A **Case** of **Homosexuality**

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As in the case of all biopathies, homosexuality is based on orgastic impotence. Specifically, the homosexual is afraid of heterosexuality, and it is a primary task of therapy to enable the patient to face this fear. Although homosexuality can occur in any character type, from a therapeutic standpoint, one encounters two types of homosexual patients. In certain cases, the homosexual behavior clears relatively quickly in the course of therapy. In others, removal of the behavior is particularly difficult because it is intimately associated with underlying character- ological defenses. This is true in the case of the passive-feminine homosexual.

The passive-feminine character is essentially an anal character who has given up the phallic level and wards off genital impulses with anal and passive surrender. He may resort to homosexuality as an expression of his anal surrender. These cases are difficult to treat not only because of their inordinate fear of heterosexuality but also because their homosexual indulgence provides a certain degree of sexual release and substitute gratification, albeit at a great sacrifice to their emotional well-being. Their defense against genitality is very strong, and therapy is quite prolonged, requiring not only a clear understanding of the patient's structure, but also a great deal of persistence.

Anamnesis

The patient was a 36-year-old, single, white, male bank teller who came to therapy because of his homosexuality. He had had homosexual fantasies from early adolescence, accompanied by severe guilt feelings. He had been a practicing homosexual for seventeen years, averaging two to three different sexual contacts per week. For the most part, these were one-time affairs. He masturbated frequently, fantasizing men forcibly penetrating him anally. In both his homosexual practice and his fantasies he picked strong men whom he assumed had a larger penis and therefore more virility than he. With these sexual contacts, he played the passive-feminine role. His own penis felt dead, and mastur-

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bation was accompanied by sensations in his rectum like those during defecation. When he was a child, his parents would warn him that he would get palsy or become feeble-minded if he masturbated. He habitually wore underclothes that were soiled with semen and feces. He had a great deal of "belly anxiety" and was generally very frightened, especially when facing strong males.

He felt a great inhibition in his work ability and had a poor mechanical aptitude. He knew that he could function much better if he were healthy. During his adult life, he had never had any conscious heterosexual desire.

Medical history revealed that he was chronically constipated. He took suppositories daily, sat on the toilet for long periods of time, and was very preoccupied wtih his bowel movements.

The mother was the dominant parent. As a child, the patient had an intense interest in girls and vivid heterosexual fantasies. His mother found out about his sexual play and told his father, who did nothing about it. The patient was ten when his heterosexual feelings disappeared on the death of his father, about which he was ambivalent. On the one hand, he was glad because the father was a weakling and because he had preferred the patient's older sister to him; on the other hand, he felt responsible for his death, renounced his aggressive drives, and became the kind of boy his mother wanted him to be—gentle, compliant, and studious. This, however, was at the expense of his aggression and interfered with his being accepted by male peers. He defended himself strongly against having male interests, especially where competition was involved, for fear of being exposed as inferior. He hated the summertime, for his peers were then involved with sports and he remained aloof from them. Despite his athletic habitus, his athletic abilities were surprisingly poor.

Biophysically, he was attractive, well-developed and muscular. He did calesthenics and body-building exercises compulsively. His eyes appeared passive and showed anxiety. He was in touch with this and was able to express it when his eyes were opened wide. His eyes crossed when he attempted to roll them. He was ab'e to make angry faces briefly, although this quickly turned into a soft, passive expression. His voice sounded anxious and whiney, and had an effeminate quality. His throat was constricted, but he was able to shout. The thorax was rigid and held in the inspiratory position. The intercostal muscles were tense and very sensitive to touch. The abdominal musculature was hard. His back was arched, the paraspinal muscles were hypertrophied, especially on the right side, his buttocks was tense and pressed into the couch.

The lower extremities were well developed and also tense. He was able to hit the couch forcibly, and he kicked in a squashing manner.

His general appearance was one of a highly energetic and apprehensive individual. He was heavily armored throughout, but gave a superficial appearance of looseness.[1] On the surface, he was overly friendly and submissive, accepting whatever I said, but there was a great deal of distrust, sneakiness, and spite underneath.

Therapy

Focusing on his most immediate character resistance, his cunning and submissiveness, gradually led to some critical remarks regarding me. He said I was not as physically well developed as he originally thought. He then became frightened of me and stated that coming to therapy was like a dreaded homosexual encounter. This was said with a disparaging smile and was followed by more criticism: He didn't feel anything. He felt sorry for me. I was working too hard, but, despite this, nothing was happening.

I also mobilized his anal rage by having him kick. Briefly, he made snarling faces, but soon stopped, feeling that he had to stay in control. He stated that I might not like what he was doing, and then he directed another jibe at me: I am not really as strong as he thought. He quickly added that he wants me to be strong so he can get excited by me. I related this to his passivity and told him that he must be frightened of me.

Working on his eyes brought out superficial misery and crying sounds, but he immediately protested, stating that it was all fake, and then retreated by going to sleep. I continued to mobilize his eyes, which began to improve slightly. He was able to feel some fear, but he soon became spiteful and resorted to his typical "nothing is happening" complaints. I pointed out his obstinacy and told him that he resisted therapy so that he could put something over on me, that undermining therapy was the only way he could be victorious. This seemed to make sense to him, but he was still too frightened to give up the negative attitude, so I continued to mobilize his fear biophysically.

Further work on his eyes and his chest produced strong currents in the upper segments. He became afraid of these involuntary sensations, broke out in a cold sweat, and felt dizzy. He was obviously not prepared for this degree of sensation. He had thoughts of dying and felt very apprehensive. He was on the verge of crying but didn't. Instead, he

iThe passive-feminine character typically seems soft and yielding, but, in therapy, this proves to be a kind of armoring that is very difficult to dissolve.

resorted to his typical "nothing is happening" attitude.

I worked on his spite by having him kick, which discharged a great deal of energy. He looked frightened, but, when I pointed this out, he again denied feeling anything. He became passive, smiled in a cunning
way, and began talking ingratiatingly in a seductive, effeminate voice. I focused not on what he was saying but on the form of his expressions, mimicking all of his effeminate behavior. This led to a violent outburst of rage for a brief moment and was followed by an intensification of all his passive-feminine characteristics. He smiled in a foxy way, complaining that we were not getting anywhere, and expressed distrust: "How can I believe you when you say everything is a defense?"

At this point, one aspect of his transference towards me became crystalized. He stated that he wanted me to like him, but that I should stay at a safe distance. I should support his illusion of our relationship, which was one in which he obtained support from me. I should not get so close as to take away his protective defenses. This illustrates the typical transference situation that develops in these cases. The passive-feminine character defends himself against his own aggressive drives, as well as those of others, by means of anal surrender (passivity). He achieves this by becoming close to those he fears, developing an exaggerated and artificially friendly attitude towards them. At the same time, this attitude provides a degree of substitute gratification for his anal unsatisfied impulses. On a superficial level, his "nothing is happening" complaints meant that I was not giving him the love and affection that he expected. He stated that he lived like a hedonist, for the pleasure of the moment. I told him that he was contenting himself with crumbs, both in therapy and in his daily life, that all his substitute gratifications (his homosexual contacts and his relationship with me) were retained at a terrible price to his emotional integrity, that this not only drained his aggressive energy, but also made him feel guilty and worthless. I told him to eliminate all homosexual activity for at least two days prior to each session.[2] He admitted being distrustful of me: Why should I really be interested in him? I'm really seeing him for the money, etc.

I kept after his fear by focusing on his sneaky facial expression. His entire face was tight, the eyes squinted. I had him exaggerate this expression by squeezing his face. This was followed with more work on

2The orgonomist generally treats homosexuality in the same way he treats alcoholic behavior, that is, he explains to the patient that his homosexuality is a defense, that as long as he persists in it, he is sabotaging his therapy and for this reason he needs to abstain entirely during the course of therapy. In practice, this is very difficult for patients to follow, particularly in the initial stages, but it is always present as a goal. — EFB

his character. On the surface, he was compliant and submissive, wanting my approval. Beneath this, he was defiant, spiteful, and wanting to undermine therapy since this was the only way he could get revenge on me. This interpretation was confirmed by the following childhood memory that had made a profound impression on him.

As a child, the patient and his father used to urinate together to see who could last longer, who had the bigger stream, etc. He was always aware of his father's larger penis. At a certain point, he decided that he was not going to compete with his father any more and made the conscious choice of retreating to his mother. He thus began to relinquish overt competition. From then on, he began to secretly find fault with males who were stronger than he, since this was the only way that he could get back at them. I interjected that, since he must render me impotent, he felt he could not rely on me to help him and that he compensated by developing a superior, "healthy" attitude, convincing himself that he really does not need anyone to help him since nothing is wrong with him. As will become clear later, these defensive attitudes were triggered by the surfacing of his deep misery and his castration anxiety.

He kept defending himself tenaciously with his "I don't feel anything" attitude. I kept working on his spite, as well as his defensive passivity. This produced a challenging look, followed by a general feeling of well-being. I continued to vigorously mobilize his eyes which gradually brought out a fear of losing things, as well as a fear of looking. He said he was always afraid of losing things, and, if he did not scrutinize things too carefully, he could avoid becoming aware of his loss.

Although this was an indication that his castration anxiety was surfacing, I nevertheless continued to work on his anal rage. Vigorous mobilization of the paraspinal muscles produced powerful kicking to the point that he felt as if his back were going to break. He looked more aggressive and expressed more verbal criticism of me. Then, reluctantly, he admitted to being afraid of comparing genitals and said that he hated any male whose penis was larger than his. Yet, he longed to be aggressive and secure the respect of his peers. However, he felt that he could never compete with other men: His penis was too small, they were far ahead of him, etc.

As his anal aggression became further mobilized, he was able to look defiantly at me and regularly felt pleasurable sensations after kicking. He began to feel on top of the situation and laughed at the thought that he had somehow exceeded me.

At this time, he first became interested in women and had fleeting, pleasurable heterosexual sensations. He began dating, but an attempt at intercourse showed that he was erectively impotent. This first glimmer of genital functioning and his subsequent disappointment produced a retreat into anality. He became impatient, complaining that I was not giving him his potency and had self-deprecating thoughts regarding his budding sexuality: "Who do I think I'm kidding?" Expressing disappointment at the size of his own penis, he again sought out homosexual partners who had larger penises.

I *intensified* the mobilization of the paraspinal muscles, which at this time felt somewhat softer, working also on the muscles of the thighs and legs. This produced a strong expansion with intense warm perspiration and a feeling of openness in his head. He felt cocky and confident for a *short time.*

Following this, he had intercourse with ejaculation for the first time, but with very little pleasure. He was still very tentative regarding his newly found potency, and felt on the brink of disaster. He said: "I'm afraid the wrath of God will fall on me!"

With further mobilization of his rage, he gave into the strongest aggressive hitting that he had expressed thus far. He felt this aggression in his eyes, as well, and he expressed vigorous biting movements. Even he was amazed at the tremendous strength he displayed. He became very excited at the prospect of meeting different women, but his anticipation of becoming impotent again made him retreat into the relative security of his homosexuality. Although he behaved outwardly confident and aggressive with women, he refrained from putting his budding sexuality to the test. As his fear of disappointment became intensified, he again began having thoughts of being omnipotent. He stated that he could get better on his own, that he did not need me anymore. He then became impatient, exclaiming: "I want potency now!" He was angry at me for not giving it to him. Working on the buttocks and legs produced a strong sensation of pressure traveling from the back of the pelvis into the penis, accompanied by intense pleasurable feeling in the buttocks. The sensation of pressure in the penis developed into a sensation of itching and prickliness.

Intensification of genital sensations increased his fear of disappointment and also his castration anxiety. He had thoughts of his penis being cut off. On the couch, he could not tolerate lying still. This brought out feelings of misery and utter helplessness. I therefore encouraged him to do absolutely nothing. He became very restless and terror-stricken and was on the verge of crying. But he could not express it because of the

armor in his throat. He literally jumped off the couch when I gently began to mobilize his throat. He was very shaken and felt as if he were going to his execution. -

This was followed by a strong phase of resistance. Biophysically, he kept going off in his eyes. He had trouble focusing and felt as if a harsh chemical were being poured into them. He looked horrified. Character- ologically, his sneakiness reappeared in full force. He also became distrustful and expressed more negative criticism: I don't really care about him, this is only a business for me, etc. I told him he himself had to decide whether or not he wanted to change, that the only way he would was by giving up his substitute life and fantasies and to stop using therapy as a prop to be superior to other men. I told him he could have homosexual feelings, but that he was only hurting himself by acting on them. I stated that he maintained a neurotic dependence on me by expecting a substitute penis. At the same time, he felt secretly superior to me by not facing the fact that he needed help. This struck home. He was able to recognize how he secretly subverted therapy, and he became more genuinely cooperative and independent. He began working on his own in therapy for the first time. He resorted to masturbation with homosexual phantasies instead of homosexual behavior and felt the necessity of taking hold of his life so that he could maintain his own aggression.

His misery began surfacing again, but this made him feel terrified and helpless. In the session, he became very resistive, reverting to cheating me out of success by turning therapy into a battle of wills. I therefore proceeded to mobilize his paraspinal muscles. This time, he had the urge to hit with his pelvis as well as to kick. Following this, he recalled his vivid heterosexual interest and sex-play as a little boy. These feelings disappeared at age 10 when his father died. He recalled the ambivalence that he felt regarding his father's death and how this event ushered in his passive-feminine attitude.

In the following session, he again became critical of my therapeutic abilities and accused me of not helping him. I repeated that he constantly put me in a position of failing, that this was the only way that he could get revenge on me. He finally admitted that he hated to see me be successful and said angrily: "It's all a game. You don't care anyway." I told him that it was *he* who made therapy a game. He became very shaken and was on the verge of tears. He again became more seri- out about getting well and began admitting his desire for a woman.

At this time, he recognized that his mother had the same businesslike aloofness toward him that he had toward others. He saw this as the

basis for his superficial attitude towards people. He further realized that she never accepted any gift from him and saw this as evidence that she never really accepted him as a male. He admitted wanting to get close to me but said it was safer to be critical and aloof.

I kept working on the passive expression in his eyes by having him look aggressively, with rapid darting glances, in all directions. This produced a strong openness in his head accompanied by chills in his body. A wealth of anal memories related to his toilet training followed. He smelled "baby shit" and recalled the numerous accidents he had as a child, which he continued to have even as an adult. Again, he felt defiant and frightened. The thought of meeting a woman produced a deadness in his penis. He felt a big "No!" there and said: "They don't deserve to be given anything." Mobilizing his occiput gave further expression to his defiance. He again smelled "baby shit" and had the feeling he was being forced to do something against his will. At the same time, he felt in his face a strong identification with his mother.

He clearly saw his mother was standing in the way of his heterosex- uality. He had to constantly account to her and could never do anything independently of her. Further mobilization of the paraspinal muscles produced an expression of pure murder in his face. Defiantly, he dug his head into the side of my chair. This expression of intense hatred enabled him to give into deeper crying. He had a soft sweet feeling in his chest and smelled a "milky female odor."

He was able to eliminate all homosexual channels briefly, and, for the first time, he was able to masturbate with heterosexual fantasies by squeezing his buttocks.[3] He felt that he was squeezing pleasure from his buttocks forward to his penis through a narrow opening.

He became more serious regarding therapy and admitted that he had used therapy as a prop all these years. Facing his fear of confronting his mother enabled strong phallic aggressive impulses to break through for brief periods, and he had a desire to date many women. He had occasional heterosexual relations, although without ejaculation. This produced a flood of castration fears. He fantasized that his, girl friend was cutting off his penis with a knife. This was followed by fantasies of stabbing her to death. He then had a dream in which a man cut a large black hole in his thigh.

By this time, despite his intense fears, he was able to tolerate strong energy movement without attempting to sabotage therapy. I mobilized his terror with gagging, and his organism went into an intense general

[3]Though his fantasies are hetersosexual, the masturbation is still anal.

ized contraction with cold sweats and nausea. This reaction was followed by further opening with currents in his eyes and head. He became more trusting, which was indicated by the following dream: He overhears his uncle and his mother making disparaging remarks about him. He goes into the room and rebukes them and then states that he is going to speak to his boss (me) about this.

At this time, the state of his sexual functioning was as follows: With homosexual partners, he felt confident and able to behave in a phallic manner, assuming the aggressive role. With women, however, he felt that he must perform completely on his own, that is, without the help of another man's penis. Therefore, he had to fantasize another man's larger penis. He was feeling more in his groin with women than he did with men, with a strong prickliness in his penis, but he still could not ejaculate during heterosexual intercourse. The sexual excitation would quickly drain from his penis when genital sensations increased beyond a certain point. This inevitably resulted in a strong disappointment reaction, and he would retreat into homosexuality for support and relief.

Facing his heterosexual fears further crystalized his castration anxiety. I mobilized a very tender spot in the right occiput. He became terrified and was on the verge of crying, feeling utterly helpless and pinned down. He remembered at five years of age being held down to have a boil lanced from his ear and recalled the following childhood fantasy: He is being taken to the electric chair. If he could get to his penis and masturbate, he would have the power to fight off his execution.

In his relationship with women, he still equivocated. He behaved as if he were walking on eggshells. Yet he had fantasies of murdering women. I told him that he was evasive, that, although he displayed no anger toward women openly, he showed it nevertheless by finding fault with them and ultimately rejecting them. He stated that he had to be shifty since this was the only way that he felt women would allow him to use his penis even though he ended up not caring one way or the other for them. Recognizing his artificial behavior, he became more direct with women and was able to tolerate a greater sexual charge in their presence. He began having wild heterosexual fantasies as he had had in his adolescence, prior to the onset of his homosexuality.

Again, he had a dream of losing *things. In* another dream, he compared the size of his penis with that of another man's. In a third dream, three men are urinating over a fire, one of whom is his boy friend. He becomes very anxious when his boy friend gets lost. This dream indicates that his homosexual defense was weakening as he was able to begin to face his castration anxiety. His impulses to cry were strongly

fought off. He was desperately holding on to his neurotic facade. On the surface, he appeared "carefree" and "superior." Breathing produced strong gagging. He raised his nose in order to get away from a bad odor. He recalled soiling his pants until he was in junior high school and how his mother would clean his dirty underwear. He was mother's little boy, and in this way he outranked his sister. He recalled always feeling sloppy and untidy as a child. Later, in his adolescence, he took up weight-lifting and body-building because he could not stand feeling dirty and sloppy.

I mobilizd his back, chest, and jaw. He was terrified of breaking down and *crying.* He admitted his fear of being dependent on me. He said he could never trust his mother enough to cry in front of her, since he felt too insecure in his relationship with her, so now he could not cry in front of anyone.

A strong resurgence of his homosexuality followed in a desperate attempt to flee from his terror and misery. But this activity was no longer able to satisfy him.

Now I mobilized his chest consistently. He recalled the "electric chair" fantasy and secret source of power. I pressed down on the sternum. He tolerated this procedure more than he had in the past and gave into deep heart-rending crying, but it was not accompanied by tears. He felt as if his chest were being crushed. This regularly alternated with pulling his chest and nose up and becoming "Mr. Superior." Gradually, his chest became softer. He was able to tolerate more anxiety in his chest and arms as long as he had an outlet for his terror. This enabled his misery to surface and he felt like a little boy.

He then had the following dream: He is at one end of a bar while his boss is at the other end. He has to get past him, but something is pulling him back. His mother tries to help, but he tells her to leave him alone. This dream indicates that he was breaking his neurotic dependence on his mother.

Further mobilization of his chest produced strongly sadistic feelings toward women. He hit the couch, as he felt like beating them, and said amazedly: "No wonder I'm frustrated with them!" This was followed by a strong surge of heterosexual feelings and produced a greater degree of chest mobilization as he gave in to making strong, defiant faces and giving vent to angry shouts. He felt an openness in the upper part of his body as though it were a big tube from the mouth to the umbilicus. He became even more determined to get well and to give up his neurotic behavior.

This was confirmed by the following dream, which signifies that he

is regaining his own penis: He is having a child. At first it is lifeless, but he is able to revive it by rubbing it. It turns into a beautiful baby boy or a penis.

I continued deeper mobilization of his eyes and chest, where the major source of armoring still remained. Gradually, his genital sensations for women increased, and he began displaying a greater degree of aggressiveness.

He had the following dream: The patient and his mother are at a railroad station. The patient boards the train, leaving his mother behind. He checks to see if he has all his belongings and sees that nothing is missing. This dream indicates a reunciation of the Oedipal wishes and denial of castration.

Although he was more serious and tolerated a greater degree of sexual feeling than before, he still expressed his resistance by retaining one homosexual relationship. I told him that his homosexuality was an escape which prevented him from fully facing his terror. He finally relinquished the last homosexual attachment, and this produced the greatest expression of misery thus far. For the first time, his crying was accompanied by some tears. At this time, he himself became capable of frankly discussing and exposing his various homosexual holdouts. This enabled him to maintain his erective potency for longer periods, although it was with anxiety. During the following week, he was extremely anxious. His potency was still quite precarious, and, on one attempt at intercourse, he was erectively impotent. This terrified him and intensified all his neurotic attitudes. He became dissatisfied and wanted to leave therapy, stating that therapy was a crutch. I again told him that he sought a substitute penis from the therapist, and, since he could not have it, he wanted to quit. This put him more in touch with the terror behind his sexual attraction to strong males.

Again I was able to mobilize his misery to the limit of his tolerance: His head became pale and contracted. Biophysically, he was in shock. This ushered in his castration anxiety in full force. He recalled his fear of his father for having the larger penis, and how he identified with his mother to protect himself. Looking directly at me brought his fears into sharp focus. He became frightened that I would become angry with him. He was afraid of *revealing himself for what he was.* Since he was afraid of looking directly at men, he looked down at their genitals. This made him feel either passive or masochistic. He admitted sneakily looking at men's penises and secretly thinking to himself that his was bigger. Then followed his fears of looking at the vagina. At first, he thought that it was ugly. Gradually he came in touch with the fear behind this attitude.

Each time he expressed a secret thought to me, he felt exposed and then was able to give in to deeper crying.

He was making a strong attempt to curb his sneakiness and face a new girl friend openly. This made him feel as if he were going to his execution. Tolerating his fear of exposure was the same as facing his castration anxiety. This produced the deepest crying that he had thus far expressed in therapy. He was full of genuine sadness and tenderness. His eyes were open and expressed longing. He tolerated strong energy movements that began to include the genital. His ability to be open in front of me eliminated his neurotic character traits of sneakiness and submissiveness. His new girl friend produced an excitation that he had not felt before, and he felt very sexually aggressive. He said he felt "like a lion" with her and was capable of tolerating very strong sexual feelings for her.

He then came into contact with one aspect of the origin of his homosexuality. During the session, he tried to have an image of his father, but was unable to. He thought of how weak his father was. He recalled desperately wanting a strong father, but it was his mother who wore the pants in the house. The patient was contemptuous of his father's weakness. This made it impossible for him to establish contact with his own penis and this was why he had to look to other males. Not only was he afraid of his father for his bigger penis, but beneath this he hated him for being so weak that he could not identify with him.[4]

He gave in to deep sobs and felt a deep love for his girl friend. He began living with her and tolerated getting closer to her. Although this was very frightening, he did not resort to any substitute activity. On one occasion, his fear of her was so intense that it actually paralyzed him. Expressing his fears to her enabled him to open up sexually to her and to have intercourse. For the first time, he was able to face his sexual fears on his own!

In a later session, crying for his mother was followed by a fear of calling for her because he knew that she would not come. He then felt angry and resentful, which was followed by his becoming cold and contracted. He felt he had relived the entire process of his armoring as an infant during this session.

Breathing and tolerating sensations gradually expanded his biosystem further. His body became soft, and he lost all his passive-feminine character traits, as well as his homosexual urges. He married his girl friend

[4]It should be noted, however, that in *this patient it was the mother and not the father* who was the main source of frustration and thus also the object of the fear and of the passive-feminine behavior occasioned by it. The mother was the castrating person.

and now has two children. Recently, he told me he felt he was just at the beginning of his life.

This case presentation illustrates the orgone therapy of a passive- feminine homosexual. Consistent emphasis on his main character resistance, his deception through exaggerated friendliness and submissive behavior, eliminated his passive-feminine attitude, which was nothing but a reaction formation against repressed aggressivity. Biophysically, it was imperative to focus on the anal-sadistic rage (kicking and squeezing) so that one could fully mobilize the phallic aggression. This enabled the patient to face his castration anxiety and to give up homosexuality, replacing it with heterosexual functioning. The last part of therapy, the establishment of orgastic potency, is still in progress at this time.