'Not very happy and mixed with a lot of Nervousness'

'NOT VERY HAPPY AND MIXED WITH A LOT OF NERVOUSNESS'. THE PRIEST AS THERAPIST IN CATHOLIC MENTAL HEALTH CARE

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Between 1958 and 1965, a Catholic Pastoral Center in Amsterdam was specifically geared to providing mental care to homosexuals. The Center was part of a Catholic mental health organization and was staffed by several clergymen and psychiatrists. Its establishment directly followed from contacts that evolved earlier in the 1950s between the Amsterdam-based homosexual rights organization and several Catholic clergymen, psychiatrists, and psychologists who were open to new scientific insights around homosexuality. COC board members noted that increasingly they encountered Catholic homosexuals who were in moral conflict and felt a need for mental support. The director of the Amsterdam Catholic organization for mental health, psychiatrist C.J.B.J. Trimbos (1920-1988), listened to the homosexual movement's criticism that the Church showed too little understanding for concerns related to homosexuality. With the knowledge of the Dutch episcopate and in collaboration with the nationwide Catholic organization for mental health, Trimbos took the initiative to establish the Pastoral Center, which on the basis of 'psycho-hygienic insights' was equipped to provide mental support to Catholic homosexuals. The Center was set up as an experiment and the experiences gained by the care providers had to serve as basis for advice to the Dutch bishops about 'the pastoral approach of Catholic homophiles.'[1]

The realization and the care-providing practice of the Pastoral Center – the subject of this article – are to be understood against the backdrop of specific changes in the thinking about homosexuality within the Dutch Catholic community since the 1930s.[2] Despite the Church's official rejection of homosexual behavior as unnatural and sinful, some influential Catholic physicians and clergymen expressed alternative biomedical and psychological viewpoints. A differentiation was made between sinful homosexual acts that should be condemned and possibly prevented and a homosexual disposition, which by itself could not be considered a sin and which had to be accepted as a deplorable, pathological fate. The possible biological and psychological causes of the homosexual disposition were debated extensively among Catholic physicians, psychiatrists, and clergymen. In the 1930s and 1940s some doctors, often supported by priests, experimented with psychotherapy, chemical therapies, and even castration, but others were more reserved about the possibilities of curing a homosexual disposition. In the 1950s psychological explanations of homosexuality as a flaw, a neurotic disturbance of normal development during childhood and puberty, gained ground among Catholic psychiatrists.

Closely connected to the differentiation between disposition and behavior, two distinct categories were distinguished: so-called 'true homosexuality,' which was purportedly determined biologically or psychologically by an innate drive, and so-called 'pseudo-

[1] Overing (1964), p. 11; achtste/negende jaarverslag (1959/60), p. 19; Sleutjes (1980); Warmerdam/Koenders (1987), p. 299.

[2] See Oosterhuis (1992).

homosexuality', which was considered as contingent 'perverse' behavior of essentially 'normal' men and women. From the point of view of pastoral theology, these two forms of homosexuality were to be considered in different ways. As confessors and spiritual advisers, priests would have to take counsel with a physician before making their judgment on homosexual 'sinners'. Only in the case of pseudo-homosexuality was such behavior to be treated as a mortal sin for which the offender was accountable. Although psychiatrists had introduced the concept of pseudo-homosexuality, it was mainly defined in moral terms. Moral judgment vis-à-vis 'true' homosexuals, however, should be geared towards a medical or psychiatric diagnosis. Clergymen and doctors were advised to cooperate closely: they should come to a common understanding and judgment of homosexuality. This served in fact as the Pastoral Center's basic starting-point. It should be noted that its homosexual clients did not simply serve as passive objects of pastoral and psychiatric interference. In this paper I argue that new ways of dealing with homosexuality were not simply imposed on clients from above as the result of a clear-cut pastoral and medical strategy; rather, they came about by muddling through in a process of interactions between clergymen, psychiatrists, and Catholic homosexuals.

The clients and their problems

In its seven-year existence, the Pastoral Center has provided care to a total of 211 clients, of which 166 records are still available.[3] This material is quite unique because it offers insight into the practice of pastoral care, about which little documentation is available, partly on account of the secret of the confessional. Apart from correspondence involving clients or third parties (relatives, friends, employers, parish priests and other care-providers), the records contain reports from priests and psychiatrists of the Pastoral Center in which they sometimes quote or paraphrase comments from clients. The priests involved wrote the most elaborate notes. This can be explained from the nature and structure of the care providing. Because the Pastoral Center primarily catered to individuals with difficulties pertaining to religious concerns, the first person they would talk to was a clergyman. Based on one or more talks, he would write up a report for either the Center’s staff or a psychiatrist, if at least one was brought in for the client’s treatment. This only happened if a priest or client deemed it desirable to do so; this also explains why in many records a psychiatric report is absent. In their turn, psychiatrists would sometimes refer a client back to one of the clergymen. Size, accessibility, and level of information of the various texts in the records strongly vary, depending on the practical function they fulfilled, the length of the treatment (ranging from one session to a dozen or more during several years), and the frequency of the care-providing contacts (ranging from once a week to once every six months). Most notes were made on the basis of the first talks conducted by care providers with clients to establish the nature of their difficulties.

It is hard to ascertain to what extent the records provide a representative image of the situation and daily world of Catholic homosexuals around 1960. The information in the texts is not only fragmentary, but also strongly colored of course by selection, the retrospective

[3] The records of Pastoral Center are numbered 1 to 211. In my references I have followed this numbering, thereby adding the formal role of the author of the notes and, between brackets, the year the client involved first came to the Center.

gaze, and especially the interpretation of specific problems by clients and care providers alike. In this paper I am concerned in particular with the interpretations of those who requested and provided aid, as well as with the divergent and changing formulations they used to articulate problems around homosexuality and potentially solve them. I have read the data in the records as (constantly shifting) meaning constructions of the actors involved and my description of them involves a historical reading of their (changing) interpretations. If information in the records offers reason to do so, I will also pay attention to the social context.

The Pastoral Center's clientele largely consisted of men. Only 10 of the 166 records are about women.[4] As far as the age of clients was concerned, those in their twenties were represented most strongly, followed by those in their thirties and by teenagers, respectively. The number of clients over forty was quite small. That most clients were younger men can largely be explained from the fact that frequently the discovery and awareness of homosexuality and the interrelated uncertainties gave rise to the decision to seek help at the Pastoral Center. The large number of men around thirty struggling with their identity and sexuality suggests that around 1960, on account of the influence of social pressure and the isolation in which many found themselves, individual coping often proved troublesome and potentially lasted quite some time. From their occupation and education it can be derived that most clients came from the lower and middle classes. Slightly less than half of those seeking help at the Pastoral Center did so at their own initiative. A small majority sought help at the Center after being advised to do so by others (priests, friends, relatives and acquaintances, psychiatrists and family physicians, employers, lawyers and probation officers).

Although the Pastoral Center was geared toward homosexuals with problems in the religious domain, the care providers also addressed other concerns. Aside from the inner struggle with homosexual desires, conflicts at work and clashes between parents and children were given ample attention. Other recurring difficulties pertained to homosexuality in marriage, persecution by police and the law, as well as relational problems. If one client was helped by being reassured in one or several talks (or, at least, he did no longer show up afterward), another client might need sustained counseling or referral to more specialized care providing services. Inasmuch as the problems were unrelated to Catholicism, I will largely leave them unconsidered here: my argument concentrates on the relationship between religion and homosexuality. In fact, it were not just Catholics who knocked on the Center's door: Protestants, Jews, and those not belonging to any church made up slightly over ten percent of the clientele.

Most clients came to the Pastoral Center because they struggled with inner conflicts and feelings of guilt. Many complained about being rejected by the Church or a lack of understanding among the clergy. Often, parish and other priests[5] who reproached

[4] One can only speculate about the reason for this limited number. Several records suggest that the male gender of the care providers could form an obstacle for women to call in the Pastoral Center's help and that the care providers took lesbian women less seriously than homosexual men. Perhaps this was tied to the image of woman as sexually passive, an image that was prominent in particular in Catholic circles. Client 142 (1962); psychiatrist 40 (1960); psychiatrist 36 (1959); psychiatrist 58 (1960); psychiatrist 141 (1962).

[5] To prevent misunderstandings, in this and in the next three paragraphs, I refer to the way priests in general, *not* the Pastoral Center's clerical counselors, approached homosexuality.

homosexuals for being sinful, who denied them absolution, or who urged them to suppress their desires would merely fuel their inner struggle. A few priests viewed marriage as a remedy and advised homosexual men to begin amorous relations with women, sometimes telling them they were actually bisexual. Some followed up on such advice, much to their regret. Other priests insisted on psychotherapy or would refer homosexual men to a psychiatrist. Before going to the Pastoral Center, nearly fifty clients had already been referred to seek psychiatric aid. Their stories suggest that in the 1940s and 1950s medical involvement with homosexuality varied widely: ranging from advice to accept one's leanings and learn how to lead your own life to the encouragement to pursue heterosexual contact and marriage; from psychoanalysis, which mostly would end prematurely because of the long duration or high cost, to (hardly successful) attempts at a cure with the help of medicines, hormone treatment, or carbonic and LSD treatment. Sometimes psychiatrists raised castration as an option, but in most cases this was not pursued. Among all the clients, two men were actually castrated.

Despite many complaints about the clerical approach, the records do not allow one to conclude that crude rejection and repressive measures were the order of the day in the Catholic Church. The records reveal that many priests showed restraint or even adopted a benevolent stance. Some of them approved of a homosexual friendship or would soothe a man, for instance, by saying that 'his homophile expressions did not cause any serious evil.'[6] A young man told that his confessor, who knew about his homosexual relationship, did not commit himself, 'probably not to make [the client] worry needlessly.'[7] The private nature of the confessional offered priests the possibility to speak with two mouths. Outwardly they had to condemn homosexuality as a sin, but in the confessional they could adopt a more flexible and tolerant stance. Not only was there a gap between official morality and pastoral care practice; the reactions among the clergy substantially differed: 'some confessors accept it, others don't,' as one of the clients noted.[8] Again other priests refused to discuss it, perhaps believing that keeping it under wraps was the best remedy.

It is striking that from a young age many men had had ample sexual experiences, sometimes with friars and priests. Catholic institutions such as boarding schools, seminaries, and monasteries, which were differentiated based on gender, offered opportunities for homosexual contact in particular.[9] Regular sexual contacts might also last for years without those involved viewing themselves as homosexual, even if some of them would have felt 'different' or sinful. Likewise, they might not even know the word 'homosexual'.[10] And if they were caught, generally the sanctions were limited, often involving punishments that were common for other more or less serious 'sins'. For example, one psychiatrist noted about

[6] Priest 76 (1960).

[7] Priest 73 (1960).

[8] Priest 15 (1958).

[9] Priest 15 (1958); psychiatrist 24 (1958); priest 38 (1959), psychiatrist 202 (1964); priest 17 (1958); psychiatrist 127 (1962); psychiatrist 179 (1963).

[10] Priest 37 (1959); psychiatrist 46 (1959); priest 23 (1958), 46 (1959), priest 119 (1961), psychiatrist 134 (1962), psychiatrist 178 (1963), priest 182 (1963).

a young man who persistently took the initiative to having 'sexual contact [...] with very many fellow-pupils' at a boarding school that occasionally he was punished by teachers 'to do one hour of mandatory study in his free time.'[11]

The unpredictability or contradictions in pastoral care were in fact a source of anxiety among Catholic homosexuals. Many did not quite know what was proper or not and they went to the Pastoral Center with questions about the nature and implications of purported Catholic norms. Were they allowed to have a friend or live together with one?[12] Were they supposed to confess having homosexual contacts or could one 'follow one's own conscience'?[13] Their discontent pertained not exclusively to the Church's interference and sanctions, but rather to the lack of clarity and the unwillingness of many priests to talk about homosexuality. Some announced they no longer wanted to hide their homosexuality within the Church – probably the most common conduct in the Catholic world – because they experienced that as hypocrisy, as 'dishonest' and 'insincere'.[14] As a young man complained: 'you can never give yourself as you are.'[15] Many took a critical stance, wanting the Church to show a 'different attitude' or 'much more understanding and openness.'[16] One of the clients wondered: 'Is it not the duty of the clergy to point out to people (and why not from the pulpit) that as Christians they should show charity vis-à-vis homosexuals as well?' He felt that the Church 'greatly fell short' and was guilty of 'banishing the homophile minority.'[17] A teacher felt that clergymen voiced 'the most ridiculous things' about homosexuality and an office clerk argued 'that a possible demand of the Church to not have sexual contact with a friend is simply ludicrous, because this cannot be excluded from the "friendship".'[18] Likewise, other clients had trouble 'sensing the sinfulness of sex' and did not see why they should feel 'sorry and moral regret.'[19]

If it is hardly surprising as such that Catholic homosexuals had a hard time with the Church, it is quite revealing how they expressed themselves about it. Their formulations make clear that a sizable number of clients refused to accept any clerical 'preaching'.[20] Apparently, hushing up, self-denial, and leading a double life were not taken for granted anymore. Many statements found in the records suggest a certain degree of self-awareness and assertiveness. Catholic morality was experienced as bothersome, but at the same time

[11] Psychiatrist 180 (1963).

[12] Priest 30 (1959); priest 116 (1961).

[13] Priest 137 (1962); client 105 (1959).

[14] Priest 58 (1960); priest 137 (1962); priest 184 (1963); psychiatrist 132 (1962); psychiatrist 208 (1965).

[15] Psychiatrist 151 (1962).

[16] Priest 116 (1961); priest 35 (1959).

[17] Client 76 (1960).

[18] Priest 18 (1958); priest 19 (1958).

[19] Priest 32 (1959); priest 35 (1959); client 2 (1958).

[20] Priest 72 (1960).

most clients did not want to leave the Church. Numerous clients in fact came to the Pastoral Center because somehow they felt a need, as a 45-year-old woman put it, 'to reconcile Christianity and homosexuality with each other.'[21] They wondered whether one could lead a 'responsible' life as a Catholic homosexual and whether there was 'room for homosexual people in the Church'?[22] Some men even wanted to become priest or monastic (which was not always welcomed by the care providers because these homosexuals thus would 'escape' their own feelings).[23]

The requests for help reflect the dilemma faced by many clients. Their comments suggest a highly religious sense of guilt and loyalty to the Mother Church on the one hand, and increasing doubts about Catholic morality on the other. Only few actually complied with the Catholic commandment of sexual abstinence. Notably those who lived in Amsterdam or who regularly went there to seek pleasure struggled with the gap between religious doctrine and their own sexual behavior. By the late 1950s Amsterdam had a gay reputation already, as well as a tolerant climate, particularly in comparison to other parts of the country, notably the predominantly Catholic South, where homosexual rights organizations were still unthinkable.[24] Lots of men had moved to Amsterdam because of its urban anonymity and the opportunities of the then already existing homosexual subculture to meet 'kindred spirits' and to engage in sexual contacts. The city allowed one, as some men noted, to lead a 'life of your own.'[25]

Quite a few clients, however, experienced their new life in Amsterdam with mixed feelings. The city not only offered the opportunity of freedom and the chance 'to build a new life,'[26] but it also gave rise to uncertainty, doubts, and the fear of solitude and a gradual moral 'downfall'.[27] Having hasty and multiple sexual contacts triggered feelings of guilt and internal conflict.[28] As one of the Pastoral Center's priests characterized the homosexual life of a 26-year-old youth leader: 'not very happy and mixed with a lot of nervousness.'[29] Many clients oscillated between the enticements of Amsterdam and their moral conscience. Inward conflict and mental tensions occurred in particular, it seems, in situations where one could escape the social control of family, neighborhood, and the Church, while traditional Catholic norms and values – though subject to eroding – still had a solid footing. 'Wants to enjoy life

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[21] Client 184 (1963).

[22] Priest 73 (1960); client 189 (1964); priest 121 (1961); psychiatrist 124 (1962).

[23] Priest 72 (1960).

[24] Roodnat (1960), pp. 92-108; Duyves (1989).

[25] Priest 21 (1958); client 148 (1962).

[26] Priest 154 (1962).

[27] Priest 122 (1962); psychiatrist 89 (1961).

[28] Psychiatrist 52 (1960); priest 37 (1959); priest 64 (1960); psychiatrist 180 (1963); priest 35 (1959); priest 74 (1960); psychiatrist 151 (1962); priest 76 (1960); staff 18 (1958); priest 63 (1960); priest 137 (1962); psychiatrist 132 (1962).

[29] Priest 182 (1963).

while not get trapped religiously,' as one psychiatrist in one of his reports concisely summarized the dilemma of many.[30]

To most clients, freedom was attractive and within reach. As their autonomy grew larger, the Church's rejecting stance was increasingly regarded as injustice while its morality was more and more experienced as constrictive. On the other hand, however, many Catholic homosexuals still felt too attached to the Catholic world to discard its views and certainties. They shied away from liberty and autonomy. These entailed, as one of them submitted, that 'you enter into an unknown life,' or, as another one put it, that you 'had to live life' on your own.[31] On account of the 'forced loneliness', 'the specter of having to remain alone,' a lack of certainty, and a sense of insecurity, many clients tended to view a homosexual life as 'difficult' and 'meaningless'.[32] The seeds of the desire to 'be who you are'[33] were present, but for most clients it was hard to imagine how their life would take on meaning outside the given frame of the Church, marriage, family, and work. Apart from religion, the prospect of no marriage and family – which especially in the 1950s and 1960s counted as the essential basis for a full and happy life – was a source of great anxiety.

These particular problems of Catholic homosexuals partly were an effect of social changes in the 1950s. Growing prosperity and social mobility had gradually increased the overall freedom to choose and move around. Established boundaries of class, religion, and between city and countryside faded, and this caused the contradictions between social practice and the restrictive Catholic norms and values to grow larger. Numerous clients were caught in between the constraints of religious tradition and the wider possibilities of everyday modern life.

The care providers: their difficulties and solutions

One of the main objectives of the Pastoral Center was to keep Catholic homosexual men and women in the Church. The care providers realized that many of them might be disappointed by the Church, but that was not yet a reason, in their opinion, to turn away from it. Clients who expressed all too harsh criticism of the clergy were considered 'aggressive', 'bitter', 'hateful', and 'wayward', or were attributed a 'crude mentality' and 'strong oppositional leanings.'[34] At the same time, in order to prevent apostasy among homosexuals, pastoral care providers would need to show more understanding for this 'group of fellow-believers at risk,' as one psychiatrist put it.[35] In their striving to help homosexuals by teaching them, as one of the care providers put it, 'a livable morality and ethics within the do's and don'ts of our

[30] Psychiatrist 156 (1962).

[31] Psychiatrist 123 (1962); psychiatrist 177 (1963).

[32] Psychiatrist 44 (1959); psychiatrist 134 (1962); priest 37 (1959); psychiatrist 41 (1959).

[33] Psychiatrist 130 (1962).

[34] Priest 18 (1959); priest 32 (1959); priest 38 (1959); psychiatrist 54 (1960).

[35] Psychiatrist 49 (1959).

Church,'[36] they had to adopt a cautious approach. This care was provided with the consent of the Dutch bishops and within the established Catholic order it was not possible openly to discuss its religious morality.

The records regularly refer to 'new insights' used by the priests of the Pastoral Center to reassure their clients who suffered from moral anxiety and sense of guilt. What these new insights exactly amounted to is hard to distill from their divergent and sometimes contradictory advice. Still, it is clear that commonly the clerical counselors did not have ready available answers to their clients' moral questions. The new pastoral approach gradually evolved through the experience gained in practice. The priests and psychiatrists regularly consulted among themselves, referred clients to another priest, and, if needed, would ask for advice from the Center's moral theologian. If in one case a counselor would speak severely to his client, telling him that he sinned or should refrain from sexual contact, in another case he would show more restraint and tacitly allow it. Care providers might insist on control and sublimation, for instance by telling clients to concentrate on work, study, hobby, or religious ideals, but in other instances they tacitly if not explicitly suggested that it was permitted, or they would react stoically when their clients confessed their sexual experiences.

Like their clients, the care providers wrestled with moral dilemmas. The contradictions and ambivalences found in many of their reports cannot only be explained from the improvisational nature of pastoral care; they are also tied to the individualizing and psychologizing approach followed. The priests tailored their advice to the divergent personal circumstances and drives of their clients. It was essential which meaning of homosexuality applied to them. Was there a homosexual disposition or was it rather a matter of certain homosexual behaviors? Did it involve a love relationship or 'random' contacts? Did sexual interaction take place, and if so, was it motivated by love, or exclusively by lust? Before judging morally, the priests first had to establish whether or not someone was 'really' homosexual. The least doubt was enough for referral to a psychiatrist, the expert who could establish, as one priest put it, whether someone had 'a justified homophile inclination.'[37]

Time and again, care providers had to decide on whether or not clients were in fact homosexual. Their outward appearance could offer some clues. Phrases such as 'this is a real homosexual, also looks like one (not to be touched with ten-foot-pole),' 'seems to me – also in dress and appearance – typically 100% homosexual,' and 'overdressed, swinging boy' are quite common, in particular in the psychiatric reports.[38] In the view of the care providers, men who through their words and gestures left a feminine impression, who dressed unconventionally – notably tight pants and suede shoes leapt to the eye – or who displayed more than usual attention for external appearance were unmistakable 'homosexual types'. In women they would notice specific masculine features.

But more important than their outward look was what the clients told about their sexual experiences, fantasies, dreams, emotional life, and childhood. The care providers attached much meaning to feminine predilections of men and alleged masculine features of

[36] Psychiatrist 49 (1959).

[37] Priest 51 (1960).

[38] Psychiatrist 49 (1959); psychiatrist 183 (1963); psychiatrist 54 (1960).

women. Men who told that as a boy they played with dolls, knitted, did embroidery, and sewed clothes, or who liked doing household chores, enjoyed dressing up, and had an interest in fashion thus confirmed that they had 'always been different.'[39] In addition, both the priests and psychiatrists devoted much attention to the upbringing of the clients and their relationship with their parents. Dominant mothers and weak or absent fathers are ubiquitous in the reports, while excessive mother bonding, disturbed relationships with fathers, and failed mother and father identifications occur frequently. If a limited number of clients was raised in a 'normal' or 'pleasant' family, many suffered hard times when growing up as a result of a lack of parental love, a lack of a 'warm' family atmosphere, a bad marriage of the parents, a (too) rigid upbringing, or a lengthy stay at boarding schools.

With their development-psychology and psychoanalytical perspective, care providers distanced themselves from views that prevailed in the Catholic world and that linked homosexual behavior to moral degradation, contagion, or temptation. The frequent questions of the psychiatrists about diseases and disorders, notably sexual deviations, among relatives seem to suggest they considered homosexuality as hereditary and physically determined, but it is more likely that such questions were part of their medical routine, and therefore we should not attach too much meaning to them. By and large, their interpretive frame was psychological rather than medical. Although they viewed homosexuality as 'abnormal', 'deviance', 'defect', or 'lack', this did not yet imply it was a disease symptom. The frequent references to mental disorders – qualifications like 'neurotic', 'unbalanced', 'disintegrated', and 'psychopathic' recur in the records – pertained not so much to homosexual leanings as such, but to how clients reacted to social rejection. As 'outcasts' and 'banished', they suffered from 'loneliness', 'isolation', 'fear', and 'meaninglessness'.[40] The care providers did not go as far as to suggest that social and religious norms were responsible for social exclusion, as some clients did. Rather the care providers shifted attention from the actual pressure of the social environment, which was hard on homosexuals, towards their inner coping with it. Where a man complained that he 'was despised by the masses and driven out of his job,' a priest wrote: 'He is more than *sensitive*, sort of collapses every now and then, *feels* he is an outcast.'[41] Another man who constantly 'clashed' with his immediate surroundings, according to the priest, clang too much to what others thought about him; he lacked self-awareness.[42] About a student a priest noted: 'He *experiences* his homosexuality as very complex, fear of being expelled from society.'[43] Others had problems, according to the care providers, because they '*felt* banished', 'let down and frustrated by everyone,' or 'impeded in their social life' and 'inhibited'.[44] Such formulations reveal the extent to which the care providers reduced social conflicts to individual's emotional reactions to such

[39] Psychiatrist 146 (1962).

[40] Priest 5 (1958); priest 15 (1958); priest 17 (1958); priest 21 (1958); priest 26 (1958); priest 37 (1959); psychiatrist 38 (1959); priest 106 (1960).

[41] Client and priest 5 (1958) [my italics], cf. priest 79 (1960).

[42] Priest 79 (1960).

[43] Priest 15 (1958).

[44] Psychiatrist 10 (1958); priest 21 (1958); psychiatrist 38 (1959) [my italics].

conflicts. Still, they also observed the difficult social position of homosexuals: they were not so much sinful or ill but pitiful and in need of help.

That the psychiatrists distanced themselves from the common medical approach of homosexuality also shows from their reservations regarding a possible cure. In this respect several clients were pleasantly surprised. One of them, as a psychiatrist notes, 'slowly loosens up once he finds out that I am not going to treat him.'[45] Although some clients were referred to other psychiatrists for psychotherapy, it cannot be deduced from the notes whether they were meant to be cured from their sexual inclinations of from the associated mental and nervous problems.[46] In general the psychiatrists did not act on requests from clients or their parents to cure them of their inclination. Most had to accept that their leaning was 'incurable'. The only option for them was 'self-acceptance'.[47]

Inasmuch as the records can serve as evidence, the collaboration between Pastoral Center's priests and psychiatrists did not cause friction. The priests were progressive clergymen who were positive about professional mental health care. Still, several different emphases are noticeable. The psychiatrists showed less clemency with clients who continued to worry because of their religion. Where the priests showed much patience and understanding regarding the 'spiritual need' and 'pitifulness' of clients, the psychiatrists would observe a lack of 'sense of reality' and 'balance', and they characterized some, as far as their religious experience was concerned, as 'woolly', 'vaguely idealistic', 'oversensitive', 'sentimental', 'unstable', 'weak', or even 'hysteric'.[48] Several records suggest that the priests would adjust their initial emphatic attitude after consultation with the psychiatrist, shifting their attention from the clients' inner conflicts to their presumed mental defects, which was not always to their advantage.

The calling on psychiatrists in pastoral care more or less served as backing for the priests. Catholic moral theologians tended to consider homosexual disposition as such not as sinful. A human being was not free to choose his inclination, the reasoning was, and this is why people could not be held accountable for it. In Catholic moral theology free will was a necessary condition for committing sins. A psychiatric examination had to establish whether someone was a 'real', 'manifest', 'original' or 'innate' homosexual, who 'outside of one's own decision' had this inclination and really 'could not do otherwise.'[49] A careful examination of the motivations was necessary for a well-considered moral judgment. It mattered much to the care providers to clearly distinguish so-called pseudo-homosexual behavior from homosexual proclivity. Men and women who engaged in same-sex sexual interaction (or who might do so), and who did so not on the basis of some inevitable inner urge, but as a

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[45] Psychiatrist 202 (1964).

[46] Psychiatrist 114 (1961); psychiatrist 124 (1962); psychiatrist 109 (1961); psychiatrist 190 (1964); psychiatrist 207 (1964); psychiatrist 112 (1961); psychiatrist 209 (1965); psychiatrist 210 (1965); psychiatrist 36 (1959); psychiatrist 40 (1959).

[47] Priest 13 (1958); priest 18 (1958); priest 37 (1959); priest 64 (1960); priest 173 (1963).

[48] Psychiatrist 5 (1958); psychiatrist 24 (1958); psychiatrist 58 (1960); psychiatrist 76 (1960); psychiatrist 100 (1961).

[49] Priest 15 (1958); priest 28 (1958); priest 34 (1959); priest 35 (1959); priest 37 (1959); psychiatrist 132 (1962).

result of other causes and motives – such as habituation, financial reasons (prostitution), or an environment in which the other sex was absent – could count on warnings and reprimands. Because essentially they were heterosexual, they ought not to evade the 'responsibility of marriage.'[50] When, on the other hand, psychiatric diagnosis indicated a homosexual disposition, priests could justify safeguarding homosexuality from being judged in terms of sin and guilt. A psychologically based disposition made homosexuals essentially 'different' from 'normal' people. As victims of an inescapable lot they were in a 'special situation' and therefore, as one of the priests wrote, it was 'impossible to apply to them […] the objective moral rules of the Church.'[51]

Besides possible homosexual behavior of 'normal' men, the promiscuity and anonymous sex of homosexuals greatly worried the priests, and these constituted a major reason for urging clients to go to confession. Although care providers advised some to move to Amsterdam, they also warned in advance for 'the oft-occurring perils.'[52] Irregular and multiple sexual contacts were not just sinful, the care providers felt, but also a sign of mental immaturity. 'Seems really homosexual; has a hard time; is infantile, immature [...] ; still has a long way to go [...] towards building a full life,' as one priest judged a 29-year-old man, who admitted that 'in times of intense sexual excitement' he engaged in multiple sexual contacts, without feeling too guilty about it.[53] Quite a few homosexuals, according to the psychiatrists, had a 'polygamous' or 'promiscuous' inclination and suffered from relational problems, unsociability, and 'loneliness', or found 'no peace' because they had no 'ideals'.[54] One of the priests said to be struck by 'homosexual people having little future, merely clinging to the present.'[55] By urging them to give 'meaning' to their life 'in normal society', thus sublimating their drives, as it were, care providers believed they could curb the risk of moral degeneration.[56]

Sex and friendship

Such advice and admonishments were in line with traditional Catholic morality, which offered homosexuals hardly any other choice but abstinence. This is not the full story, however. Although care providers constantly pointed to the perils of homosexual lust, at the same time they hinted at the notion that abstinence as a demand was little realistic if not

[50] Psychiatrist 124 (1962).

[51] Priest 49 (1959).

[52] Priest 110 (1961); psychiatrist 13 (1958); priest 25 (1958); priest 38 (1959); priest 74 (1960); priest 48 (1959); priest 38 (1959).

[53] Priest 89 (1961).

[54] Psychiatrist 163 (1963); psychiatrist 198 (1964); psychiatrist 151 (1962); psychiatrist 30 (1959); psychiatrist 38 (1959); priest 110 (1961); priest 35 (1959); psychiatrist 7 (1959).

[55] Priest 114 (1961).

[56] Psychiatrist 24 (1958); priest 108 (1961); priest 94 (1959); priest 74 (1960); psychiatrist 44 (1959); psychiatrist 176 (1963); priest 108 (1961).

unhealthy. In their view, in fact, it was not quite normal for homosexuals to refrain from sexual interaction. One priest wrote that a very devout man who claimed 'heavenly bliss to be more valuable to him [...] than any physical contact whatsoever' – a view that according to religious morality was perfectly laudable – took 'a rather odd stance for such people.'[57] Other clients who in response to detailed questions from care providers showed little sexual interest and experience were seen to be 'undeveloped' or 'immature'.[58] 'Personally my impression is that sexually this boy is nowhere yet,' as one priest noted about a 25-year-old young man who could not accept his homosexuality and rather wanted to marry than give way to his urges.[59] Some clients, according to the care providers, showed an 'irrational' 'rejection' and 'disgust' vis-à-vis sexual matters.[60] The forced suppression of emotions and desires in some Catholic milieus, so they observed, frequently led to 'insincere feelings of guilt', unhealthy inhibitions, neurotic disorders, and frustrations.[61] The notes of one psychiatrist about a 26-year-old nurse – raised in a rigid Catholic family and suffering from 'horrible feelings of guilt' – underscore that the care providers were aware that Catholic morality sometimes brought about serious mental problems: 'Fear. A constant feeling of deadly sin [...] Always obsession. Confession: always remained silent about everything. [...] fear-neurotic-depression picture.'[62]

The care providers' notes repeatedly show the tension between the duty to suppress sexual inclinations, as dictated by the Church, and the advisability to recognize and express them for the sake of mental health. Sexual desires had to find a way out to prevent neurotic repression. The awareness that the traditional restrictive morality was at odds with mental health was a major incentive for the care providers to interpret theological guidelines broadly. 'Helping people' was quite different from 'imposing objective moral rules,' as one of the psychiatrists wrote to a parish priest who objected to what he saw as unacceptable advice by the Pastoral Center.[63] Homosexuals should not suppress sexual needs, but regulate them in a 'responsible' manner. The most striking innovation in pastoral care providing was the positive valuation of steady relationships, and this catered to a strong need among Catholic homosexuals. Many claimed to find 'happiness', 'security', 'a footing', 'peace', or 'safety' in steady friendships.[64] Under special conditions, sexuality within a 'good friendship' was 'responsible' and 'meaningful', the priests concurred, not only to prevent random sexual

[57] Priest 106 (1960).

[58] Psychiatrist 170 (1963); psychiatrist 190 (1964).

[59] Priest 143 (1962).

[60] Priest 79 (1960); psychiatrist 8 (1958); psychiatrist 167 (1963); psychiatrist 46 (1959).

[61] Psychiatrist 167 (1963); priest 129 (1962); priest 8 (1958); psychiatrist 10 (1959); psychiatrist 30 (1959); psychiatrist 130 (1962).

[62] Psychiatrist 210 (1965).

[63] Psychiatrist 49 (1959).

[64] Priest 26 (1958); priest 37 (1959); priest 99 (1961); priest 102 (1961); psychiatrist 120 (1961); psychiatrist 122 (1962); priest 137 (1962); priest 24 (1958), priest 120 (1961); priest 35 (1959).

contacts 'out of carnal lust,' but also to contribute to 'personal development.'[65] Sexual interaction was 'not a matter of sin and guilt' when the relationship, like in a good marriage, was based on 'love' and 'loyalty'.[66] Through self-examination clients ought to find out whether they could meet this moral condition and they had to be willing to account for their motivations. For example, one of the priests advised a 35-year-old man with moral worries 'not to pursue [lust] for its own sake, but also not to consider sexual contact in the context of sincere friendship as sinful,' if at least he showed to be prepared 'to continue to be responsible – and not to disguise the improper.'[67]

In some cases, care providers left their clients in the dark on purpose about the moral acceptability of sexual interaction. After a priest reassured a 21-year-old woman by saying that the 'inclination' and 'friendship' were not sinful, he left the question of the sinfulness of sexual contact unanswered by advising her to deal with it 'not until the situation would present itself.'[68] A priest advised a man with religious problems – who was refused absolution by his parish priest because of his homosexuality and who did not dare to take Communion without confession – to 'find out for himself whether it was sinful to him.'[69] Similarly, a woman who, troubled by 'moral conflict', came to the Pastoral Center asking whether it was permitted that she lived together with a female friend, received ambiguous advice. Not because cohabitation would be sinful or immoral, but because the psychiatrist felt she wanted 'to pass on the responsibility for her actions to us.' He wrote to the priest: 'not to tell her whether or not it was permitted; she herself has to bear the responsibility for it.'[70] When moral judgment of sexual relations was at stake ambiguous advice was hardly an exception, and this might pose a challenge to clients who were used to the Church's carefully defined do's and don'ts. Some will have been left behind with more doubt and uncertainty rather than less. For example, one man wrote that he was fobbed off 'with spiritual talk' and he criticized the priests for their lack of clarity.[71]

Still, it is possible to discover coherency and structure in the advice provided by the Pastoral Center. In the emphasis on self-knowledge, self-motivation, and personal responsibility pastoral care clearly displayed features of psychotherapy. From their frequent evaluative remarks about the talkativeness and verbal powers of clients it shows that the care providers did not favor a passive, wait-and-see attitude. Those who articulated their concerns well and were willing and capable of speaking candidly about themselves, their personal history, and their intimate (sexual) experiences, and who also showed a perspective of their own on the issue, were one up on those who were less articulate. An active stance

[65] Priest 99 (1961); priest 184 (1963); priest 73 (1960); priest 110 (1961); priest 74 (1960; priest 184 (1963).

[66] Priest 3 (1958); psychiatrist 116 (1961); priest 189 (1964); priest 28 (1958); priest 25 (1958); priest 26 (1958).

[67] Priest 70 (1960).

[68] Priest 40 (1959).

[69] Priest 102 (1961).

[70] Psychiatrist 51 (1960).

[71] Client 76 (1960).

and an adequate description of the problems served as first steps towards their solution. Having your own opinion, even if it was accompanied with a certain 'general contemporary'[72] criticism of the Church, was valued, in particular when the client considered himself co-responsible for a solution of his problems. Where their formulations stood in the way of a solution, the care providers tried to get clients to view their difficulties in a different light by changing the problem definition.

Instead of offering clear moral guidelines, which some clients in fact wanted from the priests, the care providers pointed to the importance of individual conscience and own judgment. They sought to make it clear to clients that a 'livable morality' was not imposed from outside or above, but was based on inner conviction. Clients were continuously stimulated to engage in self-reflection and moral self-judgement. Many who suffered under an awareness of sin and feelings of guilt were advised to consult their own moral conscience and formulate a judgment on their own about what was and what was not responsible. A man who worried about his hiding of having sexual contact with his friend for his confessor would be told at the Pastoral Center that only 'what is *experienced* as sin' belonged in the confessional box.[73] In other words, as the priest told others as well, your 'conscience defines the level of guiltiness,' whereby another priest noted in a record that some feelings of guilt were not 'real'; one could feel guilty 'against one's better judgment.'[74] In the eyes of the care providers the problem of many clients was that they viewed the religious do's and don'ts as an absolute moral standard and experienced it as an obligation imposed from outside and above. As one priest wrote about a client who appeared to be a 'convinced and practicing Catholic': 'awareness of sin without insight. Based on written and overheard principles [...] in the area [of] religion: no feeling [...] little energy and autonomy.'[75] The priest wrote about another young man who came to the Pastoral Center looking for 'certainty': 'Guilt complex. […] [T]oo strong "worry" – springing from notion of duty.'[76]

In the specific ways in which the care providers interpreted and reformulated their clients' problems attention shifted from a rejecting attitude of the Church and the sinfulness of homosexuality toward the way religion was individually experienced. One client, who 'had no conviction but still attended mass,' was, as the priest wrote, 'religious in a superficial way.'[77] And the man who, according to the priest, just wanted to be reassured that he still belonged to the Church, but who was 'not very outspoken', was characterized as 'primitive' and 'superficial'.[78] In response to a client who still had problems with confession after the priest had explained to him that the measure of guilt was determined by one's own moral

[72] Priest 137 (1962).

[73] Priest 137 (1962) [my italics].

[74] Priest 99 (1961).

[75] Priest 48 (1959).

[76] Priest 23 (1958).

[77] Priest 2 (1958).

[78] Priest 80 (1960).

conscience, one priest wrote: 'Still has a very formal point of view.'[79] About another client, whom he soothed by saying that homosexuality 'was not a sin to him,' the priest noted that the man did not 'internalize' this advice.[80] Apart from frequent qualifications like 'superficial' and 'primitive', the care providers also used such terms as 'immature' and 'undeveloped' to indicate that many clients' religious sense was not based on inner conviction, but merely on formalities, convention, or coercion.[81] The priests believed that a lack of internalization could lead to a frenetic attitude that might not only cause mental harm, but that might also cause clients to discard their sense of sin impulsively. Clients who 'simply' felt 'there was noting wrong in' homosexuality, or who said, for instance, 'it was no sin actually because [their] friend held the same view', reasoned, according to the priest, in an 'oversimplified' and 'primitive' manner and showed a 'narrow-minded moral development' or a lack of 'self-analysis'.[82]

Significantly, then, the care providers shifted the emphasis from fixed religious moral rules to personal conscience and individual responsibility. This shows that pastoral care was shaped through a redefinition of Catholic norms and values. With their ideas about a 'livable morality' and a personal, individual way of believing the care providers stressed general Christian-humanistic values such as 'love of one's fellow-men', 'solidarity', 'understanding', and 'openness'. Many religious problems, according to the care providers, resulted from a religious experience in which coercion, passive docility, conformism, and fear prevailed. Their interpretation of Catholicism implied not only that sexual morality became slightly less suffocating, but also that believers had to meet other and psychologically higher standards. Many Catholics, raised on the basis of authoritarian principles, were inclined to take a passive or wait-and-see attitude and, in the view of the care providers, showed too little personal autonomy or initiative.

The latter did apply not only at a religious level, but also, for instance, to the ways in which parents and children dealt with each other. Repeatedly the care providers voiced criticism of 'traditional' families in which 'paternalistically minded' fathers and 'devout' mothers took a too rigid stance and children obtained no opportunity to talk 'confidentially' en 'openly' with them.[83] On closer inspection, unyielding Catholic parents were found to be too rigid and too austere. As one priest noted disapprovingly about a client's parents, who, as he wrote, reflected the 'standard type of [a] closed family': 'Everything must be cared for in minute detail.'[84] Not only did the care providers try to foster a sense of understanding with parents for their homosexual son or daughter; they also urged them to resolve conflicts by talking about them, through negotiation and compromise. Often they showed understanding

[79] Priest 99 (1961).

[80] Priest 26 (1958).

[81] Priest 2 (1958); priest 24 (1958); priest 48 (1959); priest 79 (1960); psychiatrist 89 (1961); priest 102 (1961); priest 189 (1964).

[82] Priest 102 (1961); priest 77 (1960); priest 102 (1961); priest 79 (1960); priest 75 (1960).

[83] Psychiatrist 132 (1962); psychiatrist 155 (1962).

[84] Priest 67 (1959).

of homosexual youngsters who tried to escape the rigid paternalism at home; in some cases they even encouraged them to assert themselves more. One of the priests' records has the following to say about a young man who told him that his parents never had had any attention for him because of their demanding business: 'He himself observes that he protested with his parents, who, as he claims, provided no support, no guidance. But he swiftly adds saying that this [protest] was of course wrong; told him that I do not quite know yet whether it was wrong indeed. There is a glimmer of protest in his attitude when talking about his home situation in this context.'[85]

The individualized and internalized experience of religion that served as standard to the care providers, as well as the assertiveness they sometimes stimulated, required another personality structure than the one fostered by traditional and authoritarian Catholicism. To develop into an individual with a self-reliant and balanced 'personality',[86] one who accepted his homosexuality and managed to give meaning to it in a responsible way, 'maturity' and 'ripeness' were needed. Condemnations in terms of sin, guilt, and moral degradation were replaced with other moral qualifications that had psychological overtones, such as 'infantile', 'undeveloped', 'immature', 'unbalanced', and 'unstable'. Rather than the clients' salvation, their mental health and resilience were center-stage. Where clients articulated their difficulties in religious terms, the care providers often used psychological criteria. Both the psychiatric diagnoses and the introspection-minded pastoral advice suggest an individualizing en psychologizing mode of interpretation. Catholic homosexuals should let themselves be led in their behaviors neither by fixed rules and norms, nor by random impulses and emotions; instead, based on a careful inner evaluation they had to find the right balance between the two.

By adopting a individualizing and psychologizing approach the care providers, trying to adapt Catholicism to the demands of social changing, exercised 'soft' coercion as part of the effort to learn Catholic homosexuals to deal with the increased social liberties. Genuine moral behavior could not be imposed from outside or above, but had to come from within. Invariably the care providers insisted on self-guidance and self-regulation. The accent thereby shifted from prohibiting homosexual acts to adding meaning to sexuality through relationship development. Acceptance and understanding went hand in hand with a new, more subtle form of control. Apart from offering solidarity and support, care providers were also concerned with keeping their clients within the Church. The promotion of lasting and monogamous relationships among homosexuals served as a strategy to keep them from pursuing random contacts and sexual interaction in public meeting places. Despite their 'being different', they could become 'simply the same' by conforming to the same moral order as married heterosexuals.

To what extent this pastoral care in fact met the needs of its clients and whether they followed the advice given to them is difficult to establish on the basis of the Pastoral Center's records. There were some clients who clearly had no use for such counseling and they resisted it, actively, by expressing their discontent, or passively, by not showing up anymore after one or two talks with the priests. This care proved hardly effective for homosexuals who had already turned their back on the church. Others interpreted the advice

[85] Priest 114 (1961).

[86] Priest 74 (1960).

to weigh the issues based on their moral conscience as a license for choosing their own lifestyle, and again others continued to brood over religious dilemmas. Still, a large number of records suggest that quite often the talks with clients soothed their conscience and that many accepted the pastoral advice with relief. In their efforts to bring Catholicism in line with social developments the pastoral care providers in particular met homosexuals who wavered as a result of the growing gap between traditional Catholic relations and the new social opportunities. If the various social changes made it possible for Catholic homosexuals increasingly to struggle out of those conventional relations, the freedom they realized also came with uncertainties and problems of meaning. Many found a more or less temporary hold in the moral guidelines of the pastoral care providers.

Conclusion

Although the clientele of the Pastoral Center did not amount to more than several hundreds of individuals during its short-lived existence, the Center's influence has been quite substantial. In the early 1960s the insights gained in the practice of care providing were diffused at conferences, in several publications and by Trimbos, who regularly voiced his views before a wide audience on Catholic radio. In a roundabout way, psychiatrists and clergymen expounded that for the time being medical treatment of homosexuals offered little prospect of a cure while moral preaching failed to solve anything. It was more advisable to accept homosexual dispositions, alleviate feelings of guilt, appreciate 'homophile' friendships, and tolerate sexual contact in steady relationships. Thus for the first time it became public that Catholic experts no longer subscribed to the clerical condemnation of homosexual behavior.[87] Only later, in the 1970s and 1980s, similar voices could be heard in countries like Germany and Britain.[88]

This turning point in the attitude regarding homosexuality did not remain limited to Dutch Catholic circles. From the late 1950s, a similar development occurred among Protestants.[89] Within a few years confessional mental health experts and clergymen managed to bring about a change in the Dutch moral climate. Although the Netherlands was still a highly Christian country, this change contributed to the launching of the homosexual emancipation process, geared as it would be to (self) acceptance and social integration. This effort on the part of clergymen and mental health experts was marked by an apologizing, concerned, and quite ethical tone, calling not only on the sense of responsibility of homosexuals themselves but also on the compassion and solidarity of the Dutch population. It was not about sin or disease, they argued, but about regrettable social discrimination and mental suffering of a vulnerable minority. Not homosexuality, but discrimination was damaging for public mental health. This approach, which was based on psycho-hygienic expertise mixed with a sizable dose of Christian-humanist 'solidarity', strongly contributed to a public debate in which moral condemnation of homosexuals was increasingly harder to justify and became interpreted as ignorance and prejudice.

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[87] Overing (1964); Trimbos (1961), (1962) and (1965).

[88] See for example Boswell/Maguire/Ruether (1989).

[89] Janse de Jonge (1961).

The changing Catholic attitudes toward homosexuality should not be explained simply as a process in which mental health standards superseded religion; there was in fact a more complicated interplay between the development of professional mental health care and religious values. From the 1930s on, to be true, homosexuality was evermore considered a medical or psychological problem in the Catholic community, but at the same time it did not lose its meaning as a moral and religious issue. In fact, as appears from the records of the Pastoral Center and from developments in the 1960s and 1970s as well, Catholic as well as Protestant pastoral care for homosexuals gained ground and was intensified as a consequence of the growing Christian acceptance of biomedical and psychological notions of homosexuality.[90] Mental health did not replace religion, but rather contributed to a moral reorientation and a new pattern of Christian values, stressing the importance of individual conscience and responsibility as well as affection and fidelity in emotional relationships. Individual well-being and social welfare were re-conceptualized not only in terms of mental health, but also of spiritual self-realization.

The psychiatrists and clergymen of the Pastoral Center tried to help Catholic homosexuals to find a lifestyle in conformity with (modernized) religious values. Especially the vacillating role played by the clergymen in their judgments is noteworthy; as moral guides they used the strategies of social work and psychotherapy. This can be explained in the context of the more general development of Catholic mental health care from the 1940s until the 1970s. Although the influence of professionals increased, the impact of clergymen on mental health care was far from nullified. While some clergymen tended to oppose the rise of modern mental health care, because they saw it as an intrusion upon their monopoly in treating personal and spiritual problems, others participated in it. In a continuing dialogue between clergymen and mental health professionals the meaning of Christian values as well as the definition of the object of psychiatry was transformed.

In the discourse of Catholic mental health care of the 1950s and 1960s some central conceptions of traditional Catholic moral theology, such as freedom of will and moral accountability, played a crucial role. However, these terms were more and more detached from theological conceptions such as sinfulness, guilt, the inviolable soul, grace, salvation, and redemption, and they were increasingly related to psychological notions like personal growth, character, maturity, and self-reliance. Until the 1950s, in the Catholic world the object of psychiatry used to be defined in terms that indicated a lack of freedom and moral responsibility. It was associated with the non-spiritual, with the turbid pool of irrational passions and instincts, which had to be subdued for the sake of man's salvation. In the 1950s however, the concept of freedom was used by clergymen as well as professionals in such a manner that it could be connected to mental health standards in a positive way. Freedom was no longer perceived as an eternal supernatural essence of man, but rather as an ensemble of psychological capabilities that could and should be developed by good education and, if necessary, by counseling and psychotherapy. Thus, inside the institutions of mental health care, Christian values were given another meaning, so that they were in line with psychological standards. Passive obedience to moral authority was not considered a virtue any longer, and religious experience was to be rooted in inner conviction and confidence. Mental health, defined as inner freedom, was to be valued now as a precondition for a more individualized faith. Therefore, the central problem was no longer the sinfulness of man, but rather the lack of inner freedom of individuals.

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[90] Brussaard (1977).

Against this background the judgment of homosexuality by clergymen and mental health professionals changed twice during the 1950s and 1960s. While in the 1930s and 1940s attention had focused on homosexual behavior (of 'true' as well as 'pseudo'-homosexuals), which supposedly infringed on the theological norm of spiritual freedom, in the 1950s reference was increasingly made to the condition of the minority group of 'true' homosexuals, who presumably suffered from a lack of inner freedom in a psychological sense. Homosexuals could hardly be held responsible for committing sins, because they were considered as 'immature' and because they suffered from a 'deficiency in mind and free will'. Around 1960, as exemplified by the records of the Pastoral Center, the second transformation took place. This was prepared by certain developments in mental health care, especially the impact of modernist theology, phenomenological psychology, psychoanalysis, and the human relations movement. These stressed the importance of individual authenticity and stable, emotionally fulfilling relations between individuals as a refuge from the impersonal utilitarianism and materialism of modern society and as the modern mode of achieving religious values in personal life. In this context an important change in the Catholic judgment of marriage and sexuality took place: sexuality should not only serve procreation, but should be a way to express affection in relationships.

This shift from procreation to emotional relationships set the stage for a new view on homosexuality. If in the 1950s lack of freedom was supposedly situated in the psyche of homosexuals, it was now increasingly perceived as a characteristic of their social condition: they suffered from being looked upon as different and inferior, from being isolated and lonely, and from leading a meaningless life. Homosexuals could be helped now, not by treating their orientation – that had to be accepted as a destiny – but by supporting them to realize freedom in their lives. Promoting a situational and personalized morality, the priests and psychiatrists of the Pastoral Center encouraged homosexuals to shape their lives in authentic and responsible ways. They were stimulated to counter their isolation and loneliness as well as their 'irresponsible and compulsory' promiscuity by striving for stable, lasting friendships. They were expected to overcome their lack of inner freedom, so that they might take part in the same moral order as married heterosexuals.

This approach was typical for a fundamental social policy change of the emerging Dutch welfare state, which bore a Christian-Democratic stamp. Whereas before the 1950s 'deviants' had been labeled as abnormal, immoral, diseased, a-social, and deficient, while they had been excluded from the healthy and virtuous body of society, now the strategies of pastoral and social work as well as of mental health care were directed towards social integration. Now deviants such as homosexuals were supposed to be able to take part in normal society by developing their inner freedom, integrating body and soul, reforming their lifestyle and normalizing their social interactions. The emancipation of Catholic homosexuals from traditional church authority did not necessarily mean that moral control of sexual attitudes and behavior disappeared. Such control was transformed from external coercion towards internal self-constraint. The purport of the Christian sexual reform was that suppression of sexuality by rigorous divine laws, in which procreation within marriage was the standard, was superseded by a more humanistic ethical code, which stressed the meaning of sexuality for individual well-being and personal relationships. Pastoral care thus affirmed the importance and charged nature of sexuality and, also, it unintentionally contributed strongly to a consolidation of homosexual consciousness and identity.

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