Cite this article as: BMJ, doi:10.1136/bmj.37984.442419.EE (published 29 January 2004)

Papers

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

Glenn Smith, Annie Bartlett, Michael King

Abstract

Objectives To investigate the circumstances since the 1950s in which people who were attracted to members of the same sex received treatments to change their sexual orientation, the referral pathway and the process of therapy, and its aftermath.
Design A nationwide study based on qualitative interviews.
Participants 29 people who had received treatments to change their sexual orientation in the United Kingdom and two relatives of former patients.
Results Most participants had been distressed by their attraction to their own sex and people in whom they confided thought they needed treatment. Although some participants chose to undergo treatments instead of imprisonment or were encouraged through some form of medical coercion, most were responding to complex personal and social pressures that discouraged any expression of their sexuality. While many participants found happiness in same sex relationships after their treatment, most were left feeling emotionally distressed to some degree.
Conclusion The definition of same sex attraction as an illness and the development of treatments to eradicate such attraction have had a negative long term impact on individuals.

Introduction

Religious objections to same sex attraction between men have existed since at least the Middle Ages[1] but were first endorsed in law in England in the 1533 Act of Henry VIII, which classified sodomy as an illegal act between man and woman, man and man, or man and beast.[2] This law, which was re-enacted in 1563, was the basis for all male homosexual convictions until 1885, when the Criminal Assessment Act extended the legal sanction to any sexual contact between males.[2] The end of the 19th century saw the advent of the concept of homosexuality as a pathological medical or psychological condition,[3–6] which legitimised treatments to change it. The social construction of the diagnosis of homosexuality occurred within the context of powerful sociopolitical forces against any variation from the heterosexual norm that prevailed for much of the 20th century.[6] Though sexual behaviour in private between adult men was decriminalised in Britain in 1967, treatments to change homosexuals into heterosexuals peaked in the 1960s and early 1970s.[7] However, we have little knowledge of the patients who experienced, or the professionals who administered, such treatments. We conducted an oral history study of treatments to change same sex attraction in Britain from 1950 to understand why people received treatment, how they experienced it, and how it affected their lives.

Methods

All participants gave written, informed consent. They were recruited through articles in newspapers, gay magazines, and newsletters of gay groups; interviews with one of the authors (GS) on local and national radio and television discussing the project; and direct contacts with the research team. GS undertook in depth, unstructured interviews with participants that were audiotaped and transcribed for qualitative analysis.

Analysis

We analysed narratives following a chronological pattern from early development and sexual feelings to the treatment received, their lives thereafter, and their current attitudes to their treatment. We examined each transcript systematically for data relating to these aspects and extracted text segments accordingly using the software package (NVivo). All authors undertook a series of discussions about emerging themes to resolve discrepancies and reach a consensus on the meaning of the texts.

Results

Twenty nine former male patients, two female patients, and two female relatives of male patients made contact, of whom one male and one female patient eventually declined because of personal commitments. This made 31 participants who were aged 27 to 83 years (mean 54.4, SD 12.2) at interview. One was married, six had married and divorced, and the remainder were single. One man had considered himself heterosexual until experiencing same sex attraction in his early 20s, four regarded themselves as bisexual, and the remainder had consistently been attracted to same sex partners.

Life before treatment

Many participants felt they lacked parental affection during childhood and adolescence and experiencing same sex attraction gave rise to considerable anxiety. Those who grew up between 1940 and 1970 often commented on the negative influence of the British media:

> There were no positive role models and the newspapers were full of the most vituperative filth that made me feel suicidal . . . I felt totally bewildered that my entire emotional life was being written up in the papers as utter filth and perversity.
>
> Male 1

Those who confided in others were usually met with silence, condemnation, and rejection or told that their homosexual feelings constituted a temporary phase. Two who confided in their teachers were referred to psychiatrists for treatment. Although many had experimented with same sex partners, the legal and social risks involved were considerable. Isolation from other gay

young people also drove several, as young adolescents, to engage in sexual experimentation with adults and vice versa, that might not otherwise have occurred. Growing up and realising that their sexual feelings were not a passing phase increased their sense of shame and isolation. A few requested help directly from mental health professionals to change their sexual orientation. Most, however, talked about their homosexual feelings with their general practitioners. However, doctors often lacked knowledge and were uncomfortable with the disclosure of homosexual feelings:

> He said he'd never had any experience with this and no one had ever raised this before. He said, "if you come back next week I'll do some research." I went back to see the GP and he said, "well, I've been in touch with colleagues," and he said, "obviously you can't go on living with the stress and the way you are—it's wrong, it's perverse, it's a sickness."
>
> Male 2

General practitioners referred participants to NHS professionals who were known to specialise in treatment of homosexuality. Only one general practitioner counselled a participant not to have treatment. Two men were arrested for homosexual activity and underwent treatment to avoid imprisonment.

Treatments

The age at which people received treatment ranged from 13 to 40 years, with most being in their late adolescence and early 20s. Treatments described were mainly administered in NHS hospitals throughout Britain and in one case a military hospital. Those treated privately usually underwent psychoanalysis. The most common treatment (from the early 1960s to early 1970s, with one case in 1980) was behavioural aversion therapy with electric shocks (11 participants). Nausea induced by apomorphine as the aversive stimulus was reported less often (four participants in the early 1960s).

In electric shock aversion therapy, electrodes were attached to the wrist or lower leg and shocks were administered while the patient watched photographs of men and women in various stages of undress. The aim was to encourage avoidance of the shock by moving to photographs of the opposite sex. It was hoped that arousal to same sex photographs would reduce, while relief arising from shock avoidance would increase, interest in opposite sex images. Some patients reported undergoing detailed examination before treatment, while others were assessed more perfunctorily. Patients would recline on a bed or sit in a chair in a darkened room, either alone or with the professional behind a screen. Each treatment lasted about 30 minutes, with some participants given portable electric shock boxes to use at home while they induced sexual fantasies. Patients receiving apomorphine were often admitted to hospital due to side effects of nausea and dehydration and the need for repeated doses, while those receiving electric shock aversion therapy attended as outpatients for weeks or in some cases up to two years.

Oestrogen treatment to reduce libido (two participants in the 1950s), psychoanalysis (three private participants and one NHS participant in the 1970s), and religious counselling (two participants in the 1990s) were also reported. Other forms of treatment were electroconvulsive therapy, discussion of the evils of homosexuality, desensitisation of an assumed phobia of the opposite sex, hypnosis, psychodrama, and abreaction. Dating skills were sometimes taught, and occasionally men were encouraged to find a prostitute or female friend with whom to try sexual intercourse.

Many described the treatments as unsophisticated and un-erotic because of the clinical setting and images used:

> The whole week was totally un-erotic. I don't think I could have had an erection for any reason that week because I didn't like being there.
>
> Male 3

Most were kept away from others undergoing the same treatment and avoided talking to family and friends about it. One participant claimed that a male doctor whom he consulted for help with his homosexuality sexually abused him several times at the age of 14, another that one or more doctors physically assaulted him during his treatment, while a third believed his name was given to the police and his family. Nevertheless, some reported concern and sympathy from those who treated them:

> A psychologist was the man who administered the jolts to me, and he was quite charming because I could tell he couldn't be disloyal to the hospital but he kind of, in his way, tried to dissuade me from doing this.
>
> Male 4

The contrast between the depth of their sexual feelings and the simplicity of the treatment made many doubt the wisdom of the approach. Most became disillusioned and stopped the treatments themselves. Sometimes treatment ended abruptly:

> I said, "when am I going to find a breakthrough? You keep saying things will change and everything's going to be OK." She [the psychiatrist] said, "well, I'm going to have to tell you now I don't think we are going to get anywhere. To be quite honest I never expected we would in the first place. You're going to have to go home and tell your wife that you're gay and start a new life." Boom!
>
> Male 5

This man left the hospital and immediately made a serious attempt on his life. Most participants were never followed up for more than a few months.

Life after treatments

For the brother of one participant, there was no life after treatment. He died in hospital due to the side effects of apomorphine. Several sought out further treatment, usually private psychoanalysis; none had further behavioural treatments. Some believed that the treatments had helped them to deal with their sexual feelings but not in the way intended:

> Mainly that from a guilt-ridden Christian point of view it meant that at least I had tried to do something and it had proved not to work. I think it's mostly the feeling that I'd done my bit to try and deal with the problem. I found that comforting.
>
> Male 6

With the decriminalisation of certain homosexual acts in 1967 and more tolerant social attitudes, most participants were able to explore their sexuality and several found fulfilling, same sex relationships. However, most never spoke to their partners, friends, or families about their treatment. One man was content to remain celibate when treatment failed to change his orientation, asserting that the main enjoyment in his life had been his hobbies. Three other men also avoided sex altogether but unhappily claimed it was the result of treatment. Other participants married in the hope this would complete their cure. Some marriages lasted many years and resulted in children. All except one—which was essentially a sexless marriage—ended in divorce on the grounds of sexual incompatibility. Several considered that they had hurt others:

> I have great pangs of conscience that, to some extent, I have wasted [his wife's] life, which she says not. We are very much in love but it's a very gentle, very tender, very caring but platonic love and the other feelings [homosexual] are still there and mount up and up by the day.
>
> Male 7

Several remained confused and angry at their naivety in accepting treatment:

> This feeling of a lack of self worth—I think that was a tremendous impact, because I shouldn't feel like that and I don't have any gay friends who do feel like that. I think that treatment had a lot to

answer for in that respect.

Male 5

Half of the participants were continuing to receive psychological help at the time of interview. However, only one informant, who had grown up in the 1990s, still wanted to change his sexuality and thought that mental health professionals currently denied him this option.

Discussion

These narratives show that hostile family and social attitudes rather than the police or courts impelled most people to seek professional help. However, our companion paper (Online First on bmj.com) on professionals who administered the treatments, suggests that patients were referred fairly regularly from the courts.[8] 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, but many retained a sense of loss and unease.

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 it had less impact. Treatments do not seem to have been 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.[9] Although our data suggest that treatment was unsuccessful and indeed harmful, the nature of our study means that we cannot address its efficacy. Although people who changed may have been less willing to participate than those who did not, there is no evidence from outcome studies that these treatments were effective at changing sexual orientation.[7] Nor is it simply the case that the wrong type of treatment was developed. The medicalisation of homosexuality itself seems to have been the fundamental error, rather than what type of treatment arose as a consequence.

Conclusions

Homosexuality was removed from ICD-10 (international classification of diseases, 10th revision) only in 1992. 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*, *Diva 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 Éamonn McKeown for commenting on earlier drafts of this paper. We also acknowledge the support of the Camden and Islington Mental Health and Social Care Trust.

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

Contributors: MK and AB conceived the idea, devised the protocol, and obtained funding for the study. GS conducted the interviews and analysed the data in collaboration with MK and AB. All three authors contributed to the paper. MK is guarantor.

Funding: GS was supported by a grant from the Wellcome Trust History of Medicine Section.

Competing interests: None declared.

Ethical approval: Received from Royal Free Hospital NHS Trust Research Ethics Committee.

1 Davenport-Hines R. *Sex, death and punishment. Attitudes to sex and sexuality in Britain since the Renaissance.* London: Collins, 1990.
2 Weeks J. *Coming out. Homosexual politics in Britain from the nineteenth century to the present.* London: Quartet Books, 1990.
3 Foucault M. *The history of sexuality.* Vol 1. *An introduction.* Penguin: Harmondsworth, 1981.
4 Porter R. *The greatest benefit to mankind. A medical history of humanity from antiquity to the present.* London: HarperCollins, 1997.
5 Porter R, Hall L. *The facts of life: the creation of sexual knowledge in Britain, 1650-1950.* New Haven, CT: Yale University Press, 1994.
6 Hall L. *Sex, gender and social change in Britain since 1880.* New York, NY: St. Martin's Press, 2000.
7 King MB, Bartlett A. British psychiatry and homosexuality. *Br J Psychiatry* 1999;174:106-13.
8 King M, Smith G, Bartlett A. Treatments of homosexuality in Britain since the 1950s—an oral history: the experience of professionals. *BMJ* 2004 doi 10.1136/bmj.37984.496725.EE
9 Bartlett A, King M, Phillips P. Straight talking—an investigation of the attitudes and practice of psychoanalysts and psychotherapists in relation to gays and lesbians. *Br J Psychiatry* 2001;179:545-9.

(Accepted 2 December 2003)

doi 10.1136/bmj.37984.442419.EE

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

Department of Psychiatry, St George's Hospital Medical School, Jenner Wing, London SW17 0RE
Annie Bartlett *senior lecture*

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