

What is already known on this topic

Little is known about the experiences of patients in the United Kingdom who underwent treatment to change their sexual orientation in the middle part of the 20th century

What this study adds

Patients sought treatment or were referred after discussion with general practitioners, teachers, or others, and sometimes as an alternative to imprisonment

Treatments included behavioural aversion therapy with electric shocks, oestrogen therapy, religious counselling, electroconvulsive therapy, and psychoanalysis, and often had a negative impact on patients' sense of identity and place in society

No participant thought they had benefited from treatment and for many it increased their sense of social isolation and shame

It is harmful to apply medical diagnoses to human conditions that are disapproved of morally or socially

extensive. We also had few who underwent psychoanalysis, possibly because the focus is less explicit than behaviour treatments and people may often have been unaware of their analyst's intent.⁷ There is no evidence from outcome studies that these treatments were effective at changing sexual orientation.⁵

Conclusions

Our study shows the negative consequences of defining same sex attraction as a mental illness and designing treatments to eradicate it. It serves as a warning against the use of mental health services to change aspects of human behaviour that are disapproved of on social, political, moral, or religious grounds.

We thank all the men and women who participated in the study; BBC Radio Kent, Merseyside, Cornwall, Scotland, Norfolk, Foyle (Northern Ireland), Radio 4's *All in the Mind* programme, BBC Breakfast Television, *Time Out* (London), *Glasgow Herald*, *Manchester Evening News*, *Daily Mail*, *Gay Times*, *Divya Magazine*, *Pink Paper*, and many other groups that helped to advertise this study; and Jeffrey Weeks and John Warder, who provided advice at all stages of the study, and Eamonn McKeown for commenting on earlier drafts of this paper.

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professional help. Our companion paper (p 429) suggests that patients were referred fairly regularly from the courts.⁶ No participant suggested that treatment had had any direct benefits, and for many it had reinforced the emotional isolation and shame that had been a feature of their childhood and adolescence. Occasionally, it enabled acceptance of their sexuality.

Limitations

These participants may not be representative of all people who underwent treatment. Many may have died, emigrated, or been reluctant to take part. Conversely, those most affected may have been more likely to come forward than others on whom treatment had less impact. Treatments do not seem to have been

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Treatments of homosexuality in Britain since the 1950s— an oral history: the experience of professionals

Michael King, Glenn Smith, Annie Bartlett

Abstract

Objective To investigate the experiences of professionals who administered and evaluated treatments for homosexuality in Britain since the 1950s.

Design A nationwide study based on qualitative interviews.

Participants 30 health professionals who developed and practised treatments for homosexuality.

Results A range of treatments were developed to make homosexuals into heterosexuals, the most

common of which were behavioural interventions. Treatments were based on little evidence of effectiveness and were open to the criticism that legal or social pressures coerced patients. Treatments did not become mainstream within British mental health services. With hindsight, professionals realised that they had not appreciated the influence of social

Department of
Mental Health
Sciences, Royal Free
and University
College School of
Medicine, Royal
Free Campus,
London NW3 2PF
Michael King
*professor of primary
care psychiatry*
Glenn Smith
research fellow

continued over

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Department of
Psychiatry,
St George's
Hospital Medical
School, Jenner
Wing, London
SW17 0RE

Annie Bartlett
senior lecturer

Correspondence to:
Michael King
m.king@rfc.ucl.ac.uk

context on sexual behaviour. Most now regarded same sex attraction as compatible with psychological health, although a small minority considered that the option to try to become heterosexual should still be available to patients who desire it.

Conclusions Social and political assumptions sometimes lie at the heart of what we regard as mental pathology and serve as a warning for future practice.

Introduction

Interest in psychological interventions to alter sexuality increased sharply in the 1960s and 1970s.¹⁻³ Here we examine the motivations and experiences of professionals who developed and practised these treatments, and place them in the context of their professional and personal lives and the historical period in which they worked.

Methods

We had previously identified professionals who had published research in this specialty¹ and asked each to name other professionals knowledgeable about treatments. We also used professional contacts, advertisements, articles, and programmes in the national media and names given by participants in the accompanying paper (p 427). We used tape recorded, in depth interviews to explore professionals' personal and professional backgrounds; how they had become expert with particular treatments; and their attitudes to their work at the time and changes in their attitudes since that time.

Analysis

We approached the narratives using a chronological framework that formed the basis for a more detailed analysis. All authors undertook a series of discussions about emerging themes and atypical cases.

Results

We identified 44 professionals, of whom 30 (aged 50 to 80 years) agreed to participate. Some refused because they thought the topic was no longer relevant or feared receiving unwanted media attention. Two psychoanalysts had died, and one declined to be interviewed. We interviewed 12 psychiatrists, 16 psychologists, one nurse specialist, and one electrician who had developed electric shock equipment. All but two had worked in the NHS.

Life and career before administering treatments

The emerging discipline of clinical psychology was influenced by work that suggested neurotic disorders were acquired through faulty learning and might respond to behaviour modification.⁴ Clinics for the treatment of homosexuality became established in London, Birmingham, Manchester, Glasgow, and Belfast. Most professionals became involved by accident rather than design.

Well I didn't have much choice. That was a clinical placement. I was [the consultant's] first student. Basically the first year I was there, more or less all I ever did was shove electricity down homosexual patients.

Clinical psychologist

Several professionals came from pure science backgrounds and lacked awareness of the social and cultural context of human behaviour. Most had grown up in the same era of conservatism about sexuality as their patients. Most encountered gay men and lesbians for the first time as inexperienced young clinicians. They often described how treatments were experimental in nature, with scant regard for efficacy or ethics:

Here were people coming along who seemed to be asking for help, it was against the law, they wanted to change their behaviour, that's how it was presented to us. You never thought about the morality of what you were doing. You were effectively a technician.

Clinical psychologist

They rarely questioned the prevailing assumption that same sex attraction was abnormal or considered that people could adapt to their sexuality.

Treatments

Most of the professionals provided behavioural treatments, which included aversion therapy and covert sensitisation. Aversion therapy with electric shock was the most common treatment:

We had to become electrifying geniuses! The situation was you had the screen, the person sat at the table with the things [equipment] on and with a lever that they had to pull to avoid the shocks. The pictures started off with pretty men, working their way through ugly men into ugly women and into pretty women. That was the whole process literally.

Mental health nurse

Intermittent aversion schedules were commonly used, as it was believed that the new behaviour was less readily extinguished. Professionals' descriptions of treatment corresponded with patients',² although one reported that his patients had several weeks of inpatient assessment, giving the patient time to withdraw from treatment. Talking to patients was believed to compromise the effectiveness of aversion therapy. Other behavioural treatments included covert sensitisation, in which patients would counter homosexual thoughts with shameful fantasies of arrest by the police or discovery by family. Masturbating to a homosexual fantasy and switching to a heterosexual one near orgasm was also advised. Other treatments described were psychoanalysis and hypnotherapy. Treatments seemed to be used throughout the country with no general protocol or ethical guidelines. Few lesbians received treatment.

One leading advocate of treatments in the 1960s and 1970s reported that he became convinced that helping men to control compulsive homosexual behaviour was the most effective option:

Certainly after 1975 I would tell them [patients] that I didn't think it was possible to change their sexual orientation. The main people I treated were predominantly heterosexual, who felt their homosexual behaviours had become compulsive and they wanted to get them under control.

Psychiatrist

None the less, many spoke of their increasing doubts and dilemmas about the efficacy and ethics of any such treatments:

From the data I looked at, it undoubtedly inhibited their [homosexuals] sexual behaviour and there was loads of evidence of that. They were psychologically castrated if you like—heavy word. But you hadn't put anything in its place.

Clinical psychologist

Many professionals came to recognise the social context of sexual behaviour. One leader in the field was shocked to find his work publicly compared with brain washing and Nazi experimentation. Several eventually considered aversion therapy unjustifiable and pursued “softer” behavioural techniques, together with social skills training.

Outcomes of treatment

Outcome assessments were variable, and systematic follow up was attempted only in research settings. There were mixed views about efficacy of treatments, but a minority of professionals still regarded treatment as effective. Others considered that gains were more limited but that it was still possible to curb homosexual behaviour:

I think two or three people really had become satisfactorily heterosexual. The rest felt that their problems had been ameliorated in that they were either better disposed to their homosexual condition or the fear that some of them had concerning homosexual behaviour had modified, either because they had been able to reduce it, terminate it, or been able to talk to people and become more adjusted to it.

Clinical psychologist

Most doubted the treatment’s efficacy, however, and came to question whether they were acting in patients’ best interests. They began to think that patients might say anything to avoid yet more treatment or further legal repercussions:

People were referred from the courts as voluntary patients as an alternative to prison, which isn’t terribly voluntary. People were motivated to say things that weren’t actually true.

Psychiatrist

Life and career after administering treatments

None of those interviewed had made treatment of homosexuality their life work. Like their patients, they were influenced by changing public attitudes to sexuality and evolving ideas on the social politics of sexual expression. Several also spoke of their guilt about their use of these treatments, which they now regarded as a form of punishment, and their unease in talking about their involvement with family, friends, and colleagues:

I feel a lot of shame. I don’t think I’ve ever spoken about it since then, apart from now. I’m sure I’ve talked about a lot of the other clinical experiences.

Clinical psychologist

However, a small minority still maintained that same sex attraction is a mental illness requiring treatment or, at the least, is associated with psychopathology:

I thought they [homosexuals] were people who were disordered and needed treatment and psychiatric help. And I still do.

Clinical psychologist

A few even voiced concern that people who wanted to change were denied the opportunity by the demise of these treatments:

If there was a treatment that could change homosexuality for most people who wanted to change that wouldn’t feel unreasonable to me, because I still see guys who are predominantly homosexual but are really very uncomfortable with the whole gay scene. So I could see someone like that, if there was a treatment to make them heterosexual, to give it to them.

Psychiatrist

What is already known on this topic

Little is known about the personal views and experiences of medical and psychology professionals in the United Kingdom who attempted to make homosexual men and women heterosexual in the 20th century

What this study adds

Treatments varied throughout the country, with no general protocol or ethical guidelines

Behavioural treatments were most common, including aversion therapy with electric shock

Though some professionals consider that the treatments were valid, many had increasing doubts about efficacy and ethics

The evolving concepts in the light of liberalisation of public attitudes to homosexuality show how social and moral attitudes can determine what is regarded as “pathology”

Discussion

Many professionals were uneasy about the treatments for homosexuality. Others realised with hindsight that they lacked understanding of sexual behaviour within its social context. Their work was based on little evidence of effectiveness and was open to the charge that legal or social pressures coerced patients. Some professionals were excited to be in the “vanguard” of mental health, but this enthusiasm blinded them to the dilemmas facing their patients and the damage their treatments might cause. Those who felt troubled by administering these treatments were often compromised by their junior status. Treatments did not seem to become mainstream within UK mental health services. Only a small minority believed that current practice denied people distressed by their homosexuality an effective means to change their sexual orientation. Our data show how assumptions about public morality and professional authority can lead to the medicalisation of human differences and the infringement of human rights.

Limitations

We had a clearer sampling frame for recruiting professionals than we did for patients, so they are probably representative of those who undertook behavioural treatments to change sexual orientation in the NHS in the United Kingdom. However, we cannot claim that they are representative of all those who undertook treatments to change sexual orientation. We had little opportunity to interview leading psychoanalysts. We do not know how much the passage of time and changes in social attitudes influenced our participants’ recall of events or how much later rationalisation influenced their accounts.

Conclusions

Modern medical practice requires an adequate evidence base for treatments and requires that clinicians and members of government consider the adequacy and appropriateness of disease entities that

originate from the interplay of scientific and social perspectives. At a time when there is considerable anxiety about government plans to manage people with so called dangerous and severe personality disorders, this study reminds us of the risks of ignoring the association between science and society.

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Turning a blind eye: the success of blinding reported in a random sample of randomised, placebo controlled trials

Dean Fergusson, Kathleen Cranley Glass, Duff Waring, Stan Shapiro

Abstract

Objective To examine the reporting and success of double blinding in a sample of randomised, placebo controlled trials from leading general medicine and psychiatry journals.

Methods Identification of placebo controlled, randomised controlled trials from prespecified general medical and psychiatric journals indexed on Medline between 1 January 1998 and 1 October 2001, from which a random sample of 200 randomised clinical trials was chosen, of which 191 trials were evaluated.

Results Only seven of the 97 (7%) general medicine trials provided evidence on the success of blinding, with five reporting that the success of blinding was imperfect. In trials from psychiatric journals, the success of blinding was reported in eight of the 94 trials, with four reporting that the blinding was imperfect. Overall, only four of the 191 (2%) trials assessed blinding in the participants and either the outcome assessors or the investigators.

Conclusions The current lack of reporting on the success of blinding provides little evidence that success of blinding is maintained in placebo controlled trials. Trialists and editors should make a concerted effort to incorporate, report, and publish such information and its potential effect on study results.

Introduction

Although the definition of double blind varies,¹ we consider a trial to be double blind when the patient, investigators, and outcome assessors are unaware of the patient's assigned treatment throughout the conduct of the trial.² Placebos are commonly used as an inactive treatment to achieve double blinding, especially when no existing effective treatment is available.

Sometimes, placebos are proposed instead of a standard existing treatment or standard care to ensure assay sensitivity. This is the ability of a trial to distinguish effective interventions from ineffective interventions. It depends on the effect size that is to be detected, so the investigators need to know the anticipated effects of the control intervention. Placebos are ideal as their anticipated benefits are known to be marginal. If the blinding of the placebo arm is not effective then the protection against expectation effects, biased assessment, contamination, and co-intervention are all lost. Because of the importance of the success of blinding, the Consolidated Standards for Reporting of Trials (CONSORT) Group has explicitly incorporated the issue. Section 11(b) of the CONSORT statement states that the success of blinding is to be reported in the publication.³

It is not sufficient that trials describe themselves as double blind. It is also important that the efficacy of the blinding is actually assessed, and an assessment of the face validity of the double blinding is needed. To assess the reporting and success of double blinding, we chose a random sample of randomised, placebo controlled trials from leading journals in general medicine and psychiatry. Although we have focussed on placebo controlled trials, the issues discussed also arise in double blind trials with active controls.

Methods

We selected five general medical journals (*JAMA*, *New England Journal of Medicine*, *BMJ*, *Lancet*, and *Annals of Internal Medicine*) and four journals in psychiatry (*Archives of General Psychiatry*, *Journal of Clinical Psychiatry*, *British Journal of Psychiatry*, and *American Journal of*

Ottawa Health Research Institute, Clinical Epidemiology Program, 501 Smyth Road, Box 201, Ottawa, ON, Canada K1H 8L6

Dean Fergusson
scientist
Departments of Human Genetics & Pediatrics and Biomedical Ethics Unit, McGill University, Montreal, QC, Canada
Kathleen Cranley Glass

professor
Department of Epidemiology and Biostatistics, McGill University
Stan Shapiro

professor
Research Ethics and Regulation Group, Faculty of Law, University of Toronto, Toronto, ON, Canada
Duff Waring

research associate
Correspondence to: D Fergusson
dafergusson@ohri.ca

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