE 4a

FACTOR TWO. QUESTIONNAIRE 2
"LEVEL OF ACHIEVEMENT AND ABILITY TO PLAN FOR THE FUTURE"

Items*	Loading
	Questionnaire 2
USUALLY PLAN AHEAD	.73
INTELLIGENT	.68
AMBITIOUS	.64
A PRACTICAL PERSON	.60
OFTEN SUCCESSFUL	.60
THINK CAREFULLY BEFORE ACTING	.59
ACTIVE	.56
NOT EASILY INFLUENCED BY OTHERS	.54
SERIOUS MINDED	.54
CONSIDERATE	.50
OFTEN THINK ABOUT THE FUTURE	.50
PEACEFUL	.40

* Positive items only shown

APPENDIX 1b TABLE 4b

REVISED FACTOR TWO: "ACTUAL SELF"

"Achievement and ability to plan for the future"

High	Low
Usually plan ahead	Do not usually plan ahead
Intelligent	Not so intelligent
Ambitious	Not very ambitious
A practical person	Not a very practical person
Often successful	Often a failure
Think carefully before acting	Act on the spur of the moment
Active	Not very active
Not easily influenced by others	Easily influenced by others
Serious minded	Not very serious minded
Often think about the future	Seldom think about the future

APPENDIX 1b TABLE 5a

FACTOR THREE. QUESTIONNAIRE 2
"RISK TAKING"

Items*	Loading
	Questionnaire 2
SELDOM TAKE CHANCES	.61
SELDOM HAVE SEX	.59
DO NOT LIKE EXCITEMENT	.58
SELDOM THINK ABOUT SEX	.54
DO NOT ENJOY .... FORBIDDEN	.50
SELDOM LOSE TEMPER	.35

* Positive items only shown

Principal components analysis showed the three unrotated factor solutions (eigenvectors) to account for the following percentages of variance:

Questionnaire 2 86.25 per cent of common variance**.
(59.6 per cent of total variance)**

** Common variance is the percentage of the total variance accounted for by eigenvalues which are equal to or greater than unity. (For the detailed explanation and account of these and the above terms see Appendix 3b).

APPENDIX 1b TABLE 5b

REVISED FACTOR THREE: "ACTUAL SELF"

"Risk Taking"

High	Low
Often take chances	Seldom take chances
Often have sex	Seldom have sex
Like excitement	Do not like excitement
Often think about sex	Seldom think about sex
Enjoy doing things that are forbidden	Do not enjoy doing things that are forbidden

APPENDIX 1b TABLE 6a

FACTOR ONE. QUESTIONNAIRE 3 - 'STRONGLY AGREE/STRONGLY DISAGREE' SCALE.

Conformist/Rebellious behaviour

ITEMS	LOADINGS
IT IS SAFER AND WISER TO DO AS YOU ARE TOLD AND TO OBEY THE LAW AT ALL TIMES.	.79
THOSE IN POSITIONS OF AUTHORITY SHOULD BE GIVEN PROPER RESPECT BECAUSE OF THE POSITION THEY HOLD.	.78
ADULTERERS SHOULD BE SEVERELY PUNISHED AND NOT EXCUSED	.67
ANYONE WHO 'SLEEPS AROUND' DESERVES TO BECOME INFECTED WITH A SEXUALLY TRANSMITTED DISEASE	.55
HARD WORK IS THE ONLY WAY TO ACHIEVE AMBITION	.36

APPENDIX 1b TABLE 6b

REVISED FACTOR ONE: "STRONGLY AGREE/STRONGLY DISAGREE" SCALE

"Conformist/Rebellious behaviour"

It is safer and wiser to do as you are told and to obey the law at all times.

Those in positions of authority should be given proper respect because of the position they hold.

Adulterers should be severely punished and not excused.

Anyone who 'sleeps around' deserves to become infected with a sexually transmitted disease.

Hard work is the only way to achieve an ambition.

APPENDIX 1b TABLE 7a

FACTOR TWO. QUESTIONNAIRE 3

"ASSERTIVE AND SEXUALLY PERMISSIVE BEHAVIOUR"

Items	Loadings
IF YOU DON'T WATCH OUT FOR YOURSELF PEOPLE WILL TREAD ALL OVER YOU	.61
EVERYONE SHOULD HAVE THE OPPORTUNITY FOR REGULAR SEX	.56
THERE IS NOTHING WRONG WITH HAVING SEX WITH A NUMBER OF PERSONS WHETHER YOU HAPPEN TO BE MARRIED OR NOT	.55
I WILL NOT MIND VERY MUCH IF MY CHILDREN HAVE SEX BEFORE THEY MARRY	.55
LIFE IS MORE INTERESTING WHEN YOU ARE DOING RISKY AND EXCITING THINGS	.55
IT IS IMPORTANT TO LET PEOPLE KNOW THAT THEY CAN'T PUSH YOU AROUND	.54
IF YOU GET INTO A TIGHT SPOT IT IS BETTER TO HIT FIRST AND ASK QUESTIONS LATER	.49
PEOPLE WHO TAKE CHANCES IN LIFE HAVE MORE FUN THAN THOSE WHO PUT SAFETY FIRST.	.47

APPENDIX 1b TABLE 7b

REVISED FACTOR TWO: "STRONGLY AGREE/STRONGLY DISAGREE"SCALE

"Assertive and Sevually Permissive Behaviour"

If you don't watch out for yourself, people will tread all over you.

Everyone should have the opportunity for regular sex.

There is nothing wrong with having sex with a number of persons whether you happen to be married or not.

Life is more interesting when you are doing risky and exciting things.

It is important to let people know that they can't push you around.

If you get into a tight spot, it is better to hit first and ask questions later.

People who take chances in life have more fun than those who put safety first.

APPENDIX 1b TABLE 8a

FACTOR THREE. QUESTIONNAIRE 3

"PERCEPTION OF THE FUTURE"

Items	Loadings
THE FUTURE IS SO MUCH A MATTER OF LUCK THAT IT IS NOT WORTH THINKING TOO MUCH ABOUT	.86
'WHAT HAS GOT TO BE WILL BE' SO THERE IS NO POINT IN TRYING TO PLAN FOR THE FUTURE .	.82
IT IS BETTER TO LIVE FOR TODAY RATHER THAN TO THINK TOO MUCH ABOUT THE FUTURE	.69
YOUNG PEOPLE WHO DRINK AND GO INTO PUBS ARE MUCH MORE GROWN UP AND MATURE THAN THOSE WHO DO NOT	.45
IF DRUGS CAN GIVE YOU A NEW EXPERIENCE THEY ARE WORTH TRYING	.39

Unrotated factor solution accounted for 83.5 per cent common variance

62.5 per cent total variance

APPENDIX 1b TABLE 8b

REVISED FACTOR THREE: "STRONGLY AGREE/DISAGREE SCALE"

"Perception of the Future"

The future is so much a matter of luck that it is not worth thinking too much about.

'What has got to be will be' so there is no point in trying to plan for the future.

It is better to live for today rather than to think too much about the future.

Young people who drink and go into pubs are much more grown up and mature than those who don't.

If drugs can give you a new experience, they are worth trying.

APPENDIX 1b TABLE 9a

FACTOR ONE QUESTIONNAIRE 4 'TRUE/FALSE' SCALE

"Anxious and Neurotic Behaviour"

Items	Loadings
I GET TENSE AND ANXIOUS WHEN I THINK OF WHAT THE FUTURE MIGHT HOLD FOR ME	.77
I HAVE OFTEN FELT LONELY EVEN WHEN I HAVE BEEN IN THE COMPANY OF OTHER PEOPLE	.75
I NEED FRIENDS MORE THAN THEY APPEAR TO NEED ME	.73
I OFTEN FEEL MISUNDERSTOOD BY OTHERS	.73
I QUITE EASILY GET HURT BY THINGS PEOPLE SAY AND DO	.72
I FEEL I OUGHT TO ENJOY SEX MORE THAN I DO	.64
WHEN I HAVE A DRINK OF SPIRITS OR BEER I AM MORE LIKELY TO DO SO TO HELP ME RELAX RATHER THAN BECAUSE I ENJOY THE TASTE	.62
THE FUTURE HAS NO REAL SHAPE FOR ME BUT IS RATHER LIKE LOOKING INTO A FOG	.61
I OFTEN HAVE UNPLEASANT DREAMS WHICH DISTURB MY SLEEP	.56
I FREQUENTLY FEEL TIRED IN THE MORNINGS YET CAN'T SLEEP AT NIGHT	.49
I AM MORE LIKELY TO HAVE SEX WITH SOMEONE AFTER I HAVE HAD A FEW DRINKS	.38
I ONLY HAVE SEX WHEN I CAN ENJOY IT AND NOT JUST TO PLEASE MY SEXUAL PARTNER	.35

APPENDIX 1b TABLE 9b

REVISED FACTOR ONE: TRUE/FALSE SCALE

"Anxious and neurotic behaviour"

I get tense and anxious when I think of what the future might hold for me.

I have often felt lonely even when I have been in the company of other people.

I need friends more than they appear to need me.

I often feel misunderstood by others.

I quite easily get hurt by things people say and do.

I feel I ought to enjoy sex more than I do.

When I have a drink of spirits or beer I am more likely to do so to help me to relax rather than because I enjoy the taste.

The future has no real shape for me but is rather like looking into a fog.

I frequently have unpleasant dreams which disturb my sleep.

I frequently feel tired in the mornings yet can't sleep at night.

I am more likely to have sex with someone after I have had a few drinks.

I only have sex when I can enjoy it and not just to please my sexual partner.

APPENDIX 1b TABLE 10a

FACTOR TWO. QUESTIONNAIRE 4

"IMPULSIVE PLEASURE SEEKING BEHAVIOUR"

Item	Loadings
I QUITE OFTEN GET INTO ARGUMENTS AND FIGHTS	.62
IF I KNEW THAT DRUGS COULD MAKE SEX MORE PLEASURABLE AND WERE AVAILABLE TO ME I THINK I WOULD TRY THEM	.59
I GET A FEELING OF SATISFACTION OUT OF BREAKING THINGS WHEN I AM IN A TEMPER	.58
I WOULD RATHER JUST 'LIVE' WITH AN INDIVIDUAL RATHER THAN BE 'TIED' BY MARRIAGE	.46
I TEND TO MAKE PLANS FOR THE FUTURE RATHER THAN LIVE FROM DAY TO DAY	.44
I FIND THAT I AM QUITE EASILY SEXUALLY. AROUSED BY THINGS I SEE SUCH AS SEXY TV COMMERCIALS, PLAYS OR FILMS, ADVERTS IN MAGAZINES, ETC	.36

Unrotated factor solution accounted for 76 per cent common variance

54.6 per cent total variance

APPENDIX 1b TABLE 10b

REVISED FACTOR TWO: TRUE/FALSE SCALE

"Impulsive pleasure-seeking Behaviour"

I quite often get into arguments and fights.

If I knew that drugs could make sex more pleasurable and were available to me I think I would try them.

I get a feeling of satisfaction out of breaking things when I am in a temper.

I would rather just live with an individual than be 'tied' by marriage.

I tend to make plans for the future rather than live from day to day.

APPENDIX 1b TABLE 11 FACTOR SCORES

Questionnaire 2a - Actual Self

			Mean	SD	$Z=\frac{M}{SD}$
178	Index	Factor 1	-.069	.352	-.2
W=178		Factor 2	.009	.368	.02
		Factor 3	-.075	.40	-.19
106	Control	Factor 1	.020	.272	.05
N=106		Factor 2	.020	.303	.06
		Factor 3	.009	.421	.02
179	Group 1	Factor 1	.185	.355	.01
N=179		Factor 2	.021	.241	-.16
		Factor 3	-.196	.342	-.57
79	Group 2	Factor 1	.087	.301	-.05
N=79		Factor 2	.121	.310	-.05
		Factor 3	-.078	.300	-.14

APPENDIX 1b TABLE 12 FACTOR SCORES

Questionnaire 3a Strongly Agree/Disagree Scale

			Mean	SD	$Z=\frac{M}{SD}$
1	Index	Factor 1 (Rebellion)	.049	.309	.16
2	N=178	Factor 2 (Permissive/ Restrained)	.009	.390	.02
3		Factor 3 (Future Perception)	-.009	.288	-.02
	Control	Factor 1	.028	.289	.10
N=106		Factor 2	-.055	.352	-.03
	Group 1	Factor 1	-.096	.52	-.18
N=179		Factor 2	-1.64	.34	-.48
		Factor 3	-.042	.314	-.13
	Group 2	Factor 1	-.061	.399	-.15
		Factor 2	-.02	.48	-.04
		Factor 3	.046	.378	.2

APPENDIX 1b TABLE 13 - FACTOR SCORES

Questionnaire 4 - True/False Scale

		Mean	SD	$Z=\frac{M}{SD}$
Index	Factor 1	-.62	.325	-.2
N=178				
	Factor 2	-.115	.455	-.25
Control	Factor 1	-.045	.480	-.11
N=102				
	Factor 2	..048	.461	.10
Group 1	Factor 1	.261	.415	.63
N=179				
	Factor 2	-.056	.587	-.10
Group 2	Factor 1	.20 .09	.311	.64
N=79				
	Factor 2	-.036	.331	-.11

APPENDIX 1b TABLE 14

TEST OF SOCIAL INTEREST: STATISTICAL COMPARISON OF SCORES FOR HOMOSEXUALS AND HETEROSEXUALS

	HOMOSEXUALS (N = 41: Age M = 23.62: SD = 4.20)			HETEROSEXUALS (N = 34: Age M = 24.89: SD = 5.32)	P	t	df
Withdrawal	M	8.38	(3.50)	M 6.91	NS	1.13	73
	SD	5.13	(2.38)	SD 4.49			
	Norm	.....	(4.39)				
Passivity		10.25	(3.50)	M 6.91	<0.01	3.05	73
	SD	4.97	(4.08)	SD 4.38			
	Norm	.....	(10.96)				
Co-operativeness		27.83	(3.50)	M 30.52	NS	1.37	73
	SD	8.00	(4.87)	SD 8.96			
	Norm	.....	(31.45)				
Competitiveness		7.12	(3.50)	M 6.69	NS	0.41	73
	SD	4.63	(2.09)	SD 4.47			
	Norm	.....	(6.36)				
Aggression		6.09	(3.50)	M 9.08	<0.05	2.47	73
	SD	4.85	(3.62)	SD 5.60			
	Norm	.....	(6.37)				
Total Score		22.09	(3.50)	M 26.22	NS	1.56	73
	SD	11.07	(6.01)	SD 11.80			
	Norm	.....	(21.39)				
P Score		2.74		2.89	NS	0.34	73
	SD	1.89		1.95			
E		13.38		12.45	NS	1.12	73
	SD	3.95		3.05			
N		9.44		8.12	NS	1.63	73
	SD	3.80		3.10			
Anxiety		6.34		5.92	NS	0.81	73
	SD	2.46		1.90			

APPENDIX 1b TABLE 15

SUBJECTS PERCEPTIONS ON WAY OF LIFE SCALE, i.e.

i Present Way of Life

ii Predicted Way of Life in Five Years Time (Ladder scale 0-10)

Criterion for Perception	HOMOSEXUALS		HETEROSEXUALS	
	S/C Patients	Non-Patient Control Ss	Group 1	Group 2
Present	6.8	6.6	6.0	5.2
In five years time	6.0	5.0	8.0	6.0

APPENDIX 1b FIGURE 1

"THE KIND OF PERSON I AM" (ACTUAL SELF) AND
"THE KIND OF PERSON I SHOULD LIKE TO BE" (IDEAL SELF)

HOMOSEXUAL SUBJECTS' RESPONSES (S/C PATIENTS/NON-PATIENTS CONTROL Ss)

Factor Scores in Parentheses

FACTOR ONE
(Personal and Social Functioning)

Low
-2δ -1δ 1δ 2δ High
Tense, few friends, etc. Relaxed, many friends, etc.

ACTUAL SELF:
(S/C Patients)
(Non-Patient Control Ss) (-.2) (.05) P= < 0.05

IDEAL SELF:
(S/C Patients)
(Non-Patient Control Ss) (.01) (.15) P=NS

FACTOR TWO
(Achievement and ability to plan for the future)

Low
-2δ -1δ 1δ 2δ High
Not ambitious, not very intelligent, etc. Ambitious, intelligent, etc.

ACTUAL SELF:
(S/C Patients)
(Non-Patient Control Ss) (.02) (.06) P=NS

IDEAL SELF:
(S/C Patients)
(Non-Patient Control Ss) (.1) (.05) P=NS

FACTOR THREE
(Risk Taking)

Low
-2δ -1δ 1δ 2δ High
Often take chances, Enjoy forbidden... Seldom take chances, do not enjoy.....forbidden

ACTUAL SELF:
(S/C Patients)
(Non-Patient Control Ss) (-.19) (.02) P=NS

IDEAL SELF:
(S/C Patients
(Non-Patient Control Ss) (.16) (.09) P=NS

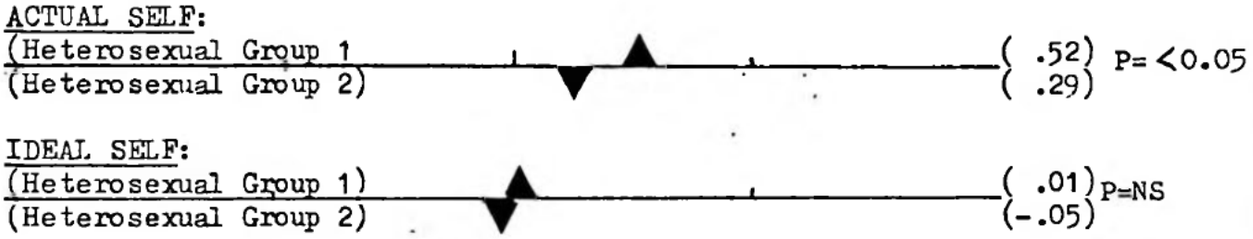
APPENDIX 1b FIGURE 2

"THE KIND OF PERSON I AM" (ACTUAL SELF) and
"THE KIND OF PERSON I SHOULD LIKE TO BE" (IDEAL SELF)

HETEROSEXUAL SUBJECTS' RESPONSES (Groups 1 and 2)
Factor Scores in Parentheses

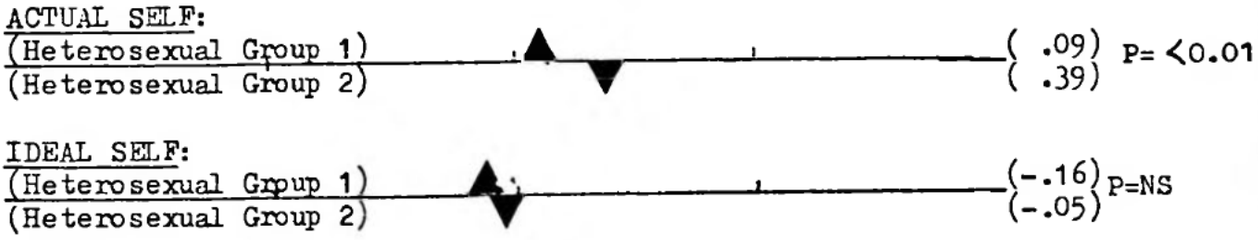
FACTOR ONE
(Personal and Social Functioning)

Low -2σ -1σ 1σ High 2σ
Tense, few friends, etc. Relaxed, many friends, etc.



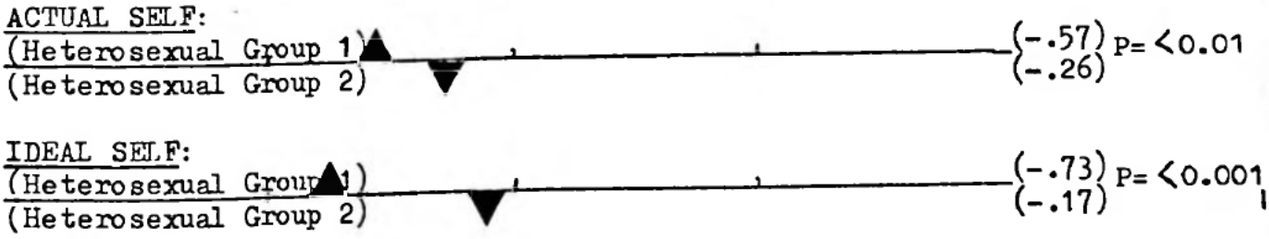
FACTOR TWO
(Achievement and ability to plan for the future)

Low -2σ -1σ 1σ High 2σ
Not ambitious, not very intelligent, etc. Ambitious, intelligent, etc.



FACTOR THREE
(Risk Taking)

Low -2σ -1σ 1σ High 2σ
Often take chances, Enjoy forbidden... Seldom take chances, do not enjoy.....forbidden..



APPENDIX 1b FIGURE 3

"THE KIND OF PERSON I AM" (ACTUAL SELF) and
"THE KIND OF PERSON I SHOULD LIKE TO BE" (IDEAL SELF)

HOMOSEXUAL S/C PATIENTS/HETEROSEXUAL GROUP 1 Subjects
Factor Scores in Parentheses

FACTOR ONE
(Personal and Social Functioning)

Low
-2δ -1δ 1δ High 2δ
Tense, few friends, etc. Relaxed, many friends, etc.

ACTUAL SELF:
(Homosexual S/C Patients) (-.2)
(Heterosexual Group 1) (.52) P= <0.001

IDEAL SELF:
(Homosexual S/C Patients) (.01)
(Heterosexual Group 1) (.01) P=NS

FACTOR TWO
(Achievement and ability to plan for the future)

Low
-2δ -1δ 1δ High 2δ
Not ambitious, now very intelligent, etc. Ambitious, intelligent, etc.

ACTUAL SELF:
(Homosexual S/C Patients) (.02)
(Heterosexual Group 1) (.09) P=NS

IDEAL SELF:
(Homosexual S/C Patients) (.1)
(Heterosexual Group 1) (-.16) P= <0.05

FACTOR THREE
(Risk Taking)

Low
-2δ -1δ 1δ High 2δ
Often take chances, Enjoy forbidden... Seldom take chances, do not enjoy.....forbidden..

ACTUAL SELF:
(Homosexual S/C Patients) (-.19)
(Heterosexual Gr 1 (-.57) P= <0.01

IDEAL SELF:
(Homosexual S/C Patients) (.16)
(Heterosexual Gr 1 (-.73) P= <0.001

APPENDIX 1b FIGURE 4

"THE KIND OF PERSON I AM" (ACTUAL SELF) and
"THE KIND OF PERSON I SHOULD LIKE TO BE" (IDEAL SELF)

Factor Scores in Parentheses

FACTOR ONE
(Personal and Social Functioning)

Low -2δ -1δ 1δ 2δ High

Tense, few friends, etc. Relaxed, many friends, etc.

ACTUAL SELF:
(Homosexual (.05)
(Heterosexual Group 2) (.29) P=NS

IDEAL SELF:
(Homosexual (.15)
(Heterosexual Group 2) (-.05) P=NS

FACTOR TWO
(Achievement and ability to plan for the future)

Low -2δ -1δ 1δ 2δ High

Not ambitious, not very intelligent, etc. Ambitious, intelligent, etc.

ACTUAL SELF:
(Homosexual (.06)
(Heterosexual Group 2) (.39) P= < 0.05

IDEAL SELF:
(Homosexual (.05)
(Heterosexual Group 2) (-.05) P=NS

FACTOR THREE
(Risk Taking)

Low -2δ -1δ 1δ 2δ High

Often take chances, Enjoy forbidden... Seldom take chances, do not enjoy.....forbidden..

ACTUAL SELF:
(Homosexual (.02)
(Heterosexual Group 2) (-.26) P=NS

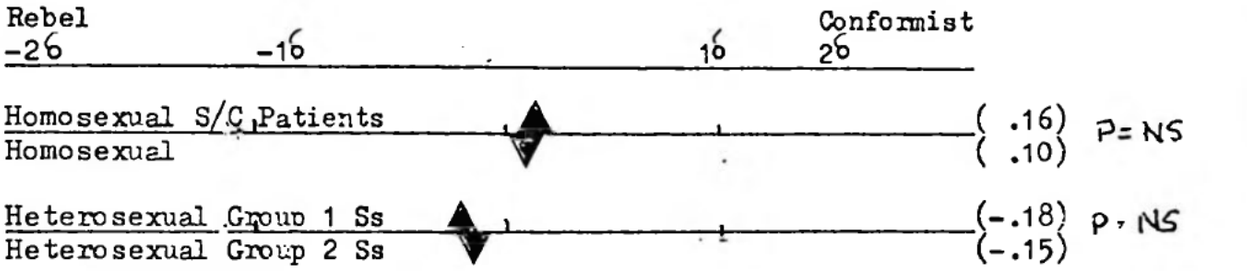
IDEAL SELF:
(Homosexual (.09)
(Heterosexual Group 2) (-.17) P=NS

APPENDIX 1b FIGURE 5

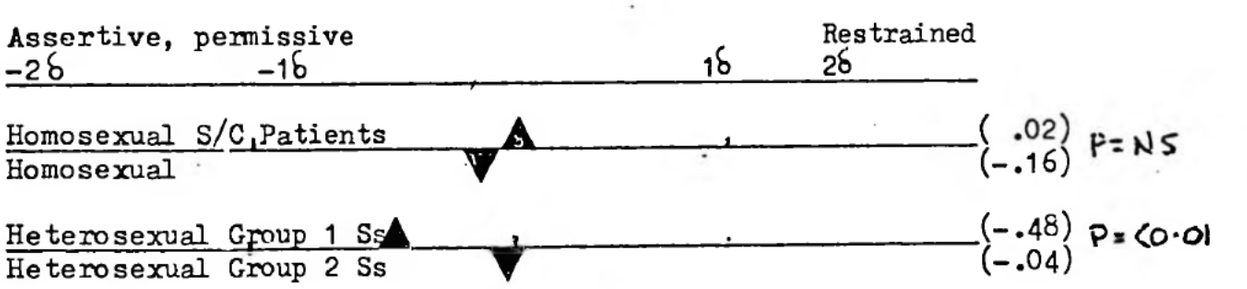
"STRONGLY AGREE/STRONGLY DISAGREE" SCALE

HOMOSEXUAL S/C PATIENTS/NON-PATIENT CONTROL Ss
HETEROSEXUAL GROUPS 1 and 2 Ss
Factor Scores in Parentheses

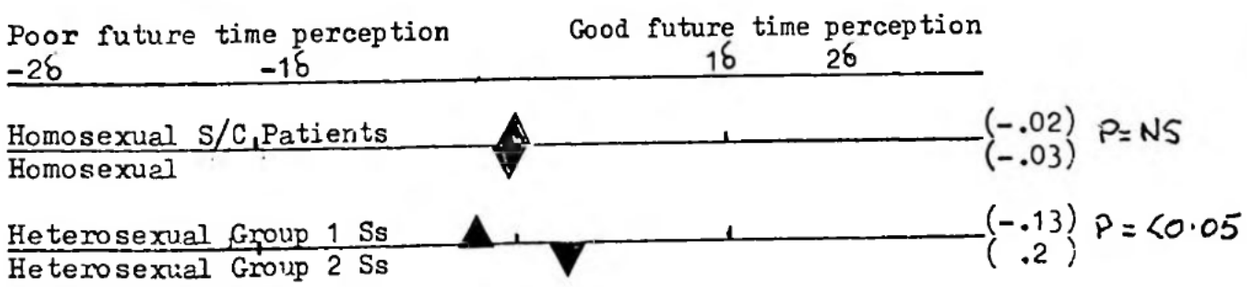
FACTOR ONE
(Rebellion-anti-authority/Conformity)



FACTOR TWO
(Assertive and Sexually Permissive Behaviour)



FACTOR THREE
(Future time Perception)

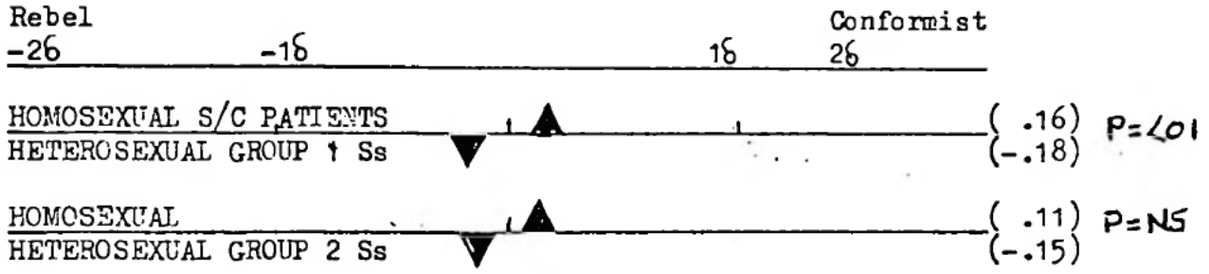


APPENDIX 1b FIGURE 6

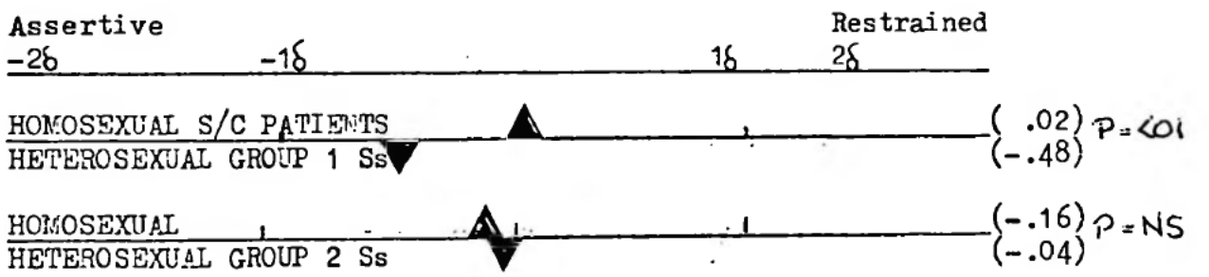
"STRONGLY AGREE/STRONGLY DISAGREE" SCALE

HOMOSEXUAL S/C PATIENTS/HETEROSEXUAL GROUP 1Ss
HOMOSEXUAL NON-PATIENT CONTROL Ss/HETEROSEXUAL GROUP 2Ss
Factor Scores in Parentheses

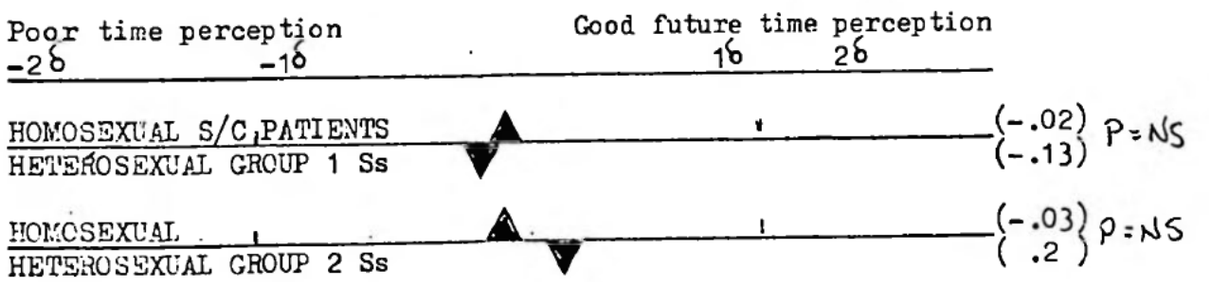
FACTOR ONE
(Rebellion-anti-authority/Conformity)



FACTOR TWO
(Assertive and Sexually Permissive Behaviour)



FACTOR THREE
(Future time Perception)

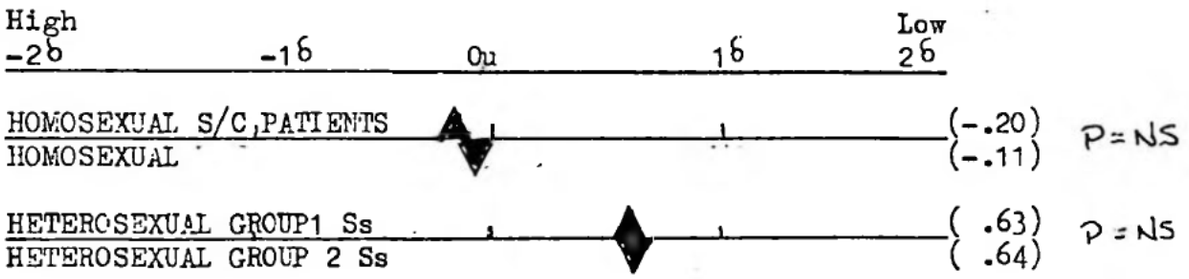


APPENDIX 1b FIGURE 7

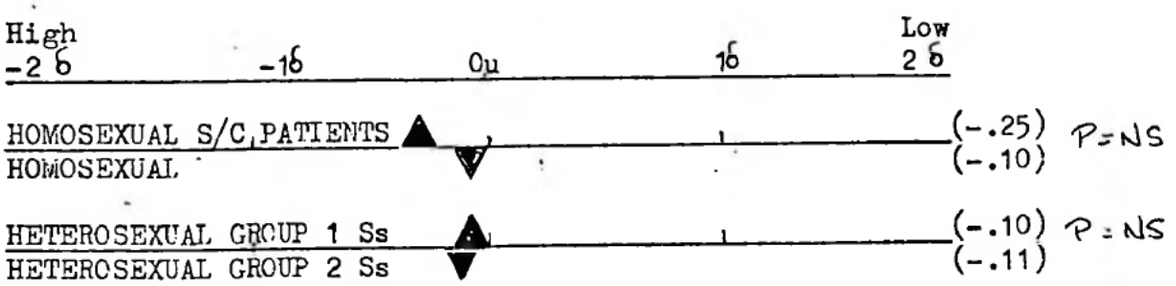
"TRUE/FALSE" SCALE

HOMOSEXUAL S/C PATIENTS/NON-PATIENT CONTROL Ss
HETEROSEXUAL GROUP 1/GROUP 2 Ss
Factor Scores in Parentheses

FACTOR ONE.
(Anxious and neurotic behaviour)



FACTOR TWO
(Impulsive Pleasure Seeking)

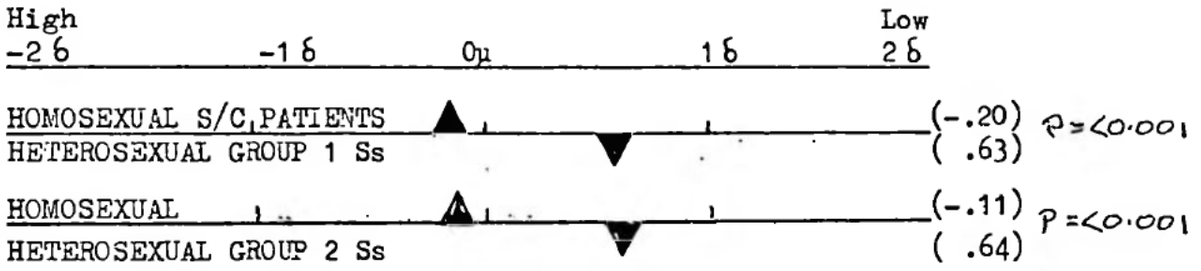


APPENDIX 1b FIGURE 8

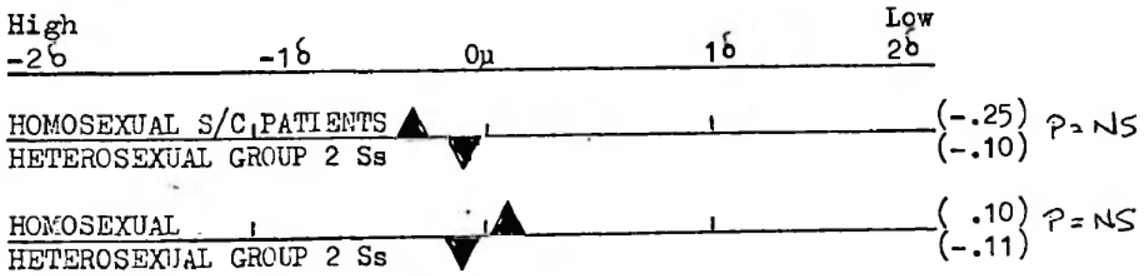
"TRUE/FALSE" SCALE

HOMOSEXUAL S/C PATIENTS/HETEROSEXUAL GROUP 1 Ss
HOMOSEXUAL NON-PATIENT CONTROL Ss/HETEROSEXUAL GROUP 2 Ss
Factor Scores in Parentheses

FACTOR ONE
(Anxious and neurotic behaviour)



FACTOR TWO
(Impulsive Pleasure Seeking)



APPENDIX 1b FIGURE 9

COMPARISON OF HOMOSEXUAL AND HETEROSEXUAL PROFILES ON TEST OF SOCIAL INSIGHT*

	T-score	Withdrawal	Passivity	Co-operativeness	Competitiveness	Aggressiveness	Total Score
	80	12	23	46	15	17	39
	75	10	21	44	14	15	36
Excessive Withdrawal	70	9	19	41	12	14	33
	65	8	17	39	11	12	30
	60	7	15	36	9	10	27
Normal Range	55	6	13	34	8	8	24
	50	4	11	31	6	6	21
	45	3	9	29	5	5	18
	40	2	7	27	4	3	15
	35	1	5	24	2	1	12
Psychosocial Immaturity	30	0	3	22	1	0	9
	25	-	1	19	0	-	6
	20	-	0	17	-	-	3

HOMOSEXUALS (N=41) ————————

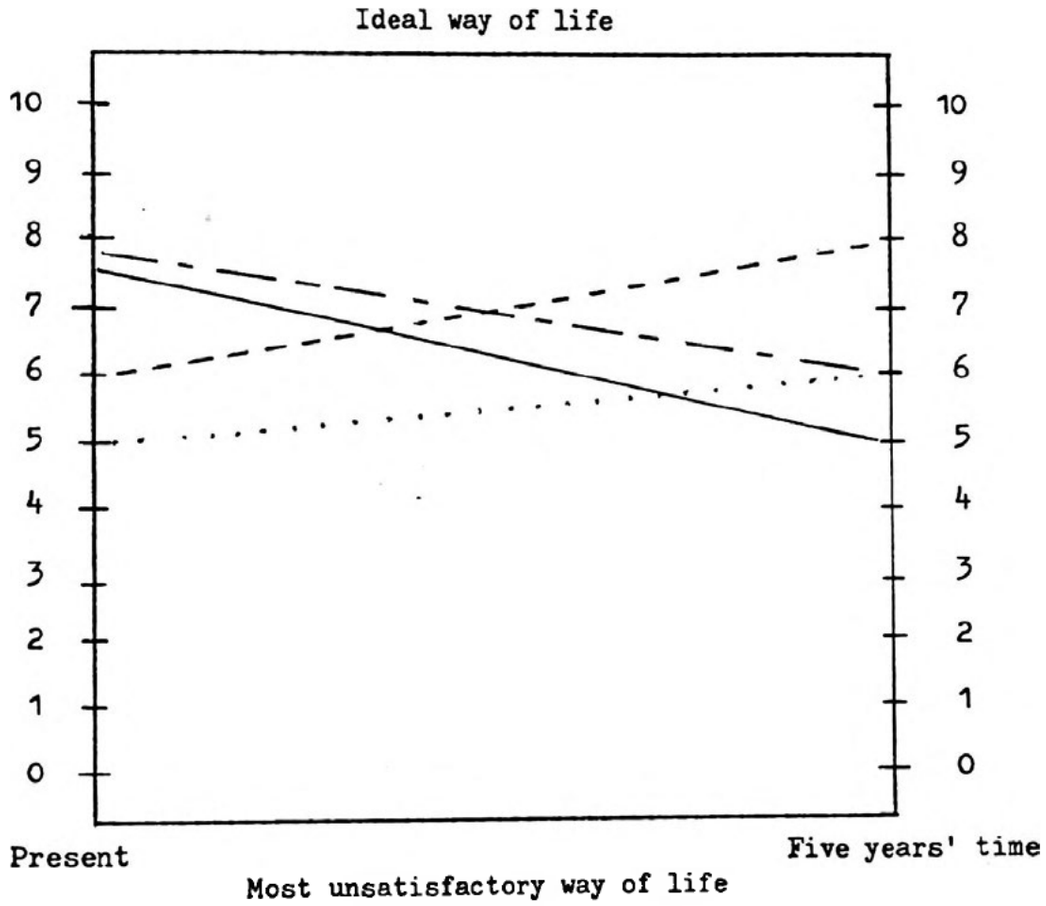
HETEROSEXUALS (N=34) – – – – – – –

* Norm values given above are those quoted for the instrument for "College Students and Adults".

App 1b

FIGURE 10

HOW SUBJECTS PERCEIVED THEIR PRESENT AND PREDICTED THEIR FUTURE



HOMOSEXUALS: S/C Patients

Non-Patient Control Group

HETEROSEXUALS: Group 1

Group 2

APPENDIX 1c

GHQ data

APPENDIX 1C TABLE 1

SUBJECTS SCORES ON GENERAL HEALTH QUESTIONNAIRE (GHQ)

S/C PATIENTS/NON-PATIENT CONTROL GROUPS

	Homosexuals		Heterosexuals	
	S/C Patients	Non-Patient Control Groups	S/C Patients	Non-Patient Control Groups
No	178	106	179	79
Mean	9.94	8.09	6.68	6.21
SD	8.69	7.14	6.19	6.26

APPENDIX 1C TABLE 2

NUMBERS OF SUBJECTS WITH GHQ SCORE OF TWELVE OR OVER

	Homosexuals		Heterosexuals	
	S/C Patients	Non-Patient Control Group	S/C Patients	Non-Patient Control Group
Number of probable cases	64	34	36	12
Totals in groups	178	106	179	79

APPENDIX 1C TABLE 3

GENERAL HEALTH QUESTIONNAIRE:

PROBABLE PSYCHIATRIC CASES* (PERCENTAGES) IN EACH SUB-GROUP

	Homosexuals		Heterosexuals	
	S/C Patients	Non-Patient Control Group	S/C Patients	Non-Patient Control Group
	%	%	%	%
Probable cases	36	34	20	15

* Where subject's GHQ score is 12 or over as recommended by authors

APPENDIX 2a

Structured Interview data

APPENDIX 2a TABLE 1

DISTRIBUTION OF SUBJECTS BY AGE AND SEX

AGE COHORTS	Homosexuals				Homosexuals			
	S/C Patients		Non-Patient Control Group		Group 1		Group 2	
	No	%	No	%	No	%	No	%
16 - 18 years	13	12.5	6	11.0	7	13.0	9	34.5
19 - 21 years	27	26.5	11	19.5	14	26.5	9	34.5
22 - 24 years	18	17.5	14	25.0	14	26.5	7	27.0
25 - 27 years	18	17.5	11	19.5	8	15.0	1	4.0
28 - 30 years	14	14.0	5	9.0	4	7.5	-	-
31 and over	12	12.0	9	6.0	6	11.5	-	-
Total Numbers	102	(100)	56	(100)	53	(100)	26	(100)

APPENDIX 2a TABLE 2

SUBJECTS' AWARENESS OF SPECIFIC SEXUALLY TRANSMITTED DISEASES AND KNOWLEDGE OF SYMPTOMS OF SYPHILIS AND GONORRHOEA

	Homosexuals				Heterosexuals		
	S/C Patients		Non-Patient Control Groups		Group 1		Group 2
	No	%	No	%	No	%	No*
Syphilis	81	79.5	50	89.5	42	79.0	4
Gonorrhoea	82	80.5	51	91.0	49	92.5	6
NSU	55	54.0	25	44.5	31	58.5	1
Trichomoniasis	4	4.0	3	5.5	2	3.5	-
Others**	40	39.0	27	48.0	23	43.5	2
IDENTIFIED CORRECT SYMPTOMS OF***							
Syphilis	70	68.5	17	30.5	18	34.0	2
Gonorrhoea	78	76.5	19	34.0	42	79.0	3
Unable to name such diseases	-	-	3	5.5	2	3.5	18
TOTAL NUMBERS	102	(100)	56	(100)	53	(100)	26

* Percentages not given : numbers too small for meaningful analysis.
** These include non-venereal infections, i.e. Thrush, Herpes, etc.
*** Subjects were asked to specify at least one of two major symptoms of syphilis and gonorrhoea

APPENDIX 2a TABLE 3

SUBJECTS' BELIEFS CONCERNING PRESENCE OF OVERT SYMPTOMS IN MALES AND FEMALES

	Homosexuals				Heterosexuals			
	S/C Patients		Non-Patient Control Groups		Group 1		Group 2	
	No	%	No	%	No	%	No	%
SYPHILIS IN THE MALE		%**		%**		%**		%**
Categories* 1	91		94		76		-	
Categories 2	9		6		20		-	
Categories 3	-		-		4		-	
GONORRHOEA IN THE MALE								
Categories 1	100		99		96		-	
Categories 2	-		1		4		-	
Categories 3	-		-		-		-	
SYPHILIS IN THE FEMALE OR PASSIVE HOMOSEXUAL								
Categories 1	92		89		98		-	
Categories 2	8		11		2		-	
Categories 3	-		-		-		-	
GONORRHOEA IN FEMALE OR PASSIVE HOMOSEXUAL								
Categories 1	93		98		90		-	
Categories 2	7		2		6		-	
Categories 3	-		-		4		-	
Total Number of Subjects Replying	81	79.5	50	89.5	49	92.0	5	-

* 1 = Always present; 2 = Sometimes overt symptoms; 3 = Rarely or never overt symptoms

** Percentage of total numbers replying

APPENDIX 2a TABLE 4

SOURCES OF SEXUALLY TRANSMITTED DISEASES : Subjects Opinions and Beliefs

HOW CONTRACTED	Homosexuals		Heterosexuals	
	S/C Patients	Non-Patient Control Group	Group 1	Group 2
	%	%	%	%
Lack of personal hygiene	-	-	2	15
Kissing and petting	-	-	-	-
Sexual intercourse	100	100	100	100
Other (toilet seats, etc)	-	-	2	9
Total Number of Subjects Replying	102	56	53	26

APPENDIX 2a TABLE 5

ATTEMPTS MADE TO OBTAIN SEX EDUCATION/INFORMATION AND EXPRESSED LEVELS OF SATISFACTION WITH INFORMATION RECEIVED

	Homosexuals		Heterosexuals	
	S/C Patients	Non-Patient Control Group	Group 1	Group 2
	No	No	No	No
Have sought information	44	28	32	4
(Percentage of total numbers)	(43)	(50)	(60)	(15)
- prior to onset of disease	14	-	8	-
- following onset of disease	30	-	24	-
Expressed level of satisfaction with information				
- High	7	6	3	-
- Moderate	14	4	7	1
- Not at all	23	13	22	3
Total Number	102	56	53	26

APPENDIX 2a TABLE 6

EDUCATION AND/OR GUIDANCE RECEIVED BY INTERVIEWS ON :
i Sexual Development and Maturation
ii Prevention of Sexually Transmitted Diseases

	Homosexuals		Heterosexuals	
	S/C Patients	Non-Patient Control Groups	Group 1	Group 2
	No	No	No	No
Offered education/guidance on sexual development and maturation	80	41	10	6
- at school	13	6	4	3
- and/or by parent(s)	15	9	6	5
- and/or other sources	72	30	1	-
Offered education/guidance about Sexually Transmitted Diseases	72	30	1	-
- at school	-	-	-	-
- and/or by parents	-	-	-	-
- and/or other sources	72	30	2	1
No such education/guidance received	22	15	43	20
Expressed as % of total numbers	21.5%	27%	81%	77%
Total numbers in groups	102	56	53	26

APPENDIX 2a TABLE 7

OPINIONS CONCERNING THE NEED FOR INFORMATION ABOUT SEXUALLY TRANSMITTED DISEASES AND MOST EFFECTIVE MEANS OF PRESENTATION*

	Homosexuals		Heterosexuals	
	S/C Patients	Non-Patient Control Groups	Group 1	Group 2
	%	%	%	%
Information most urgently needed on Prevention	4.0	5.5	7.5	77.0
Symptoms	4.0	7.0	22.5	-
Treatment methods	1.0	2.5	24.5	-
Combination of at least 2 of above	86.0	85.0	45.5	15.5
Should not be sought	5.0	-	-	7.5
Most effective means of information transmission	%**	%	%	%
TV and Radio	17.5	37.5	26.5	21.5
Popular press, magazines, etc	30.0	35.5	19.0	66.5
School - Formal classes	52.5	27.0	54.5	12.0
Total number of subjects replying	102	56	53	26

* Subjects were given only one choice and asked to specify what they believed to be the most effective means of information transmission.

** % of total number who agreed that information should be made available.

APPENDIX 2a TABLE 8

SUBJECTS INITIAL EXPERIENCE OF PREMARITAL SEXUAL INTERCCURSE : SUMMARY OF DATA

CATEGORIES**		HOMOSEXUALS*				HETEROSEXUAL	
		S/C Patients		Non-Patient Control Groups		Group 1	Group 2
		No	No	No	No	No	No
First sexual partner		hom ***	het ***	hom	het	het only reported	
Younger Category	1	6	12	9	5	17	3
	2	12	3	4	6	8	3
	3	2	-	1	-	-	-
Older Category	1	-	-	1	-	2	-
	2	33	3	15	1	14	-
	3	-	-	-	-	4	-
Same Age Category	1	1	2	1	3	1	1
	2	12	14	4	3	7	1
	3	-	2	-	3	-	-
Total Numbers Replying		102		53		53	26

* Data indicates inclusion of a minority of bisexual Ss.
** 1 = Not sexually experienced; 2 = Sexually experienced; 3 = Don't know.
*** Het = heterosexual partner. Hom = homosexual partner.

APPENDIX 2a TABLE 8 (Cont'd)

SUMMARY OF DATA TABLE (CONT'D)

	HOMOSEXUALS				HETEROSEXUALS	
	S/C Patients		Non-Patient Control Group		Group 1	Group 2
	No	No	No	No	No	No
First sexual partner	het	hom	het	hom		
Close friend	35	7	26	6	26	8
Casual acquaintance	60	15	25	12	25	-
Total stranger	7	14	5	3	2	-
Where first intercourse occurred						
Own or friends house	41		28		16	5
Holiday camp, hotel, etc	7		3		4	-
Brothel, night club	7		1		3	-
Out of doors	38		24		30	3
Total numbers replying	102		56		53	26

APPENDIX 2a TABLE 8 (Cont'd)

SUMMARY OF DATA (CONT'D)

SUBJECTS STATED REACTION	HOMOSEXUALS				HETEROSEXUALS	
	S/C Patients		Non-Patient Control Group		Group 1	Group 2
	No	No	No	No	No	No
	hom	het	hom	het		
Enjoyed	54	9	41	7	44	7
Did not enjoy	48	27	15	14	9	1
Felt happy and relaxed	54	20	33	12	44	8
Felt stressed and guilty	48	16	2	9	9	-

APPENDIX 2a TABLE 9

DRUG MISUSE AND PRE/EXTRA MARITAL SEXUAL ACTIVITY (SUMMARY OF DATA)

	HOMOSEXUALS		HETEROSEXUALS	
	%	%	%	%
Number of Misusers	27	28	36	23
Occ	16.5	30.5	26.5	15.0
Reg	11.0	9.0	7.5	7.5
Had sex whilst under influence	13.0	16.0	15.0	-
Under influence at time of first sex	5.0	3.5	3.5	-
Had sex with partner under influence	13.0	18.0	3.5	-
Effects (1)				
More likely to consent/ cooperate	7.0	14.0	13.0	-
Less likely to consent/ cooperate	2.0	5.5	-	-
No difference	4.0	-	2.0	-
Effects (2)				
More enjoyable	13.0	12.5	15.0	-
Less enjoyable	-	3.5	-	-
No difference	-	3.5	-	-
Total Number of Ss Replying	102	56	53	26

APPENDIX 2b

Structured Interview

data

(Continued)

APPENDIX 2b TABLE 1

MEAN AGE OF SUBJECTS' PARENTS AT TIME OF THEIR BIRTH (HOMOSEXUALS)

HOMOSEXUAL SUBJECTS	FATHER		MOTHER	
	Mean	SD	Mean	SD
S/C Patients (n102)	30.3	8.21	27.9	7.1
Non-Patient Control Ss (n56)	28.9	8.01	26.81	5.79

APPENDIX 2b TABLE 2

MEAN AGE OF SUBJECTS PARENTS AT TIME OF THEIR BIRTH (HETEROSEXUALS)

HETEROSEXUAL		FATHER		MOTHER	
SUBJECTS		Mean	SD	Mean	SD
Group 1 Ss	(n53)	24.5	3.9	27.8	7.1
Group 2 Ss	(n26)	23.2	5.27	26.19	4.5

APPENDIX 2b TABLE 3

NUMBERS OF SIBLINGS (MALE AND FEMALE) IN SUBJECTS FAMILY

None	10	14	4	2
One	9	9	5	2
Two	12	10	11	5
Three	3	4	8	3
Four	8	1	3	1
Five or more	5	1	4	2
Total No Replying	47	39	35	15
Total No of Subjects	102	56	53	26

APPENDIX 2b TABLE 4

DIFFERENCE IN YEARS BETWEEN NEXT SIBLING (OLDER OR YOUNGER)

	HOMOSEXUAL		HETEROSEXUAL	
	S/C Patients	Non-Patient Control Group	Group 1	Group 2
	No	No	No	No
1 - 3 years	18	15	13	6
4 - 6 years	13	7	6	4
7 or more years	6	3	-	1
No siblings	10	14	4	2
Total No Repyling	47	39	23	13

APPENDIX 2b TABLE 5

			HOMOSEXUALS		HETEROSEXUALS	
			S/C Patients	Non-Patient Control Groups	Group 1	Group 2
			%	%	%	%
AUTHORITARIAN BEHAVIOUR	MOTHER	Authoritarian	38.0	34.0	43.5	37.5
		Permissive	11.0	12.5	9.5	7.5
	FATHER	Authoritarian	23.5	14.5	32.0	30.5
		Permissive	10.0	10.5	9.5	11.5
AFFECTIONATE BEHAVIOUR	MOTHER	Overly affectionate	25.5	28.5	34.0	23.0
		Unaffectionate	9.0	7.0	9.5	7.5
	FATHER	Overly affectionate	2.0	2.0	-	-
		Unaffectionate	9.0	4.0	9.5	7.5
PRESENCE IN FAMILY HOME	MOTHER	Always present	90.0	94.5	90.5	92.5
		Seldom or Never	11.0	5.5	9.5	7.5
	FATHER	Always present	67.5	73.2	89.0	84.5
		Seldom or Never	31.5	27.0	19.0	15.5
Total Numbers Replying			102	56	53	26

APPENDIX 2b TABLE 6a

KNOWN HISTORY OF HOMOSEXUALITY AND REPORTED EARLY SEXUAL BEHAVIOUR

	HOMOSEXUALS		HETEROSEXUALS
	S/C Patients	Non-Patient Control Group	Group 1
	%	%	%
KNOWN HISTORY OF HOMOSEXUALS IN FAMILY			
Yes	13.5	14.5	2.0
No	60.0	73.0	98.0
Uncertain	26.5	12.5	-
HISTORY OF SEXUAL RESPONSE TO ANOTHER MALE (at any time)	100	100	68
AGE AT TIME OF JUST SUCH RESPONSE			
10 years or under	52.0	48.0	27.5
11 years or over	48.0	52.0	72.5
Experienced Overt sexual arousal	100	100	68.0
Subsequent sexual arousal	100	100	13.0
HISTORY OF			
Masterbation	97.0	94.0	90.0
Co Masterbation	87.0	73.0	28.5
No of Subjects Replying	102	56	53

APPENDIX 2b TABLE 6b

EARLY AND SUBSEQUENT SEXUAL BEHAVIOUR

	HOMOSEXUALS		HETEROSEXUALS	
	S/C Patients	Non-Patient Control Group	Group 1 only	
	%	%	%	
INITIAL HOMOSEXUAL (ANAL) INTERCOURSE				
Under 16	24.5	21.5	-	
16 - 18	46.0	39.5	-	
19 or over	29.5	29.0	-	
SUBSEQUENT ANAL INTERCOURSE	100	100	7.5	(No) (4)
Role on first occasion - active	45.0	50.0	-	(3)
- passive	55.0	50.0	-	(1)
Role preferred - active	32.0	25.0	-	
- passive	28.0	23.0	-	
Most frequent role - active	55.0	53.0	-	
- passive	45.0	46.5	-	
No of Subjects Replying	102	56	53	

APPENDIX 2b TABLE 7

REPORTED HISTORY OF HETEROSEXUAL RESPONSE

		HOMOSEXUALS		HETEROSEXUALS
		S/C Patients	Non-Patient Control Ss	Group 1
		No	No	No
Earliest sexual arousal to female	8-10 years of age	-	-	-
	11-13 " " "	6	3	30
	14-16 " " "	29	17	23
	17 or over	7	5	-
Earliest response to female	8-10 years of age	2	-	4
	11-13 " " "	3	2	24
	14-16 " " "	22	16	20
	17 or over	4	3	-
First heterosexual intercourse	8-10 years of age	-	-	-
	11-13 " " "	2	1	14
	14-16 " " "	14	8	28
	17 or over	20	12	11
Nos of Subjects Replying		102	56	53

APPENDIX 2b TABLE 8

PARENTAL AWARENESS AND SUBJECTS DESIRE FOR CHANGE

	HOMOSEXUALS	
	S/C Patients	Non-Patient Control Ss
Parental awareness of homosexuality		
Yes	14.5	10.5
No	62.5	59.0
Uncertain	23.0	35.5
Subjects desire for change		
Occasionally	12.5	21.5
Often	8.0	14.5
Not at all	79.5	64.0
No of Subjects Replying	102	56

APPENDIX 2c

Results of Statistical Comparison

APPENDIX 2C TABLE 1 - RESULTS OF STATISTICAL COMPARISON (Students t and Chi Square) FAMILY AND DOMESTIC VARIABLES BETWEEN CRITERION GROUPS.

		Results of t/Chi Square Comparison Groups				Degrees of Freedom Comparison Groups				Levels of Confidence Comparison Groups			
		1	2	3	4	1	2	3	4	1	2	3	4
Hypothesis 1 a	t=	1.73	2.46	4.68	0.48	156	77	153	80	NS	<0.05	<0.001	NS
" b	t=	1.84	2.67	1.86	0.06	156	77	153	80	NS	<0.05	NS	NS
" 2	X^2	0.115	0.013	2.54	0.1	1	1	1	1	NS	NS	NS	NS
" 3	X^2	8.4	0.15	6.8	6.15	5	5	5	5	NS	NS	NS	NS
" 4	X^2	3.04	2.22	5.35	0.3	3	3	3	3	NS	NS	NS	NS
" 5 a i	X^2	0.3	0.66	0.39	0.43	2	2	2	2	NS	NS	NS	NS
" ii	X^2	0.25	1.94	1.35	3.14	2	2	2	2	NS	NS	NS	NS
" iii	X^2	0.39	0.65	0.07	0.17	1	1	1	1	NS	NS	NS	NS
" b i	X^2	0.26	0.09	1.97	0.18	2	2	2	2	NS	NS	NS	NS
" ii	X^2	0.14	0.07	1.05	0.47	2	2	2	2	NS	NS	NS	NS
" iii	X^2	0.86	0.14	3.80	2.37	1	1	1	1	NS	NS	NS	NS
" c	X^2	0.57	0.18	5.4	3.62	2	2	2	2	NS	NS	NS	NS
" 6	X^2	3.00	0.47	1.67	0.80	2	2	2	2	NS	NS	NS	NS
" 7	X^2	1.38	-	-	-	2	-	-	-	NS	-	-	-
" 8 a i	X^2	0.024	3.75	0.64	2.64	1	1	1	1	NS	NS	NS	NS
" ii	X^2	0.027	3.48	2.04	0.1	1	1	1	1	NS	NS	NS	NS
" b i	X^2	4.31	1.45	0.04	0.16	1	1	1	1	<0.05	NS	NS	NS
" ii	X^2	0.15	2.31	2.01	2.90	1	1	1	1	NS	NS	NS	NS
" c	X^2	0.3	2.8	0.003	1.68	1	1	1	1	NS	NS	NS	NS
" 9	X^2	6.01	0.55	28.53	8.48	2	2	2	2	<0.05	NS	<0.001	<0.05
" 10	X^2	7.54	0.68	18.98	7.49	4	4	4	4	NS	NS	<0.001	NS

APPENDIX 2C TABLE 2 - RESULTS OF STATISTICAL COMPARISON (Students t/Chi Square) ON EDUCATIONAL VARIABLES.

		Results of t/chi Square Comparison Groups				Degrees of Freedom Comparison Groups				Levels of Confidence Comparison Groups			
		1	2	3	4	1	2	3	4	1	2	3	4
Hypothesis 1	X^2	0.57	9.78	24.61	4.51	3	3	3	3	NS	<0.001	<0.001	NS
" 2	X^2	0.11	26.34	28.67	2.08	1	1	1	1	NS	<0.05	<0.001	NS
" 3 a	X^2	4.53	0.39	3.3	0.81	1	1	1	1	<0.05	NS	NS	NS
" 3 b	X^2	0.53	0.65	0.003	0.59	1	1	1	1	NS	NS	NS	NS
" 4	X^2	16.11	18.09	20.42	16.45	7	7	7	7	<0.05	<0.05	<0.01	<0.05
" 5 a	X^2	0.55	0.19	50.81	18.26	1	1	1	1	NS	NS	<0.001	<0.001
" b	X^2	1.72	14.24	26.32	0.014	1	1	1	1	NS	<0.001	<0.001	NS
" c	X^2	2.73	14.41	6.45	9.25	3	3	3	3	NS	<0.01	NS	<0.05
" 6	X^2	3.68	53.88	4.23	56.34	1	1	1	1	NS	<0.001	<0.05	<0.001
" 7 a	X^2	0.0	0.0	0.0	0.0	1	1	1	1	NS	NS	NS	NS
" b	i X^2	21.41	6.36	17.06	7.05	1	1	1	1	<0.001	<0.05	<0.001	<0.01
	ii X^2	27.61	35.35	0.15	5.54	1	1	1	1	<0.001	<0.001	NS	<0.05

APPENDIX 2C TABLE 3

RESULTS OF STATISTICAL COMPARISON (Chi Square) ON SEXUAL VARIABLES

			Results of t/Chi Square Comparison Groups				Degrees of Freedom Comparison Groups				Levels of Confidence Comparison Groups			
			1	2	3	4	1	2	3	4	1	2	3	4
Hypothesis	1	x^2	0.39	-	-	-	1	-	-	-	NS	-	-	-
"	2	x^2	1.61	-	-	-	2	-	-	-	NS	-	-	-
"	3	x^2	17.92	-	-	-	1	-	-	-	<0.001	-	-	-
"	4	x^2	0.43	-	-	-	1	-	-	-	NS	-	-	-
"	5u	x^2	6.21	-	-	-	1	-	-	-	<0.05	-	-	-
"	5h	x^2	2.46	-	-	-	1	-	-	-	NS	-	-	-
"	6	x^2	22.69	-	-	-	3	-	-	-	<0.001	-	-	-
"	7	x^2	23.86	-	-	-	5	-	-	-	<0.001	-	-	-
"	8	x^2	0.91	-	-	-	2	-	-	-	NS	-	-	-
"	9	x^2	0.4	-	65.1	-	4	-	4	-	NS	-	<0.001	-
"	10	x^2	0.02	-	74.2	-	4	-	4	-	NS	-	<0.001	-
"	11	x^2	3.8	-	19.93	-	2	-	2	-	NS	-	<0.01	-

APPENDIX 2C TABLE 3 (Contd)

RESULTS OF STATISTICAL COMPARISON (Chi Square) ON SEXUAL VARIABLES

			Results of t/Chi Square Comparison Groups				Degrees of Freedom Comparison Groups				Levels of Confidence Comparison Groups			
			1	2	3	4	1	2	3	4	1	2	3	4
Hypothesis	12a	x^2	0.45	-	29.98	-	1	-	1	-	NS	-	<0.001	-
"	12b	x^2	-	1.6	-	-	-	1	-	-	-	NS	-	-
"	13	x^2	-		-	-	-	3	-	-	-	< 0.001	-	-
"	14	x^2	-	172.8	-	-	-	5	-	-	-	< 0.001	-	-
"	15	x^2	0.59		3.01		1		1		NS	-	NS	-
"	16	x^2	4.89		55.1		1		1		<0.05	-	<0.001	-
"	17	x^2	5.77	9.99	13.11	3.25	6	6	6	6	NS	< 0.05	<0.05	NS
"	18	x^2	22.6	173.21	31.51	43.92	3	3	3	3	<0.001	<0.001	<0.001	<0.001
"	19	x^2	23.86	172.8	158.9	51.5	5	5	5	5	<0.001	<0.001	<0.001	<0.001
"	20a	x^2	2.46	1.6	12.3	5.13	1	1	1	1	NS	NS	<0.001	<0.05
"	20b	x^2	6.21	0.1	13.6	0.76	1	1	1	1	<0.05	NS	<0.001	NS

APPENDIX 2C TABLE 4 - RESULTS OF STATISTICAL COMPARISON (Chi Square) ON SOCIAL VARIABLES

	Results of t/Chi Square Comparison Groups				Degrees of Freedom Comparison Groups				Levels of Confidence Comparison Groups			
	1	2	3	4	1	2	3	4	1	2	3	4
1 X^2	28.93	24.52	89.34	58.26	1	1	1	1	<0.001	<0.001	<0.001	<0.001
2 X^2	0.53	8.91	0.002	1.72	1	1	1	1	NS	0.01	NS	NS

TABLE 2C TABLE 5

RESULTS OF ANALYSIS OF VARIANCE AND t TESTS - PERSONALITY DATE, PEN, IPAT, TEST OF SOCIAL INSIGHT

	Analysis of Variance Comparison Groups				Degrees of Freedom Comparison Groups				Levels of Confidence Comparison Groups			
	1	2	3	4	1	2	3	4	1	2	3	4
Psychoticism Extraversion Neuroticism Anxiety	1.05	1.22	1.09	1.16	1/6	1/6	1/6	1/6	NS	NS	NS	NS
Hypothesis 1 (P)	1.29	0.4	4.01	0.35	278	256	355	179	NS	NS	<0.001	NS
" 2 (E)	0.73	0.04	-1.68	-1.0	278	256	355	179	NS	NS	NS	NS
" 3 (N)	1.66	3.96	0.77	2.47	278	256	355	179	NS	<0.01	NS	<0.05
" 4 (Anx) t=	0.12	1.4	0.14	0.75	278	256	355	179	NS	NS	NS	NS
Test of Social Insight	Comparison Groups= Analysis of Variance F=2.94				Degrees of Freedom 1/10				Level of Confidence NS			
Hypothesis 5 t=	1.13				73				NS			
" 6 t=	3.05				73				<0.01			
" 7 t=	1.34				73				NS			
" 8 t=	0.41				73				NS			
" 9 t=	2.47				73				<0.05			

APPENDIX 2C TABLE 6 - RESULTS OF STATISTICAL COMPARISONS (Students t) OF FACTOR SCORES OBTAINED FROM CRITERION GROUPS ON FACTORS 1-3 (Questionnaires 2a-3) x FACTORS 1-2 (Questionnaire 4)

	Results of t Comparison Groups				Degrees of Freedom Comparison Groups				Levels of Confidence Comparison Groups			
	1	2	3	4	1	2	3	4	1	2	3	4
Factor 1 t=	2.20	2.14	6.79	1.57	282	256	355	183	0.05	0.05	0.001	NS
2 t=	0.26	2.80	0.36	2.20	282	256	355	183	NS	0.01	NS	0.05
3 t=	-1.69	2.65	3.07	1.56	282	256	355	183	NS	0.01	0.01	NS
Factor 1 t=	0.56	0.53	3.20	1.74	282	256	355	183	NS	NS	0.01	NS
2 t=	0.98	2.75	4.0	0.57	282	256	355	183	NS	0.01	0.01	NS
3 t=	0.04	1.96	1.03	0.96	282	256	355	183	NS	NS	NS	NS
Factor 1 t=	0.35	1.07	5.04	3.94	282	256	355	183	NS	NS	0.001	0.001
2 t=	1.18	0.28	1.06	1.37	282	256	355	183	NS	NS	NS	NS

APPENDIX 2C TABLE 7- RESULTS OF STATISTICAL COMPARISON (t/Chi square) ON PSYCHIATRIC VARIABLES

	Results of t/Chi Square Comparison Groups				Degrees of Freedom Comparison Groups				Levels of Confidence Comparison Groups			
	1	2	3	4	1	2	3	4	1	2	3	4
Hypothesis 1 t=	1.85	0.56	4.2	1.86	278	256	355	179	NS	NS	0.001	NS
" 1 (Cont) X^2=	0.45	0.88	11.11	6.91	1	1	1	1	NS	NS	0.01	0.01

APPENDIX 2C TABLE 8 - RESULTS OF STATISTICAL COMPARISON (Chi square) ON OTHER BEHAVIOURAL VARIABLES

	Results of t/Chi Square Comparison Groups				Degrees of Freedom Comparison Groups				Levels of Confidence Comparison Groups			
	1	2	3	4	1	2	3	4	1	2	3	4
Hypothesis 1 a X^2=	26.74	0.82	25.1	9.1	1	1	1	1	0.001	NS	0.001	0.05
" 2 X^2=	1.03	3.48	7.6	4.19	1	1	1	1	NS	NS	0.05	NS
" 3 a X^2=	0.12	6.82	2.11	1.68	1	1	1	1	NS	0.01	NS	NS
" 3 b X^2=	2.59	17.42	3.8	2.03	1	1	1	1	NS	0.001	0.05	NS
" 3 c												

APPENDIX 3a

Description of Validated Questionnaires etc. used in the Study

PEN Inventory: The PEN Inventory is a 'descendant' of the Maudsley Personality Inventory (MPI) (Eysenck, 1959a; Knapp, 1962) and the Eysenck Personality Inventory (EPI) (Eysenck & Eysenck, 1964). Like the parent instruments, the PEN sets out to measure personality in its behavioural aspect; i.e. major dimensions which are idealised and points of a continuum and to which real people may approach to a greater or lesser degree. The original major dimensions to which Eysenck made reference were those of Extroversion (E) and Neuroticism (N). In a series of investigations carried out by Eysenck and others, such dimensions consistently emerged - almost in identical form - for both male and female samples.

In his attempts to explore further the E and the N dimensions in order to derive yet more information about them, Eysenck noted the existence of a third factor which was indicative of ".... predisposition to psychotic breakdown demonstrable as a continuous variable in the normal population and independent of E and N" (Eysenck & Eysenck, 1968b).

This factor of psychoticism (P) (Eysenck & Eysenck, 1968a, 1968b, 1969) was shown to be present as a graded characteristic. However, these P, E and N factors should not be regarded as being independent of one another, the correlations for males being NE=.14; NP=.30; EP=.13. The PEN Inventory is an easily administered question and answer, pencil and paper type questionnaire (App. 2a) which is given to the subject for completion. A 'Lie Scale' (L) - the rationale for which originated in the famous Heartshorne & May Character Education Enquiry - is a means of eliminating 'response set' and the process of 'faking good'. For the purposes of this study, an L score of seven was employed

as the criterion beyond which completed inventories were rejected.

IPAT Anxiety Scale Questionnaire: The IPAT Anxiety Scale is yet another question and answer, pencil and paper inventory (App. 2a) which has been specifically constructed to measure free floating, manifest anxiety level. The scale was developed by Cattel and Schier, (1963) from a conbination of anxiety related primary questionnaire scales. A single best weighted composite forty-item questionnaire scale was selected. The IPAT anxiety test has been shown to possess an impressive level of construct (internal) validity, +.85 - +.90 for the total scale, and also to be comparatively robust of the criterions of external, concrete validity, viz. the criterion of psychiatric evaluation of anxiety. The IPAT Anxiety Scale employs a stencil type standard key for scoring.

Test of Social Insight: This test was regarded as being of particular relevance - not only because of similar design characteristics to other material used in the project - but because the social problems with which it deals are most pertinent to those investigated in this project. This is particularly true of those dealing with home and family relations and interpersonal relationships whilst at work and doing leisure pursuits.

The Test of Social Insight - in both its Youth and Adult Edition - aspires to appraise the characteristic mode of reaction employed by a given individual in resolving interpersonal (social) problems (Cassel, 1959b). Both Editions are pencil and paper tests containing 60 multiple choice items each having five alternative response opportunities. Test items offer one of the following modes of resolution of the problem specified in the item: "withdrawal", "passivity", "co-operativeness", "competitiveness" and "aggressiveness". The characteristic pattern of the given

individual is determined from the frequency of modes of solution chosen. The social problems which are dealt with in the total number of items can be ascribed to four major spheres of typical life drama: viz. home and family relations, authority figures and social agencies, play and avocational interests and work and vocational interests. Cassel admits that the responses obtained on the Test of Social Insight are by no means certain to be reflected in actual behaviour. However, he further points out that " ... the individual who offers 'undesirable' responses reveals less potential for reacting as effectively socially as those who offer 'favourable' answers". The Test of Social Insight was developed, standardised and validated in the U.S.A., a fact which occasionally reflected in the vocabulary and in the situations described.

General Health Questionnaire (GHQ): The General Health Questionnaire has been developed by Goldberg (1969) as a means of identifying psychiatrically disturbed respondents. The author has given special attention to the need to distinguish sufficiently between personality traits and current symptomatology. The General Health Questionnaire is not in any sense therefore, a personality test. Rather has it been developed for the precise purpose of providing an accurate measure of each respondent's degree of non-psychotic psychiatric illness at the time of the questionnaire completion. The General Health Questionnaire has been validated both in a general practice setting and in the Medical Out-Patients Department of a general hospital. Scores obtained on the instrument have been shown to correlate well with an independent assessment by a psychiatrist (0.8). It has also been shown to identify 95% of patients who are found at interview to be psychiatrically disturbed. The

General Health Questionnaire is a paper and pencil type test containing sixty questions dealing with current feelings and behaviour. The instrument takes approximately 15 minutes to complete.

APPENDIX 3b

Description of Statistical Procedures used in the Study

1. Chi Square Test This statistical technique permits comparative analysis of those results which cannot be handled by the use of the t-technique, i.e. where the calculation + comparison of Means + Standard Deviations is inappropriate. In applying Chi Square the observed results are compared with results expected according to some hypothesis about the population. For example, it may be hypothesised that there would be no difference in the proportion between an experimental and a control group on say, attitude toward their family home. This would, therefore, be a 50-50 hypothesis (null hypothesis) where any deviation from the 50-50 proportion would be hypothesised due to chance fluctuation. Chi Square permits testing for the significance of the divergence of observed frequency from that expected on the basis of the equal probability hypothesis.

2. t-test Where data is in the form of two means as, for example, representing an experimental and a control group, it is desirable to employ a statistic procedure for calculating the significance of any difference between them. The t-test is a well established technique for computing just such a difference. The t-ratio is a ratio in between the difference of the two group means and the standard error of the difference. The t-test provides a moderately robust test which can in fact, cope with a fair degree of skewness. However, in order to check on the significance of the differences between the variances of two samples from the same population, variance ration F is calculated. If the sample variances are such that the two samples could not have been drawn from the same population, it would be useless to ascertain whether the difference between the means is statistically significant. In all cases where

t-tests have been carried out on data in this report, F tests were first completed to check the comparability of the distribution.

3. Analysis of Variance The major limitation in computation of t is that only two means/proportions/variances may be considered at any one time. The fundamental concept entailed in analysis of variance is to partition the sum of squares of deviations of each observation from multiple means/proportions/variances into components that can be attributed to different sources of variation. In its simplest form, comparative analysis of variance between two group means etc. would be computed. In such an instance, the results would be the same as for calculation of t. The particular value of application of analysis of variance does however, reside in its unique capacity to answer the question "Are there one or more significant differences anywhere among multiple samples which are subject to comparative analysis?".

4. Factor Analysis The most distinctive characteristic of factor analysis is its data reduction capability. Factor analytic techniques enable the user to see whether an underlying pattern of relationships exists in his data such that the data may be reduced to a smaller set of factors or components which may be used as variables.

'Factor Analysis' is not a unitary concept since it describes the general classification of a variety of procedures. Such procedures form the alternatives available at each of the three customary steps in the technique. The three basic steps are the preparation of correlation matrix, the extraction of the initial factors and the rotation to a terminal solution.

The preparation of the correlation matrix involves the calculation of appropriate measures of association for a set of

given variables, i.e. the computation of a correlation co-efficient between each variable and every other variable which is to be included in the analysis. The extraction of initial factors is an exploration of the data-reduction possibilities by constructing a set of new variables which is based on those interrelations referred to above. Most commonly, this procedure is carried out by using defined factors, i.e. defining the new variables as linear combinations of the original variables. This approach of using defined factors is called Principal Components analysis and is a relatively straight-forward method of transforming a given set of composite variables or Principal Components which are orthogonal to each other. The first principal component is the single best summary of linear relationship exhibited in the data, the second, the best under the condition that it is orthogonal to the first, i.e. it must account for the second largest proportion of variance not accounted for by the first principal component. The number of principal components is determined by the specification of the minimum eigenvalue criterion. The programme used for analysis (The Statistical Package for the Social Sciences, SPSS), retains and prints only components with eigenvalues greater than or equal to unity. This criterion ensures that only components accounting for at least the amount of average variance of a variable will be treated as significant. In rotating principal components into terminal factors, the major option available is one of choice between an orthogonal rotational method (varimax, quartimax or equimax) or an oblique rotational method (promax) (oblique factors, unlike orthogonal factors, may be correlated). Whichever method is chosen, the basic impetus for employing any form of rotational

method is the same - simpler and theoretically more meaningful factor patterns. The rotational method chosen in the case of this particular analysis was the orthogonal rotational method (varimax) since it was felt that this method best satisfied the theoretical and practical needs of the research problem.

No factor structure is in itself unique, e.g. one factor solution can be transformed into another without in any way violating the basic assumptions or the mathematical properties of a given solution. In fact, not all statistical factor solutions are equally meaningful in theoretical terms. Some are more parsimonious and simple than others; some are more informative than others. The desired end is to produce a terminal solution of orthogonally rotated factors which adequately accounts for each subject's answers in terms of a very much smaller number of 'hypothetical constructs'. These 'hypothetical constructs' (or factors) comprise variables with factors loadings which display the strength of their association with the factor as a whole. All items with associated loadings of .4 and over were included whereas items with loadings below .4 were excluded from a given factor.

The titles which are assigned to the respective factors are to some degree subjective and intuitive, although they are in no sense arbitrary. Each title is powerfully influenced by the nature of the given factors marker variables, i.e. those with the highest loadings and therefore possessing the strongest factor association. The greater the homogeneity among all the variables which comprise that factor, the stronger its claim to refer to a specific attitude or personality trait.

Factor Scoring In the study, three principal factors were obtained for each questionnaire. The principal components; analyses leading to these factors were used to obtain factor scores for every person in the investigation. For each questionnaire, the values of the variables of interest were normalised and simply inserted into the principal components models to obtain three new variables for each person corresponding to the three factors calculated for that questionnaire. This reduced the data on each questionnaire to three new variables (factor scores) based on the original observations. Such factor scores were computed for each sub-group within the sample.

APPENDIX 4

Instruments used for Data Collection

M	F

KB	NB	E..	WY

CODE .....

SOURCE .....

DATE .....

PLEASE READ CAREFULLY

Please tick in box indicating whether you are male or female. MALE ☐

FEMALE ☐

We are asking for your help and co-operation in completing a Questionnaire. A number will be placed on this front sheet and this is for the purpose of coding, since all the information from all the questionnaires will be fed into a computer. ONCE THIS IS DONE ALL COMPLETED QUESTIONNAIRES WILL BE DESTROYED.

Do NOT write your name anywhere on the questionnaire.

Please do not discuss the questionnaires or the answers you have given with any other individual(s) who may be present at the time of completion, since we want your answers to be regarded as strictly confidential.

Please do not glance through the questionnaire or turn over to the next page until you have completed the one that is before you. THIS POINT IS MOST IMPORTANT.

Do not hesitate to ask for help should you have any problems with or worries about the questionnaire.

WE THINK THAT YOU WILL ENJOY COMPLETING THE QUESTIONNAIRE, BUT PLEASE REMEMBER THAT IT IS VERY IMPORTANT THAT YOU SHOULD ANSWER ALL QUESTIONS AS ACCURATELY AS POSSIBLE.

WE VERY MUCH APPRECIATE YOUR HELP AND CO-OPERATION.

NOW PLEASE TURN OVER

PLEASE READ EACH QUESTION CAREFULLY AND PLACE A TICK OR WRITTEN ANSWER, WHICHEVER IS REQUIRED, IN THE SPACE PROVIDED

1. How old are you

2. Were you born in Scotland — Yes / No

3. If you have answered NO to Question 2, what was your country of birth?

4. Are you still at school? — Yes / No

5. If you have left school, how old were you when you left and did you enjoy it? — Age ... / Enjoyed / Didn't enjoy

6. If you have left school, have you had any further education/training? — Yes / No

7. If you have answered Yes to Question 6, was this education — Part time / Full-time

8. Are you still attending — Yes / No

9. If your answer is Question 8 is No, is it because you — Completed / Left before completion

PLEASE READ CAREFULLY. QUESTIONS 10 and 11 SHOULD BE ANSWERED ONLY IF YOU ARE IN FULL TIME OR PART TIME EMPLOYMENT. IF YOU ARE UNEMPLOYED AT PRESENT OR ARE A HOUSEWIFE DO NOT ANSWER QUESTIONS 10 AND 11, BUT PASS TO QUESTION 12.

10. What are you employed as? Give the name of your job, i.e. state whether you are a bricklayer, barmaid, accountant, teacher or whatever — Part time / Full time

11. Do you feel your present job holds — Good prospects / Not very good prospects

P.T.O.

PLEASE READ CAREFULLY. QUESTION 12 SHOULD BE ANSWERED ONLY IF YOU ARE WHOLLY UNEMPLOYED AT THE PRESENT TIME. NOTE THIS INCLUDES HOUSEWIVES. IF YOU ARE NOT WHOLLY UNEMPLOYED OR YOU ARE NOT A HOUSEWIFE, DO NOT ANSWER QUESTION 12.

12. What were you last employed as? Give the name of your job, i.e. state whether you were a bricklayer, barmaid, accountant, teacher or whatever.

Full-time ☐
Part-time ☐

PLEASE READ CAREFULLY. HOUSEWIVES ONLY TO ANSWER NEXT FOUR QUESTIONS. IF YOU ARE NOT A HOUSEWIFE, PASS TO QUESTION 17

13. Is your husband in full-time employment

Yes ☐
No ☐

14. If your husband is in full-time employment what is he employed as? Give the name of his job; i.e. state whether he is a bricklayer, accountant, engineer, teacher or whatever. ☐

15. If your husband is not in full time employment what was he last employed as? Give the name of his job. ☐

16. Are you employed at the present time

Full-time ☐
Part-time ☐
No ☐

ALL PERSONS SHOULD ANSWER THE FOLLOWING QUESTIONS

17. Is your father

Living ☐
Dead ☐

18. If your father has died, did he die

Before you started school ☐
In your early school days (i.e, before 12th birthday) ☐
In your later school days (i.e, after 12th birthday) ☐
After you had left school ☐

P.T.O.

19. Whether your father is still living or not, what is/was he employed as.
If he is unemployed what was he last employed as. (Give the name of his job)

20. Is your mother

Living ☐
Dead ☐

21. If your mother has died did she die

Before you started school ☐
In your early school days (i.e, before 12th birthday) ☐
In your later school days (i.e, after 12th birthday) ☐
After you had left school ☐

22. If your parents are both still alive are they

Living together ☐
Not living together divorced ☐

If not living together state reason

23. How many brothers/sisters do you have
If none, put a nought in the appropriate box.

Brothers ☐
Sisters ☐

24. Is/was your family home

A happy place ☐
Not a very happy place ☐
In between ☐

25. Are you married

Yes ☐
No ☐

26. If you are married are you:

Living with husband/wife ☐
Separated ☐
Divorced ☐
Widowed ☐

27. Have you any children (whether married or not)

Yes ☐
No ☐

p.t.o.

PLEASE READ CAREFULLY. If you have answered YES to Question 27, answer the next two questions also. If you do not have any children, please pass to Question 30.

28. How many children do you have. Write number ☐☐

29. Is your child/are your children (write number in box or boxes)

Living with you	☐
Living with other relatives	☐
In local authority care	☐
Adopted	☐
In an institution	☐

ALL PERSONS SHOULD ANSWER THE FOLLOWING QUESTION

30. With whom do you now live:

Alone	☐
Parents or In-laws	☐
Own marital home	☐
Other relatives	☐
Foster parents	☐
Friends of same sex only	☐
" of opposite sex only	☐
Friend(s) of both sexes	☐

31. What kind of accommodation do you live in

High-rise Flat	☐
Tenement Building	☐
Terraced or semi-detached	☐
Detached	☐
Hostel	☐
Main Door Flat	☐
Rooms	☐
Other (Please specify	☐

32. Where did you live and grow up as a child. (If in Glasgow, give Postal Code, if you know it. If you do not live in Glasgow, please give the name of the town or nearest town

District of Glasgow ☐ Postal Code ☐

Town or nearest town ☐

P.T.O.

33. Where are you living at the present time? District of Glasgow [ ] Postal Code [ ]

34. Do you belong to any of the following organisations or social groups? (Tick the appropriate box or boxes; if none, tick None.

- Youth Club [ ]
- Political organization [ ]
- Church or Religious organization [ ]
- Sports or Athletic Club [ ]
- Cultural Organization [ ]
- None [ ]
- Other (please specify) [ ]

35. Have you ever been a member of a Gang sometimes known as 'Tongs'

- Yes [ ]
- No [ ]

36. Have you ever previously attended a clinic for the treatment of a Venereal Disease

- No [ ]
- Yes, Once [ ]
- Yes, more than once [ ]

37. Have you ever had pre-marital or extra marital sexual intercourse

- Yes [ ]
- No [ ]

PLEASE READ CAREFULLY. If you have answered YES to Question 37, you should also answer the following questions. Otherwise please pass to Question 43.

38. Did this take place

- Within past week [ ]
- Within past month [ ]
- Within past 3 months [ ]
- Within past 6 months [ ]
- More than 6 months ago [ ]

39. How old were you when you first had sexual intercourse? State whether heterosexual or anal. homosexual(anal)

- Age [ ]
- Het'l [ ]
- Hom'l [ ]

40. How many sexual partners have you had? (heterosexual or homosexual)

	Het'l	Hom'l
Past week	[ ]	[ ]
Past month	[ ]	[ ]
Past 3 months	[ ]	[ ]

P.T.O.

	Het'l	Hom'l
41. How many times have you had sex within the past three months?		
Not at all	☐	☐
Once	☐	☐
Between 1 & 5 times	☐	☐
Between 6 & 10 "	☐	☐
More than 10 "	☐	☐
42. How many sexual partners have you had within the past three months?		
None	☐	☐
One	☐	☐
Between 1 & 5 partners	☐	☐
Between 6 & 10 partners	☐	☐
More than 10 partners	☐	☐

ALL PERSONS SHOULD ANSWER THE NEXT QUESTIONS:

43. Do you smoke?

- No ☐
- Yes, occasionally ☐
- Yes, regularly ☐

44. Do you drink alcohol?

- No ☐
- Yes, occasionally ☐
- Yes, regularly ☐

IF YOU ANSWERED <u>YES</u> to Question 44, answer Question 45; otherwise pass to Question 46.

45. Which kind of alcohol are you most likely to drink?

- Beer ☐
- Wines ☐
- Spirits ☐
- Combination of all 3. ☐

46. Have you ever taken or used drugs which were not prescribed for you by a doctor - excluding, aspro, aspirin, cough medicines, etc.

- Yes ☐
- No ☐

<u>PLEASE READ CAREFULLY.</u> If you have answered YES to Question 46, you should answer the following questions; otherwise pass to Question 50.

47. Did you take or use them

- Within past week ☐
- Within past month ☐
- Within past 3 months ☐
- Within past 6 months ☐
- More than 6 months ago ☐

P.T.O.

48. How many times have you taken or used drugs within the past three months

- Not at all ☐
- Once ☐
- Between 1 & 5 times ☐
- Between 6 & 10 times ☐
- More than 10 times ☐

49. Which of the following drugs have you experienced which have not been specifically prescribed for you

	Occas-ionally	Regularly
Cannabis/Pot/Hash		
Amphetamine/Speed/Pep		
LSD/Acid		
Tranquillizers		
Barbiturates		
Other sleeping pills		
Heroin or morphine		
Glue/Thinners (Sniffing)		

50. Have you ever been offered drugs

- Yes ☐
- No ☐

51. Do you know where you could obtain drugs if you wanted them?

- Yes ☐
- No ☐

52. At which three of the following places are drugs most easily available. Put a 1 in the box for place where drugs are most easily available, 2 for your second choice and 3 for your third.

- Parties ☐
- Dances ☐
- Pubs ☐
- The Street ☐
- Cafes ☐
- Other places - specify ☐
- Dont know ☐

P.T.O.

ALL PERSONS SHOULD ANSWER THE NEXT QUESTION

53. Have you ever appeared before a Court or Children's Panel charged with an offence?

Yes (Once)	
Yes (more than once)	
No	

PLEASE READ CAREFULLY. If you have answered YES to Question 53, you should answer the remaining two questions.

54. If you have so appeared before a Court or Children's Panel, what was the exact nature of the offence.

55. How did the Court find you?

Not Guilty	
Guilty	
Not Proven	

ALL PERSONS PLEASE READ

WE SHOULD LIKE TO THANK YOU FOR COMPLETING THIS QUESTIONNAIRE. PLEASE BE ASSURED OF THE ENTIRE AND ABSOLUTE CONFIDENTIALITY OF YOUR ANSWERS. AS SOON AS THIS INFORMATION IS FED INTO A COMPUTER ALL QUESTIONNAIRES WILL BE DESTROYED. IN ANY EVENT, NO IDENTIFYING MARKS ARE PUT ON INDIVIDUAL DOCUMENTS - THEY ARE COMPLETELY ANONYMOUS.

PLEASE READ CAREFULLY

We would like you to describe as accurately as you can the kind of person that you are.

HERE IS A PRACTICE QUESTION:

THE KIND OF PERSON I AM

Relaxed ☐ ☐ ? ☐ ☐ Tense

If you are a relaxed kind of person, put a tick (like this ✓) in one of the boxes on the LEFT (the extreme left box would represent very relaxed and the box just left of the centre would represent fairly relaxed.)

If however, you regard yourself as being a tense kind of person, put a tick in one of the boxes on the RIGHT (the extreme right box would represent very tense and the box just right of centre would represent fairly tense.)

Most people are able to decide between two alternative descriptions as to which describes them most accurately, that is to say, what kind of person they are. If you cannot decide between two descriptions then put a circle round the question mark (like this (?)) BUT YOU SHOULD HARDLY EVER-IF AT ALL FIND IT NECESSARY TO USE THE QUESTION MARK.

That question was just for practice. Now put a tick by each of these questions using the box which you believe best describes the kind of person you are.

THE KIND OF PERSON I AM

A practical person	☐ ☐ ? ☐ ☐	Not a very practical person
Intelligent	☐ ☐ ? ☐ ☐	Not so intelligent
Follower	☐ ☐ ? ☐ ☐	Leader
Relaxed	☐ ☐ ? ☐ ☐	Tense
Often lose temper	☐ ☐ ? ☐ ☐	Seldom lose temper
Not very self-confident	☐ ☐ ? ☐ ☐	Self confident
Like excitement	☐ ☐ ? ☐ ☐	Do not like excitement
Have many friends	☐ ☐ ? ☐ ☐	Have few friends
Act on the spur of the moment	☐ ☐ ? ☐ ☐	Think carefully before acting

PLEASE TURN OVER

Still thinking about the KIND OF PERSON I AM ...

An interesting person	☐☐ ? ☐☐	Not a very interesting person
Usually plan ahead	☐☐ ? ☐☐	Do not usually plan ahead
Often think about the future	☐☐ ? ☐☐	Seldom think about the future
Easily influenced by others	☐☐ ? ☐☐	Not easily influenced by others
Ambitious	☐☐ ? ☐☐	Not very ambitious
Often have sex	☐☐ ? ☐☐	Seldom have sex
Active	☐☐ ? ☐☐	Not very active
Enjoy meeting people	☐☐ ? ☐☐	Do not enjoy meeting people
Often takes chances	☐☐ ? ☐☐	Seldom takes chances
Not Very happy	☐☐ ? ☐☐	Quite happy
Often successful	☐☐ ? ☐☐	Often a failure
Seldom lonely	☐☐ ? ☐☐	Often lonely
Considerate	☐☐ ? ☐☐	Rather thoughtless
Often depressed	☐☐ ? ☐☐	Seldom depressed

/PLEASE TURN OVER ...

Still thinking about THE KIND OF PERSON I AM ....

Trusting of others	☐☐ ? ☐☐	Not very trusting of others
Prefer company	☐☐ ? ☐☐	Prefer to be alone
Able to attract members of the opposite sex	☐☐ ? ☐☐	Do not attract members of the opposite sex
Not very serious minded	☐☐ ? ☐☐	Serious minded
Seldom think about sex	☐☐ ? ☐☐	Often think about sex
Aggressive	☐☐ ? ☐☐	Peaceful
Do not enjoy doing things that are forbidden	☐☐ ? ☐☐	Enjoy doing things that are forbidden

PLEASE TURN OVER/

PLEASE READ CAREFULLY

People have different ideas about many things. Here is a list of ideas that some people believe in. You will probably agree with some of them and disagree with others. Sometimes you may agree strongly and at other times you may disagree strongly. Now and then you may be uncertain as to whether you agree or disagree and we have prepared a box for this purpose. You should use this box as little as possible by trying to make up your mind one way or another and most people will be able to do this. Read each of these sentences carefully then put a tick in the appropriate column - that is, the one that agrees with your own point of view.

IMPORTANT Please remember that we want to know what you think about thsse statements. THERE ARE NO RIGHT OR WRONG ANSWERS - ONLY POINTS OF VIEW.

	Strongly Agree	Agree	Uncertain	Disagree	Strongly Disagree
It is better to live for today rather than to think too much about the future					
Older people tend to judge the younger generation by their appearance					
Life is more interesting when you are doing risky and exciting things					
I will not mind very much if my children have sex before they marry					
Those in positions of authority should be given proper respect because of the position they hold					
If you don't watch out for yourself people will tread all over you					
The 'pill' has made it much easier to have sex whenever you feel like it					
"What has got to be will be", so there is no point in trying to plan the future					
It is safer and wiser to do as you are told					

PLEASE READ CAREFULLY

	Strongly Agree	Agree	Uncertain	Disagree	Strongly Disagree
Anyone who 'sleeps around' deserves to become infected with a sexually transmitted disease					
The future is so much a matter of luck that it is not worth thinking too much about					
It is important to let people know that they can't push you around					
If drugs give you a new experience they are worth trying					
There is nothing wrong with having sex with a number of persons whether you happen to be married or not					
Hard work is the only way to achieve an ambition					
People who take chances in life have more fun than those who put safety first					
If you get into a tight spot, it is better to hit first and ask questions later					
Adulterers should be severely punished and not excused					
Young people who drink and go into pubs are much more grown up and mature than those who don't					
Everybody should have the opportunity for regular sex					

PLEASE TURN OVER ...

We would now like you to answer the following questions by putting a ring round either TRUE or FLASE whichever is right for you. Here is a practice question:-

I AM A FAIRLY REGULAR DRINKER

If you are a fairly regular drinker or, for that matter, a very regular drinker, you should put a ring roun TRUE (like this (true)). If, however, you are not a fairly regular drinker, or if you do not drink at all, you should put a ring round FALSE (like this (false)).

That was just a practice question, now read each statement carefully and answer it as accurately as you can.

REMEMBER, we are not interested in knowing how particular individuals answer these questions and again we assure you that all your answers throughout the entire questionnaire are STRICTLY PRIVATE AND CONFIDENTIAL.

I sometimes use sex to escape from reality	TRUE	FALSE
I quite often get into arguments and fights	TRUE	FALSE
I have often felt lonely even when with other people	TRUE	FALSE
The contraceptive pill makes me less anxious about sex than I think would have been the case before it came available	TRUE	FALSE
I often feel misunderstood by others	TRUE	FALSE
I get a feeling of satisfaction out of breaking things when I am in a temper	TRUE	FALSE
The future has no real shape for me but is rather like looking into a fog	TRUE	FALSE
I feel that I ought to enjoy sex more than I do	TRUE	FALSE
I get tense and anxious when I think of what the future might hold for me	TRUE	FALSE
I frequently feel tired in the mornings yet can't sleep at night	TRUE	FALSE
I find that I am quite easily sexually aroused and excited by things that I see such as sexy television commercials, plays or films, adverts in magazines etc.	TRUE	FALSE
I need friends more than they appear to need me	TRUE	FALSE
I am much more likely to have sex with someone after I have had a few drinks	TRUE	FALSE
I would rather just 'live' with an individual rather than be 'tied' by marriage	TRUE	FALSE
If I knew that drugs could make sex more pleasurable and were available to me, I would try them	TRUE	FALSE

PLEASE TURN OVER/

PLEASE READ CAREFULLY

I quite often have unpleasant dreams which disturb my sleep TRUE FALSE

I quite easily get hurt by things people say and do TRUE FALSE

I only have sex when I can enjoy it and not just to please my sexual partner TRUE FALSE

I tend to make at least some plans for the future rather than just live from day to day TRUE FALSE

When I have a drink of spirits or beer I am more likely to do so to help me relax rather than because I enjoy the taste TRUE FALSE

P.E.N. INVENTORY

Name_____ Age_____ Sex_____ P =
E =
N =
L =

INSTRUCTIONS

Please answer each question by putting a circle around the 'YES' or the 'NO' following the question. There are no right or wrong answers, and no trick questions. Work quickly and do not think too long about the exact meaning of the question.

REMEMBER TO ANSWER EACH QUESTION

1. Are you more distant and reserved than most people? YES NO
2. Do you find it hard to get going some mornings? YES NO
3. Do most things taste the same to you? YES NO
4. If you say you will do something do you always keep your promise, no matter how inconvenient it might be to do so? YES NO
5. Can you get a party going? YES NO
6. Can you usually make up your mind easily? YES NO
7. Do you enjoy hurting people you love? YES NO
8. Once in a while do you lose your temper and get angry? YES NO
9. Would you do almost anything for a dare? YES NO
10. Have you ever been afraid of losing your mind? YES NO
11. Are you generally in good health? YES NO
12. Do you occasionally have thoughts and ideas that you would not like other people to know about? YES NO
13. Would you enjoy hunting, fishing and shooting? YES NO
14. Do you do much day dreaming? YES NO
15. Was your mother a good woman? YES NO
16. Are ALL your habits good and desirable ones? YES NO
17. Do you nearly always have a "ready answer" when people talk to you? YES NO
18. Do you find it hard to keep your mind on what you are doing? YES NO
19. Have you had more trouble than most? YES NO
20. Do you sometimes gossip? YES NO
21. Are you rather lively? YES NO
22. Are you ever "off your food"? YES NO
23. Do you worry a lot about catching diseases? YES NO
24. Would you always declare EVERYTHING at the customs, even if you knew that you could never be found out? YES NO
25. Do you like plenty of bustle and excitement around you? YES NO
26. Do you often feel fed up? YES NO
27. Do you like mixing with people? YES NO
28. Have you had an awful lot of bad luck? YES NO
29. Have you ever been late for an appointment or work? YES NO
30. Do you get depressed in the mornings? YES NO
31. Are there several people who keep trying to avoid you? YES NO
32. Of all the people you know, are there some whom you definitely do not like? YES NO

PLEASE TURN OVER

33. Would you call yourself happy-go-lucky? YES NO
34. Does your mood often go up and down? YES NO
35. Do you let your dreams warn or guide you? YES NO
36. Do you sometimes talk about things you know nothing about? YES NO
37. Can you usually let yourself go and enjoy yourself a lot at a gay party? YES NO
38. Do you sometimes feel you don't care what happens to you? YES NO
39. Is there someone who is responsible for most of your troubles? YES NO
40. As a child, did you always do as you were told immediately and without grumbling? YES NO
41. Do you like people around you? YES NO
42. Do you ever feel "just miserable" for no good reason? YES NO
43. Do people generally seem to take offence easily? YES NO
44. Do you sometimes get cross? YES NO
45. Do you like going out a lot? YES NO
46. Are you often troubled about feelings of guilt? YES NO
47. Would you take drugs which may have strange or dangerous effects? YES NO
48. Do you sometimes laugh at a dirty joke? YES NO
49. Do you like practical jokes? YES NO
50. Do you feel self pity now and again? YES NO
51. Did you love your mother? YES NO
52. Are you completely free from prejudices of any kind? YES NO
53 Do you normally prefer to be alone? YES NO
54. Do you worry a lot about your looks? YES NO
55. Do you have enemies who wish to harm you? YES NO
56. Do you sometimes boast a little? YES NO
57. Do you find it hard to show your feelings? YES NO
58. Do you often feel very weak all over? YES NO
59. Do your friendships break up easily without it being your fault? YES NO
60. Do you always answer a personal letter as soon as you can after you have read it? YES NO
61. Would you call yourself talkative? YES NO
62. Do you sometimes feel uneasy indoors? YES NO
63. Do people mean to say and do things to annoy you? YES NO
64. Do you sometimes put off until tomorrow what you ought to do today? YES NO
65. When you were a child did you often like a rough and tumble game? YES NO
66. Have you always thought of yourself as different to others? YES NO
67. Was your father a good man? YES NO
68. Have you sometimes told lies in your life? YES NO
69. Do you like telling jokes or funny stories to your friends? YES NO
70. Have you ever wished you were dead? YES NO
71. Would you have been more successful if people had not put difficulties in your way? YES NO
72. Would you rather win than lose a game? YES NO
73. Do you make friends easily with members of your own sex? YES NO
74. Do you usually work by fits and starts? YES NO
75. Would it upset you a lot to see a child or animal suffer? YES NO
76. When you make new friends do you usually make the first move? YES NO
77. When you are in a crowded place like a bus do you worry about dangers of infection? YES NO



SELF ANALYSIS FORM

NAME _____ TODAY'S DATE _____
First Middle Last

SEX _____ AGE _____ OTHER FACTS _____
(Write M or F) (Nearest Year) (Address, Occupation, etc., as instructed)

CONFIDENTIAL

Inside this booklet you will find forty questions, dealing with difficulties that most people experience at one time or another. It will help a lot in self-understanding if you check Yes, No, etc., to each, frankly and truthfully, to describe any problems you may have.

Start with the two simple examples just below, for practice. As you see, each inquiry is actually put in the form of a sentence. By putting a cross, X, in one of the three boxes on the right you show how it applies to you. Make your marks now.

1. I enjoy walking _____ Yes ☐ Occasionally ☐ No ☐

A middle box is provided for when you cannot definitely say Yes or No. But use it as little as possible.

2. I would rather spend an evening:
(A) talking to people, (B) at a movie _____ A ☐ In between ☐ B ☐

About half the items inside end in A and B choices like this. B is always on the right. Remember, use the "In between" or "Uncertain" box only if you cannot possibly decide on A or B.

Now:

1. Make sure you have put your name, and whatever else the examiner asks, in the place at the top of this page.
2. Never pass over an item but give some answer to every single one. Your answers will be entirely confidential.
3. Do not spend time pondering. Answer each immediately, the way you want to at this moment (not last week, or usually). You may have answered questions like this before; but answer them as you feel *now*.

   Most people finish in five minutes; some, in ten. Hand in this form as soon as you are through with it, unless told to do otherwise. As soon as the examiner signals or tells you to, turn the page and begin.

STOP HERE & WAIT FOR SIGNAL

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		A		Do not write in this column
1. I find that my interests, in people and amusements, tend to change fairly rapidly	True ☐	In between ☐	False ☐	
2. If people think poorly of me I can still go on quite serenely in my own mind	True ☐	In between ☐	False ☐	
3. I like to wait till I am sure that what I am saying is correct, before I put forward an argument	Yes ☐	In between ☐	No ☐	G(−)
4. I am inclined to let my actions get swayed by feelings of jealousy	Sometimes ☐	Seldom ☐	Never ☐	
5. If I had my life to live over again I would: (A) plan very differently, (B) want it the same	A ☐	In between ☐	B ☐	
6. I admire my parents in all important matters	Yes ☐	In between ☐	No ☐	C(−)
7. I find it hard to "take 'no' for an answer", even when I know what I ask is impossible	True ☐	In between ☐	False ☐	
8. I doubt the honesty of people who are more friendly than I would naturally expect them to be	True ☐	In between ☐	False ☐	
9. In demanding and enforcing obedience my parents (or guardians) were: (A) always very reasonable, (B) often unreasonable	A ☐	In between ☐	B ☐	L
10. I need my friends more than they seem to need me	Rarely ☐	Sometimes ☐	Often ☐	
11. I feel sure that I could "pull myself together" to deal with an emergency	Always ☐	Often ☐	Seldom ☐	
12. As a child I was afraid of the dark	Often ☐	Sometimes ☐	Never ☐	
13. People sometimes tell me that I show my excitement in voice and manner too obviously	Yes ☐	Uncertain ☐	No ☐	O
14. If people take advantage of my friendliness I: (A) soon forget and forgive, (B) resent it and hold it against them	A ☐	In between ☐	B ☐	
15. I find myself upset rather than helped by the kind of personal criticism that many people make	Often ☐	Occasionally ☐	Never ☐	
16. Often I get angry with people too quickly	True ☐	In between ☐	False ☐	
17. I feel restless as if I want something but do not know what	Very rarely ☐	Sometimes ☐	Often ☐	
18. I sometimes doubt whether people I am talking to are really interested in what I am saying	True ☐	In between ☐	False ☐	Q
19. I have always been free from any vague feelings of ill-health, such as obscure pains, digestive upsets, awareness of heart action, etc.	True ☐	Uncertain ☐	False ☐	
20. In discussion with some people, I get so annoyed that I can hardly trust myself to speak	Sometimes ☐	Rarely ☐	Never ☐	
			A Score	

CONTINUE ON NEXT PAGE.

B

21. Through getting tense I use up more energy than most people in getting things done	True ☐	Uncertain ☐	False ☐
22. I make a point of not being absent-minded or forgetful of details	True ☐	Uncertain ☐	False ☐
23. However difficult and unpleasant the obstacles, I always stick to my original intentions	Yes ☐	In between ☐	No ☐
24. I tend to get over-excited and "rattled" in upsetting situations	Yes ☐	In between ☐	No ☐
25. I occasionally have vivid dreams that disturb my sleep	Yes ☐	In between ☐	No ☐
26. I always have enough energy when faced with difficulties	Yes ☐	In between ☐	No ☐
27. I sometimes feel compelled to count things for no particular purpose	True ☐	Uncertain ☐	False ☐
28. Most people are a little queer mentally, though they do not like to admit it	True ☐	Uncertain ☐	False ☐
29. If I make an awkward social mistake I can soon forget it	Yes ☐	In between ☐	No ☐
30. I feel grouchy and just do not want to see people: (A) occasionally, (B) rather often	A ☐	In between ☐	B ☐
31. I am brought almost to tears by having things go wrong	Never ☐	Very rarely ☐	Sometimes ☐
32. In the midst of social groups I am nevertheless sometimes overcome by feelings of loneliness and worthlessness	Yes ☐	In between ☐	No ☐
33. I wake in the night and, through worry, have some difficulty in sleeping again	Often ☐	Sometimes ☐	Never ☐
34. My spirits generally stay high no matter how many troubles I meet	Yes ☐	In between ☐	No ☐
35. I sometimes get feelings of guilt or remorse over quite small matters	Yes ☐	In between ☐	No ☐
36. My nerves get on edge so that certain sounds, e.g., a screechy hinge, are unbearable and give me the shivers	Often ☐	Sometimes ☐	Never ☐
37. If something badly upsets me I generally calm down again quite quickly	True ☐	Uncertain ☐	False ☐
38. I tend to tremble or perspire when I think of a difficult task ahead	Yes ☐	In between ☐	No ☐
39. I usually fall asleep quickly, in a few minutes, when I go to bed	Yes ☐	In between ☐	No ☐
40. I sometimes get in a state of tension or turmoil as I think over my recent concerns and interests	True ☐	Uncertain ☐	False ☐

STOP HERE. BE SURE YOU HAVE ANSWERED EVERY QUESTION.

B Score

GENERAL HEALTH QUESTIONNAIRE

Please read this carefully:

We should like to know if you have had any medical complaints, and how your health has been in general, over the past few weeks. Please answer ALL the questions on the following pages simply by underlining the answer which you think most nearly applies to you. Remember that we want to know about present and recent complaints, not those that you had in the past.

It is important that you try to answer ALL the questions.

Thank you very much for your co-operation.

HAVE YOU RECENTLY:-

1. - been feeling perfectly well and in good health?	Better than usual	Same as usual	Worse than usual	Much worse than usual
2. - been feeling in need of a good tonic?	Not at all	No more than usual	Rather more than usual	Much more than usual
3. - been feeling run down and out of sorts?	Not at all	No more than usual	Rather more than usual	Much more than usual
4. - felt that you are ill?	Not at all	No more than usual	Rather more than usual	Much more than usual
5. - been getting any pains in your head?	Not at all	No more than usual	Rather more than usual	Much more than usual
6. - been getting a feeling of tightness or pressure in your head?	Not at all	No more than usual	Rather more than usual	Much more than usual
7. - been able to concentrate on whatever you're doing?	Better than usual	Same as usual	Less than usual	Much less than usual
8. - been afraid that you were going to collapse in a public place?	Not at all	No more than usual	Rather more than usual	Much more than usual
9. - been having hot or cold spells?	Not at all	No more than usual	Rather more than usual	Much more than usual
10. - been perspiring (sweating) a lot?	Not at all	No more than usual	Rather more than usual	Much more than usual

PLEASE TURN OVER

HAVE YOU RECENTLY:-

11. - found yourself waking early and unable to get back to sleep?	Not at all	No more than usual	Rather more than usual	Much more than usual
12. - been getting up feeling your sleep hasn't refreshed you?	Not at all	No more than usual	Rather more than usual	Much more than usual
13. - been feeling too tired and exhausted even to eat?	Not at all	No more than usual	Rather more than usual	Much more than usual
14. - lost much sleep over worry?	Not at all	No more than usual	Rather more than usual	Much more than usual
15. - been feeling mentally alert and wide awake?	Better than usual	Same as usual	Less alert than usual	Much less alert
16. - been feeling full of energy?	Better than usual	Same as usual	Less energy than usual	Much less energetic
17. - had difficulty in getting off to sleep?	Not at all	No more than usual	Rather more than usual	Much more than usual
18. - had difficulty in staying asleep once you are off?	Not at all	No more than usual	Rather more than usual	Much more than usual
19. - been having frightening or unpleasant dreams?	Not at all	No more than usual	Rather more than usual	Much more than usual
20. - been having restless, disturbed nights?	Not at all	No more than usual	Rather more than usual	Much more than usual
21. - been managing to keep yourself busy and occupied?	More so than usual	Same as usual	Rather less than usual	Much less than usual
22. - been taking longer over the things you do?	Quicker than usual	Same as usual	Longer than usual	Much longer than usual
23. - tended to lose interest in your ordinary activities?	Not at all	No more than usual	Rather more than usual	Much more than usual
24. - been losing interest in your personal appearance?	Not at all	No more than usual	Rather more than usual	Much more than usual
25. - been taking less trouble with your clothes?	More trouble than usual	About same as usual	Less trouble than usual	Much less trouble
26. - been getting out of the house as much as usual?	More than usual	Same as usual	Less than usual	Much less than usual
27. - been managing as well as most people would in your shoes?	Better than most	About the same	Rather less well	Much less well
28. - felt on the whole you were doing things well?	Better than usual	About the same	Less well than usual	Much less well

HAVE YOU RECENTLY:-

29. - been late getting to work, or getting started on your housework?	Not at all	No later than usual	Rather later than usual	Much late than usua
30. - been satisfied with the way you've carried out your task?	More satisfied	About same as usual	Less satisfied than usual	Much le satisfi
31. - been able to feel warmth and affection for those near to you?	Better than usual	About same as usual	Less well than usual	Much less well
32. - been finding it easy to get on with other people?	Better than usual	About same as usual	Less well than usual	Much less well
33. - spent much time chatting with people?	More time than usual	About same as usual	Less than usual	Much less than usual
34. - kept feeling afraid to say anything to people in case you made a fool of yourself?	Not at all	No more than usual	Rather more than usual	Much more than usual
35. - felt that you are playing a useful part in things?	More so than usual	Same as usual	Less useful than usual	Much less useful
36. - felt capable of making decisions about things?	More so than usual	Same as usual	Less so than usual	Much less capable
37. - felt you're just not able to make a start on anything?	Not at all	No more than usual	Rather more than usual	Much more than usua
38. - felt yourself dreading everything that you have to do?	Not at all	No more than usual	Rather more than usual	Much more than usua
39. - felt constantly under strain?	Not at all	No more than usual	Rather more than usual	Much more than usua
40. - felt you couldn't overcome your difficulties?	Not at all	No more than usual	Rather more than usual	Much more than usua
41. - been finding life a struggle all the time?	Not at all	No more than usual	Rather more than usual	Much more than usua
42. - been able to enjoy your normal day-to-day activities?	More so than usual	Same as usual	Less so than usual	Much less than usua
43. - been taking things hard?	Not at all	No more than usual	Rather more than usual	Much more than usua
44. - been getting edgey and bad-tempered?	Not at all	No more than usual	Rather more than usual	Much more than usua
45. - been getting scared or panicky for no good reason?	Not at all	No more than usual	Rather more than usual	Much more than usua
46. - been able to face up to your problems?	More so than usual	Same as usual	Less able than usual	Much less able

PLEASE TURN OVER

HAVE YOU RECENTLY:-				
47. - found everything getting on top of you?	Not at all	No more than usual	Rather more than usual	Much more than usual
48. - had the feeling that people were looking at you?	Not at all	No more than usual	Rather more than usual	Much more than usual
49. - been feeling unhappy and depressed?	Not at all	No more than usual	Rather more than usual	Much more than usual
50. - been losing confidence in yourself?	Not at all	No more than usual	Rather more than usual	Much more than usual
51. - been thinking of yourself as a worthless person?	Not at all	No more than usual	Rather more than usual	Much more than usual
52. - felt that life is entirely hopeless?	Not at all	No more than usual	Rather more than usual	Much more than usual
53. - been feeling hopeful about your own future?	More so than usual	About same as usual	Less so than usual	Much less hopeful
54. - been feeling reasonably happy, all things considered?	More so than usual	About same as usual	Less so than usual	Much less than usual
55. - been feeling nervous and strung-up all the time?	Not at all	No more than usual	Rather more than usual	Much more than usual
56. - felt that life isn't worth living?	Not at all	No more than usual	Rather more than usual	Much more than usual
57. - thought of the possibility that you might make away with yourself?	Definitely not	I don't think so	Has crossed my mind	Definitely have
58. - found at times you couldn't do anything because your nerves were too bad?	Not at all	No more than usual	Rather more than usual	Much more than usual
59. - found yourself wishing you were dead and away from it all?	Not at all	No more than usual	Rather more than usual	Much more than usual
60. - found that the idea of taking your own life kept coming into your mind?	Definitely not	I don't think so	Has crossed my mind	Definitely has

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TEST OF SOCIAL INSIGHT

(Adult Edition)

DIRECTIONS

On the following pages are 60 questions about social situations. Each question is followed by five possible answers. Choose the ONE answer you consider the best. Mark your answers on the separate answer sheet. Record your choices by making a heavy black mark under the letter which corresponds to your answer.

Example:

a b c d e

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1. You approach a person of the opposite sex whom you mistook to be a new friend. After several minutes of conversation you discover your error. What do you do?

a. Apologize, and walk away.
b. Stop talking, and smile in a friendly way.
c. Apologize, and introduce yourself.
d. Insist that you recall the person, and try to remember from where.
e. Scold yourself for the mistake.

2. An instructor has given you a much lower grade than you feel you deserve. What do you do?

a. Insist that you receive a fair grade.
b. Ask the instructor for an explanation.
c. Do nothing, and act natural.
d. Transfer to another instructor.
e. Ask for an examination to show that you really know the materials.

3. Members of your family insist that you join them on a holiday picnic, but you prefer to remain home and rest. As the father of the family, what do you do?

a. Discuss the matter with the family, and give them your reasons.
b. Insist that they go without you.
c. Suggest that everyone go deep sea fishing with you.
d. Go along to the picnic, but sleep in the family car while there.
e. Tell them you have an important business matter for the day.

4. The boss has just scolded you severely in public for a mistake for which you indicated you were sorry. What do you do?

a. Pretend you hear him, but don't listen.
b. Say you are sick, and leave.
c. Tell him many other persons have made the same mistake.
d. Ask him to scold you in private.
e. Tell him you are very sorry, and that you will do better.

5. While visiting at the home of a close friend, a second guest, unknown to you, tries to sell a funeral plan. What do you do?

a. Listen to the sales speech.
b. Tell him you are not in the market for a funeral plan.
c. Tease the salesman about being rude to your friend's guests.
d. Talk with other persons during the sales speech.
e. Go home immediately, and give an excuse to your friend.

6. You believe that it was your pet dog that destroyed a neighbor's flower garden, but the dog was not actually observed. What do you do?

a. Explain your regrets, and offer to pay for the damages.
b. Suggest that the neighbor is at fault for not building a fence.
c. Say that there are many other dogs in the neighborhood.
d. Get rid of your dog, and say nothing.
e. Say nothing unless asked by the neighbor.

7. A bright student received an "A" last term. You observe him cheating in an examination. What action do you take?

a. Tell the student that cheating is a violation of self honor.
b. Report the incident to the instructor.
c. Transfer out of the class.
d. Do nothing unless asked by the instructor.
e. Ask the other students to hide their materials from the cheating student.

8. Other members of your family are eager to watch a special television show that comes on the same time as your favorite weekly program. What do you do?

a. Go out for the night on business.
b. Go to the local bar, and watch your favorite program there.
c. Say nothing, and look at the special program.
d. Invite the family to see a big stage show that is currently playing.
e. Insist that you watch your own favorite program.

9. Fellow employees are collecting money for an expensive gift to give a departing boss whom you dislike very much. What do you do?

a. Do what others are doing.
b. Refuse to donate, and say nothing.
c. Donate a very small sum, and say nothing.
d. Have a separate going-away party for the boss at your house.
e. Refuse to donate, and explain exactly how you feel.

10. The school principal has called you to say that your "teen" age boy is playing "hookie" for the third day this week. What do you do?

a. Insist that your boy quit school and get a job if he plays "hookie."
b. Ask your son to decide if he wants to go to school or quit.
c. Call your son in, and ask for an explanation.
d. Call your son in, and punish him severely.
e. Ask your son to act as his own policeman, and to report to you the next time he plays "hookie."

11. Several adults in a mixed sex group are telling dirty (sexy) stories. You don't think this is respectable. What do you do?

a. Walk away, and say nothing.
b. Remain, but do not participate.
c. Try to tell better stories than they do.
d. Tell them you do not approve of telling such stories.
e. Tell them that such behavior is very childish, and they ought to be ashamed.

12. You observe two boys from your neighborhood shop-lifting (stealing) in a nearby store. What do you do?

a. Do nothing, and mind your own business.
b. Call the police, and report the incident.
c. Leave the store, and forget the incident.
d. Ask the boys to return the stolen materials.
e. Give the boys a lecture on honesty loud enough for others to hear.

13. You find yourself at the circus sitting next to a friend who is married, but he is obviously dating another woman. What do you do?

a. Ask him about his wife and family.
b. Try to change your seats.
c. Make sarcastic remarks about false husbands that he can hear.
d. Pretend you do not notice him.
e. Act natural, and do not embarrass him.

14. A fellow employee often tries to give you orders. What do you do?

a. Pretend you don't hear what he says.
b. Walk away, and say nothing.
c. Tell him to mind his own business.
d. Order him around.
e. Discuss the matter in a friendly way with the boss.

15. You have forgotten to attend a party given by a close friend. You wanted very much to attend. What do you do?

a. Call the friend and apologize; and request that you be invited to the next party he gives.
b. Say you had an important meeting, and could not make his party.
c. Do nothing.
d. Insist that your friend was at fault for not calling to remind you.
e. Avoid seeing your friend so that you will not have to explain.

16. While studying in a crowded library, you are disturbed by a loud talker. What do you do?

a. Check out some books, and go home.
b. Look for a quiet corner to study in.
c. Ask the loud person to be quiet.
d. Talk very loudly yourself.
e. Call the librarian, and insist that the talking be stopped.

17. In a social game of poker you observe a friend cheating several times. What do you do?

a. Pretend you do not notice.
b. Quit playing, say you are sick, and go home.
c. Say you are tired of playing, and drop out of the game.
d. Start cheating yourself.
e. Ask your friend why he is cheating.

18. You have worked many hours in a church charity drive, but your name did not appear in a news release along with the names of many other members who have worked less than you. What do you do?

a. Ask the director for an explanation.
b. Do or say nothing.
c. Start going to another church.
d. Try to work harder in the next church program.
e. Call the person in charge, and tell him off in a very angry way.

19. You overhear a conversation among some strangers in which you feel that a close friend of yours is being talked about very unfairly. What do you do?

a. Say nothing, but listen very carefully.
b. Tell the strangers that the person about whom they are speaking is a friend of yours, and that they are "dead" wrong.
c. Walk away, and don't listen.
d. Tell the strangers some of the other rumors about your friend.
e. Get angry at the strangers, and tell them off.

20. Your boss has invited you and your wife to his home for dinner, but your wife can not stand his wife. What do you do?

a. Tell the boss you have another engagement.

b. Take your wife to the dinner, but insist that she not argue with his wife.

c. Go to their home for dinner, and act natural.

d. Accept the invitation only if they will come to your house the following week for dinner.

e. Insist that your wife get along with his wife so as not to jeopardize your job.

21. A friend calls you a liar in the presence of other friends. What do you do?

a. Get into a fight immediately.

b. Tell him you feel sure he has told many lies.

c. Ask him to explain what he means by the accusation.

d. Pretend you don't hear what he says.

e. Walk away, and say nothing.

22. You overhear a female "teen" age "hoodlum" swearing at the wife of the church pastor. As the mother of another "teen" age girl, what do you do?

a. Ask the girl to stop using such foul language.

b. Do nothing.

c. Beat her if she insists on continuing such behavior.

d. Threaten to tell her parents if she doesn't stop.

e. Leave the scene, and pretend you don't hear the swearing.

23. You are strongly against the use of alcoholic drinking of any kind, but two of your friends insist that you have a highball with them to celebrate an important event. What do you do?

a. Leave, and go home.

b. Do not pay any attention to your friends.

c. Explain your belief about drinking, and do not take the drink.

d. Take the drink

e. Get angry with your friends, and insist on your rights.

24. Lately your superior has been scolding you for many small things he doesn't seem to mention to others. What do you do?

a. Threaten to quit if he doesn't stop.

b. Ask for an explanation of his recent criticism.

c. Look for another job, and say nothing.

d. Discuss the unfairness with your wife.

e. Discuss the unfairness with your superior's boss.

25. You learn that a long time friend has a five year prison record. This shocks you. What do you do?

a. Avoid seeing the friend in the future.

b. Gradually break off your friendship.

c. Tell him how you feel about it.

d. Criticize your friend for not telling you.

e. Pass the story on to other friends.

26. You learn that a friend of yours is illegally using narcotics. What do you do?

a. Suggest that he get medical help.

b. Say nothing, and keep the information in confidence.

c. Break off your relationship with this friend.

d. Turn your friend over to the law.

e. Invite your friend to live in your home, and offer to help him break the habit.

27. A friend tells you about a surprise party that is being planned for you. What do you do?

a. Express your anger, and tell him that it isn't fair for him to spoil the surprise.

b. Indicate that you already knew about the surprise.

c. Walk away, and avoid seeing him in the future.

d. Do nothing.

e. Pretend he is joking, and change the conversation immediately.

28. A friend has just bought a completely new outfit which you do not like. He asks your honest opinion. What do you do?

a. Discuss some part of the outfit you like.

b. Tell him you do not like it.

c. Tell about a nicer garment you purchased.

d. Change the conversation.

e. Walk away, and ignore the question.

29. Many close friends at work stop at a tavern each Thursday evening, and arrive home quite late. They insist on your joining them, but you are not interested. What do you do?

a. Stop with them for a short time, but go home early.

b. Say you are sorry, and go straight home.

c. Go with them to the tavern, but complain to your wife.

d. Go with them, and insist that they remain until the bar closes.

e. Agree to go for the one evening, but insist that it not be a regular event.

30. You see a badly crippled "teen" age boy being beaten by a younger uncrippled boy. What do you do?

a. Do nothing, but remain present.

b. Ask the younger uncrippled boy to stop fighting, and pick on someone his match.

c. Call the police, and report the fight.

d. Beat up the uncrippled boy yourself.

e. Walk away, and say nothing.

31. In the middle of an important public lecture you start coughing very loudly. What do you do?

a. Cough it out, and remain present.

b. Leave the audience until your cough is over.

c. Try to muffle your cough.

d. Get real angry with yourself.

e. Go to the doctor.

32. In an airplane flight during a bad storm you are thrown into the lap of a beautiful young lady. What do you do?

a. Apologize, and return to your seat.

b. Try to flirt with the lady.

c. Get angry, and blame the weather or the pilot.

d. Go to the rest room immediately.

e. Become embarrassed, and say nothing.

33. While playing volley ball in a friendly game you miss a very easy ball that loses that game. What do you do?

a. Apologize to your friends and team for the mistake.

b. Try to make it up by playing better.

c. Say nothing, and continue playing.

d. Pretend you are ill, and quit.

e. Get real angry at yourself.

34. You have been stopped for speeding by a policeman in an area where there are no speed limit signs posted. What do you do?

a. Tell the policeman that you did not know the speed limit.

b. Admit your mistake, and pay the fine.

c. Insist that nearly everyone speeds in that area.

d. Take the case to court, and prove you are innocent.

e. Tell the policeman you were in a hurry because of an emergency.

35. The person sitting next to you in a public bus is annoying you very much by chewing and cracking his gum quite loudly. What do you do?

a. Tell the person to quit chewing so loudly.

b. Chew gum just as loudly.

c. Say nothing, and remain.

d. Get off the bus, and take the next one.

e. Change seats immediately.

36. You feel a close friend, whom you are visiting for the weekend, is very rude to you. What do you do?

a. Go home immediately.

b. Remain for the weekend, and say nothing.

c. Discuss the rude incidents and how you feel about them with your friend.

d. Be rude to your friend.

e. Tell your friend off in an angry way.

37. You learn that the man you are about to marry has been divorced. He hasn't told you about it. What do you do?

a. Break your engagement immediately.
b. Keep seeing him, but act very cold until you are sure what you will do.
c. Ask him for an explanation of his actions and deceit, and base further actions on his explanations.
d Get real angry with him, and really tell him off.
e. Call an old boy friend, and tell him you have decided to date again.

38. You enjoy dancing very much, and so do your friends, but your husband almost never takes you dancing. When he does go, he rarely dances. What do you do?

a. Invite friends to the house who enjoy dancing.
b. Give up dancing, and develop other interests that suit him.
c. Insist that he take you to dances at least twice a month.
d. On the rare occasion your husband takes you to a dance, dance with friends who are good dancers.
e. Get active in church and other activities so that you have very little time on your hands.

39. You have been told that a friend has been spreading rumors about you that are not true. These tend to hurt your good name. What do you do?

a. Spread rumors about this friend.
b. Ask your friend for an explanation.
c. Call on your friend, and tell him off in an angry way.
d. Do nothing.
e. Avoid seeing your friend, and break off your friendship.

40. You have a "teen" age son who always plays with boys who are several years younger. You feel that he should have friends his own age. What do you do?

a. Discuss the matter with him, and ask him to try and find friends his own age.
b. Do nothing.
c. Insist that he not play with any boys who are younger than he.
d. Ask some girls to the house to teach him to dance.
e. Have him attend young people groups where he can meet boys his own age.

41. A family friend whom you dislike very much insists on trying to date you. What do you do?

a. Pretend you do not understand his intentions.
b. Pretend he is joking, and try to change the conversation.
c. Discuss the matter with him, and say you do not date family friends.
d. Tell him you have too many things to do right now for dating.
e. Tell him "no," and indicate that he is not your kind of person.

42. You observe a "teen" age neighbor's girl stealing money in your home while she is visiting your daughter. What do you do?

a. Pretend you did not see the stealing.
b. Insist that the girl leave your home, and not return.
c. Volunteer to give the girl money to buy what she wants.
d. Have your daughter watch her very carefully while she is in your home.
e. Call her parents, and discuss it.

43. You invite several house guests to have dinner at a nearby expensive restaurant. You discover that you have forgotten your wallet before the dinner starts. What do you do?

a. Try to get a check cashed.
b. Pretend you are sick, and leave before the meal.
c. Tell your friends about your plight, and ask for suggestions.
d. Go home, get your wallet, and come late to dinner.
e. Express anger with yourself.

44. You have a "teen" age son who is working after school in a grocery store. You feel he should pay a small portion of his earnings for room and board to help learn the value of money. What do you do?

a. Ask him to put half of his earnings in trust with you until he is older.
b. Hint that he pay some board money, but do no more.
c. Discuss your idea with him, and agree on an amount he should pay.
d. Ask him to buy any clothes or special things that he wants while he is working.
e. Don't mention a word to him, but expect him to offer to pay some money for his room and board.

45. In an important wedding procession you stumble and tear your garment very badly, causing you to be exposed. What do you do?

a. Try to hold the torn parts together.
b. Leave the torn parts as they are.
c. Get real angry about your clumsiness.
d. Leave the wedding procession at once.
e. Follow the suggestions of those who are close to you in the line.

46. You are asked to teach a regular class in your church, but you feel that you don't have the time for preparation. What do you do?

a. Ask that you be made a substitute teacher only.
b. Tell the person in charge that you do not have time.
c. Accept the class, and say nothing.
d. Start going to another church.
e. Tell them to get someone who doesn't do his share.

47. You are at home having a loud argument with your wife. You notice a visitor standing at the door. What do you do?

a. Walk away, and quit the argument.
b. Stay where you are, but stop the argument.
c. "Shush" your wife, and ask the visitor in.
d. Argue louder, hoping the visitor will be embarrassed and leave.
e. Change the argument to a discussion, and ask the visitor to give an opinion.

48. A game warden finds a large, out of season, recently caught fish in your possession. What do you do?

a. Tell him someone else caught the fish.
b. Tell him you were just going to throw it back into the water.
c. Pretend that you just got ill, or you would have thrown it back.
d. Explain that it was just caught, and ask what to do.
e. Do nothing, and wait for the game warden to speak.

49. A minority group member is being very friendly with you, but your wife insists that you break off his friendship at once. What do you do?

a. Act the same to the minority group member as to other persons.
b. Avoid seeing the person.
c. Invite the person to your home, so your wife can learn to know him.
d. Discuss the matter with your wife, and indicate how you feel.
e. Get angry with your wife, and tell her about equality.

50. The boss asks you to go home to remove an "off-shoulder" dress which you wore to work. What do you do?

a. Tell him your dress is none of his business.
b. Quit your job, and find another one.
c. Go home, change your dress, and return immediately.
d. Pretend you get sick, and stay home the rest of the week.
e. Tell him that many of the low-cut dresses that other girls in the place wear are worse than yours.

51. You want to play the lead in a community play, but you are asked to take a minor role by the director. What do you do?

a. Ask the director to try you in a more important role.
b. Take the minor part, and say nothing.
c. Get angry, and tell the director off.
d. Tell the director that the minor role is not important enough for your ability and experience.
e. Tell the director you will not have time to help out in the play.

52. Your father has just been sent to a long prison term for embezzlement. It is a big shock to you. What do you do?

a. Brag about your father's record.
b. Avoid any discussion about your father.
c. Tell persons who ask questions that it is none of their business.
d. Act natural, and answer all questions civilly.
e. Move out of town.

53. You are a young unmarried lady. Your married boss, whom you have refused to date, is showing much attention to you. What do you do?

a. Look for another job immediately.
b. Pretend you do not notice.
c. Ask him politely to treat you as he does all other employees.
d. Boast to your friends about his special favors.
e. Threaten to tell his superior if he doesn't quit flirting with you.

54. You observe a stranger leaving a restaurant with your new hat. There is a similar old hat on the rack. What do you do?

a. Call the police, and report him.
b. Ask him if he has your new hat which he mistook for his own.
c. Do nothing, and wait to see what he will do.
d. Tell him that he may have your new hat if he can't afford to buy one for himself.
e. Leave the restaurant, and don't eat there again.

55. After waiting in a very crowded restaurant for 20 minutes for the waitress to bring your order, she arrives with the wrong order. What do you do?

a. Insist that she make the correction immediately.
b. Walk out, leave the wrong order on table, and do not pay for it.
c. Say nothing, and accept the order.
d. Report the error to the manager.
e. See if you can make satisfactory exchanges at your table.

56. You see two fellow employees destroying company property; and you have been told that you are to be promoted in the near future. What do you do?

a. Tell them to stop destroying the property or you will report them.
b. Walk away, and say nothing.
c. Pretend you do not see what they are doing.
d. Report them to the management immediately.
e. Give them a good lecture for being so juvenile.

57. An older sister who lives in the same community and attends the same church, but who dislikes you very much, continually embarrasses you in public. What do you do?

a. Walk away, and say nothing.
b. Pretend you do not hear her.
c. Visit her, talk over the matter, and explain your feelings.
d. Tell her you will have to take her to court if she continues.
e. Try to get the church pastor to get her to stop embarrassing you.

58. You have been informed that because you are a member of a certain minority group you may not have the job which had been promised you before this minority group membership was known. What do you do?

a. Say nothing, and look for another job.
b. Scold the person who informed you.
c. Ask to discuss the matter with the employment manager.
d. Discuss the unfair practice with your friends and wife.
e. Report it to the newspapers.

59. The people who live in the next apartment are often noisy until far into the morning, and particularly during the weekends. What do you do?

a. Say nothing, and look for another apartment.
b. Say nothing, and remain.
c. Discuss the matter with the apartment manager.
d. Try to make some noise yourself the next weekend, so that they will understand how distracting it can be.
e. Call the neighbor on the phone when they are making the noise; express your annoyance.

60. Shortly after you have criticized a show for its rather poor performance, and while the listeners are still present, one of the actors from the show approaches, and asks for your honest opinion. What do you do?

a. Select a portion of the show which you feel was quite good, and discuss it.
b. Indicate how you think the show might be improved.
c. Be honest, and say you think it was pretty bad.
d. Ask for the opinion of others who are present.
e. Change the conversation, and talk about some other subject.

APPENDIX 4 (Cont'd)

Interview Schedule

(Part 1)

Homosexual and heterosexual subjects.

STRUCTURED INTERVIEW SCHEDULE.

This interview schedule is designed for use with both sexes. All responses to questions should be coded on the code sheet which is designed to take account of the answers given by homosexual and heterosexual subjects and - where appropriate - as they relate to both homosexuality and heterosexuality.

KNOWLEDGE OF SEXUALLY TRANSMITTED DISEASE:

1. The term "sexually transmitted diseases" refers to a group of diseases. Do you know the names of any of these diseases?

2. If no treatment is sought and received, how serious would you say that gonorrhoea is? (Repeat question for all STDs known to subject). Maximum 8 questions with above.

3. Compared with say two years ago do you think that STDs are .....

4. If on increase/decrease, why do you think they ate increasing/decreasing?

5. If increasing, does this make you feel ....

6. On these cards - passing cards to subject - you will see five age ranges. I want you to rank (order) them so as to indicate which age range is, in your opinion, the most affected by STDs.

7. Look at the first two choices and ask - Why did you put this card first and this card second?

8. Do you know how a person gets STDs?

9. How would a person know whether he/she had gonorrhoea - what are the symptoms? (Repeat question for all STDs known to subject: Maximum 7 questions in all).

SEXUAL ACTIVITY:

10. Have you had sexual intercourse with one or more persons in the past?

11. How old were you when you first had sexual intercourse? (if at all)

12. Was this heterosexual or anal intercourse?

13. What do you remember of it?

14. How did you feel afterwards?

15. How many sexual partners have you had? (differentiate between het. and hom.)

16. What kind of feelings do you have about your sexual activity over this period?

17. What kind of feelings have you experienced (on the whole) immediately afterwards?

SEXUAL ACTIVITY AND SEXUALLY TRANSMITTED DISEASES

18. Have you ever thought that you might have contracted a sexually transmitted disease?

19. When you first thought that you had an infection, were you .....

20. What did you first think of doing?

21. What in fact did you first do?

22. Where do you usually pick up your sexual partner(s)?

HISTORY OF TREATMENT FOR STDs

23. Have you ever received actual treatment in the past for a sexually transmitted disease? (Ask next five questions only if reply to question 23 is affirmative).

24. How old were you when you first contracted a sexually transmitted disease?

(Questions 10 - 17)
Included here to provide some basic sexual data because a substantial part of the heterosexual Group 2 sample were unwilling to complete part 2.

25. When did you last receive treatment?

26. Where did you receive treatment? (Name of town and hospital/clinic).

27. What were you treated for?

28. How many times have you been infected?

SEXUAL ACTIVITY OF MARRIED SUBJECTS

29. Do you have sex with your wife/husband?

30. Would you like to have more/less sex with your wife/husband?

31. Have you ever had sex with a person(s) other than your wife or husband?

32. If yes, has this been with .....

33. Did you have sex with your wife/husband before you married her/him?

34. Did you have sex with person(s) other than your wife/husband before you got married?

35. If occasionally/regularly to question 34 - ask was this with .....

36. Did your wife/husband have sex with person(s) other than yourself before you were married?

37. Has your wife/husband had sex with person(s) other than yourself since you were married?

38. How would you react to your wife/husband having sex with other person(s).....

39. Have you ever wished to have sexual intercourse with someone other than your husband/wife?

ALCOHOL DRINKING:

40. Do you drink alcohol?

41. Had you been drinking at the time of your first sexual intercourse?

42. Had your sexual partner been drinking?

43. Have you ever had sexual intercourse with a partner who was affected by drink at the time?

44. (If yes to question 43) Do you find sexual intercourse more enjoyable with a partner who is affected by drink?

45. Is/are your sexual partner(s) more co-operative and willing after he/she has had a drink or two?

46. Have you yourself had sexual intercourse whilst affected by drink?

47. What effect does alcohol have upon your desire for sexual intercourse?

48. What effect does alcohol have upon your sexual enjoyment?

DRUG MISUSE:

49. Have you ever been offered drugs (examples) by..

50. Have you ever taken such drugs yourself?

51. <u>If yes</u> - have you taken or used them...

If no - pass to question 59.

52. Which of the following drugs have you taken?

53. When did you last take drugs?

54. Have you ever had sex whilst under the influence of drugs?

55. Do you find the experience of sexual intercourse more enjoyable after you have taken drugs?

56. If yes to question 55, ask which drugs provide the best sex experience?

57. If yes to question 55, how do drugs make sex more enjoyable?

58. Are you more likely to have sex after you have taken drugs?

59. Have you ever had sex with a partner who was under the influence of drugs?

60. Do you find the experience of sexual intercourse more enjoyable with a partner who has taken drugs?

CONTRACEPTIVE PRACTICES:

61. Do you use some form of contraception?

62. If subject has answered yes to question 61, why?

63. If subject has answered no to question 61, why not?

64. Which form of contraception do you prefer?

NEED FOR HEALTH EDUCATION - ALL SUBJECTS

65. Were you provided with a basic health education?

66. Did this include information/education about sex? Have you at any time made a positive and deliberate attempt to obtain information/education relating to sexual health and hygiene?

(Subjects with current or past history of infection)

67. Was this before or after you thought you might have an infection?

(All Subjects)

68. From which source did you obtain your information and were you satisfied or dissatisfied with the result?

69. What aspects of sexual hygiene/health do you most require information about?

70. What for you would be the most effective means of information transmission?

71. Has such health educ/info as you may have received been satisfactory?
Not very S
Not at all S
None received

72. On the basis of your own beliefs/opinions experience, is there a need for more effective H E sex educ. information service?

Physical Appearance:

Manner:

Dress:

Other relevant details:

Interview Schedule

(Part 2)

INTERVIEW SCHEDULE (Part 2)

All Subjects

1. How old were your parents in the year of your birth?

2. By whom were you raised?

3. How many brothers/sisters do you have?

4. What is your position (ordinal) within the family?

5. How would you describe your mothers behaviour within the home?

6. As above, but for father.

7. Who tends to make the decisions in your family home?

8. Has either parent been absent from home for more than a few days at a time?

9. What was the reason for absence?

10. How old were you when first you experienced sexual arousal to a male stimulus
    b female "

11. How old were you when first you actually responded (masterbation, intercourse etc.) to such arousel?

12. How old were you when (if at all) you first had heterosexual intercourse?

(If answer to No 11 is in the affirmative)

13. Was your sexual partner older/younger than you?

14. Had it been previously planned by you?

15. What do you remember of it?

INTERVIEW SCHEDULE (Part 2) Cont'd.

16. How did you feel afterwards?

17. Is there a history of homosexual tentencies/ behaviour in your family?

18. Have you ever been aroused sexually by another male without his awareness of that fact?

19. Have you ever been overtly aroused sexually by another male?

20. Did sexual behaviour ensue from such feelings?

21. Have you ever taken part in sexual behaviour with another male? (where yes, obtain details, i.e. co-masterbation, intercourse etc.)

22. Have you ever co-masterbated?

Subjects who have a history of anal intercourse

23. Which role have you tended to play?

24. Is this the same as your preferred role?

25. If active, when (if at all) have you experienced the passive role?

26. If passive, when active? (as above)

27. Which role do you now prefer?

28. Have you experienced/do you now experience a distinct preference, i.e, age, type of partner?

29. Have you experienced anal intercourse during the past three months?

Obtain response to 30, 31 if Yes to 30 above?

30. What were your principal feelings at the time?

INTERVIEW SCHEDULE (Part 2) Cont'd.

31. What have been the predominant feelings afterwards?

32. Have you experienced sexual arousal to a female within the past three months?

33. Has covert sexual behaviour (masterbation etc.) resulted from it?

34. Has overt sexual behaviour (petting, sexual intercourse etc) resulted from it?

35. Was your female sexual partner older or younger than you?

36. Was she a casual aquaintance or a close friend?

37. Was this previously planned by you?

38. Where did it take place?

39. What were your principal feelings at the time?

40. What were your predominant feelings afterwards?

41. Are your parents aware of your homosexual life-style?

<u>if yes</u>

42. how would you describe their initial reaction and their current attitude?

43. Have you ever made a conscious attempt to discuss the matter with any member(s) of your family?

44. Which(if any)family members are the most helpful and understanding?

45. Have you ever i. desired, ii. sought treatment with the intension of achieving change to a heterosexual life-style?

INTERVIEW SCHEDULE (Part 2) Cont'd.

46. Have you ever i. desired, ii. sought treatment with the intension of adjusting more satisfactorily to your homosexuality?

47. Have you ever been discriminated against on the grounds of homosexuality?