



# Mental Nursing and “Sexual ‘Deviation’”: Exploring the Role of Nurses and the Experience of Former Patients, 1935 - 1974'

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**MENTAL NURSING AND “SEXUAL  
DEVIATION”: EXPLORING THE ROLE OF  
NURSES AND THE EXPERIENCE OF  
PATIENTS, 1935-1974.**

**A thesis submitted to The University of Manchester for the degree of**

**Doctor of Philosophy in Nursing**

**in the Faculty of Medical and Human Sciences.**

**2012**

**Tommy Dickinson**

**School of Nursing, Midwifery  
and Social Work**

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**WORD COUNT: 87,977.**

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The inclusion of people who appear in the photographs in this thesis does not imply anything about their sexual orientation either now or then. Every effort has been made to trace copyright owners of the images used in this thesis and anyone claiming copyright should get in touch with the author.

## ABSTRACT

Male homosexuality was illegal in England and Wales from 1533 until 1967 and, along with transvestism, was considered an antisocial “sexual deviation” that could be “cured”. Nurses were involved in administering treatments to cure these individuals. This study used oral history interviews with fifteen nurses, along with documentary sources, to examine the meanings that nurses attached to these treatments, and represents the first attempt to examine nurses’ perceptions on providing such treatments. The study also conducted oral history interviews with seven patients and explores their experiences of receiving these treatments to obtain a better understanding of the topic in question and claim a ‘history from below’ which allows us to see historical practice from a new perspective.

The period examined by this thesis was 1935 to 1974. It begins with the publication of the first official report on the use of aversion therapy to treat homosexuality. This publication, along with prejudicial attitudes towards homosexuals and transvestites in the media and in literary, medical, sociological and legal discourses, provided some momentum for the use of aversion therapy to cure these individuals. The period ends in 1974 with the seventh printing of the American Psychiatric Association Diagnostic Statistical Manual version II, which removed homosexuality as a category of psychiatric disorder in the USA.

None of the patients in this study reported that the treatment had been effective and all were left feeling emotionally troubled by it. The study explored a number of influences that may have motivated nurses to administer these painful and distressing treatments. Nurses’ work was largely constrained by the asylum-type conditions in which they worked, and the character and quality of patient care was largely influenced by the medical staff, who appeared to have overriding control of both the institution and the nurses working within it. In addition, due to their limited knowledge base, nurses believed that it was pertinent for the well-being of a patient that nurses obey medical orders. They took on the status offered to them of obedient order-takers. Nevertheless, from accounts gathered during this study, some nurses covertly undermined their superiors and engaged in subversive behaviours to avoid participating in this aspect of clinical practice.

The thesis offers a hitherto undiscovered insight into the role of mental nurses caring for patients receiving aversion therapy for sexual deviation. In doing so, it provides insights into the way nurses may behave when a particular set of social, political and contextual factors are at play. As the first study to focus on exploring the nurses’ role in caring for sexually deviant patients, it provides in-depth historical analysis of this subject and related issues as well as a basis for further historical analysis in this area. It is envisaged that this study might also act as a reminder of the need for nurses to ensure that their interventions have a sound evidence base, and that they constantly reflect on the moral and value base of their practice and the influence that science, societal norms and contexts can have on changing views of what is regarded as “acceptable practice”.

## DECLARATION

**No portion of the work referred to in the thesis has been submitted in support of an application for another degree or qualification of this or any other university or other institute of learning.**



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## LIST OF ABBREVIATIONS

<b>APA</b>	American Psychiatric Association
<b>BACP</b>	British Association for Counselling and Psychotherapy
<b>COHSE</b>	Confederation of Health Service Employees
<b>CMN</b>	Chief Male Nurse
<b>DHEW</b>	Department of Health, Education and Welfare
<b>DSM</b>	Diagnostic Statistical Manual
<b>ECT</b>	Electroconvulsive therapy
<b>FANY</b>	First Aid Nursing Yeomanry
<b>GAA</b>	Gay Activist Alliance
<b>GLBT</b>	Gay, lesbian, bisexual and transgendered
<b>GLF</b>	Gay Liberation Front
<b>GNC</b>	General Nursing Council
<b>GP</b>	General Practitioner
<b>GRS</b>	Gender reassignment surgery
<b>HCA</b>	Hall Carpenter Archives
<b>HMC</b>	Hospital Management Committee
<b>ICD</b>	International Classification of Diseases
<b>MPA</b>	Medico-Psychological Association
<b>NA</b>	National Archives
<b>NHS</b>	National Health Service
<b>NZ</b>	New Zealand
<b>POW</b>	Prisoner of War
<b>RAF</b>	Royal Air Force
<b>RCN</b>	Royal College of Nursing
<b>RHB</b>	Regional Hospital Board
<b>RMN</b>	Registered Mental Nurse
<b>RMPA</b>	Royal Medico-Psychological Association
<b>SEAN</b>	State Enrolled Assistant Nurse

<b>SEN</b>	State Enrolled Nurse
<b>SOE</b>	Special Operations Executive
<b>SRN</b>	State Registered Nurse
<b>SS</b>	Schutzstaffel (Defence Detachment)
<b>UK</b>	United Kingdom
<b>USA</b>	United States of America
<b>USPHS</b>	United States Public Health Service
<b>USSR</b>	Union of Soviet Socialist Republics
<b>WHO</b>	World Health Organisation

## ACKNOWLEDGEMENTS

Like all histories, this thesis is a collaboration between its author and a vast number of historians, librarians, lecturers and archivists. My interest in history was first aroused by the reminiscences of my late nana, Mary Dickinson (nee Lambert), and Grandfather, Joseph Murro. As a child, I would listen attentively to their fascinating anecdotes of living through World War II, especially my Grandfather's experiences as an evacuee; they would have been delighted to see me complete this thesis. I miss them.

I owe a great deal to my supervisory team Prof. Christine Hallett, Prof. John Playle and Dr. Matt Cook. Their constant support, encouragement and insights have kept me going, pushing me farther than I ever imagined, and I am forever grateful for this.

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I'm also extremely grateful for the financial support I have received from the University of Central Lancashire; the University of Manchester: Mona Grey prize; The Royal College of Nursing: Monica Baly Award; The Royal Historical Society; and the Wellcome Trust.

I'm lucky enough to have an amazing set of friends and family who have always been very patient and encouraging in supporting me throughout my studies. They've humoured me, tolerated me and coped with my obsession with this study. For what it's worth, I offer my thanks to Donna Taylor, whose pragmatic perspective has kept me focussed, and Mark Faulkner for his constant technological support, particularly when I was ready to throw my computer out of the window! I'm very grateful to Andrew Gibbon who carefully and scrupulously read the whole thesis and offered some intellectually savvy comments. Meanwhile, Darren Mawdsley and Jon Davies were always able to make me laugh out loud when I was ready to cry. Thank you.

A special thanks goes to my parents – particularly my mum who has just been herself. She was continually there when I was ready to give it all up and always managed to get me back on track, constantly encouraging me to achieve my ambitions. I feel very lucky to have her as a mum and I love her dearly.

My colleagues in the School of Health at the University of Central Lancashire have been great. I have benefited remarkably from the open exchange of ideas with Geoff Speight and Ian Denoual. Geoff Speight's and Susan Ramsdale's comments on various bits of this thesis, from sentences to entire chapters, have made me reconsider my work and think harder about my arguments. Sharon Pagett, Marie Mather and Emma Walker very generously covered some of my teaching commitments, which allowed me to take a much appreciated and productive sabbatical. Meanwhile Carmit Erez and John Young provided vital technological support. This is a much better thesis as a result of their input – thank you. I am also extremely grateful to Claire Chatterton who has shared references and ideas along the way.

Finally, I owe a unique debt to the participants whom I have interviewed as part of my study. Thank you for inviting me into your homes and sharing your experiences. Some of the testimonies, especially those of former patients, were quite difficult to hear, and I admire your bravery in retelling me your stories. I am forever in your debt.

## THE AUTHOR

Tommy Dickinson is a Senior Lecturer in Mental Health Nursing at the University of Central Lancashire. He undertook his initial nurse education at Bournemouth University and graduated as a Registered Nurse in 2001. He worked in various nursing and nurse leadership roles in the UK and Australia before he moved into academia in 2007. He obtained an MSc in Nursing with Distinction from Bradford University in 2009. Tommy has presented and published parts of the research he undertook for his MSc dissertation, along with aspects of his PhD research, at international conferences and in peer reviewed academic journals.<sup>1</sup>

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<sup>1</sup> For the publications related to this study see appendices C & I. Throughout this thesis, referencing guidelines by The University of Manchester, Faculty of Humanities, School of Arts, Histories and Cultures have been adopted; the guidelines do not require that the publisher be given (for details of these guidelines, please see appendix A). Footnotes will be numbered sequentially within each chapter.

**To**

**Mum**

I can no other answer make but thanks,

And thanks, and ever thanks.

*William Shakespeare, Twelfth Night*

## INTRODUCTION

In December 1966, William Newman visited a public toilet on his way home from work in his family's butcher's shop in east London.<sup>1</sup> William did not need to use the facilities in the public toilet; he was 'looking for love'.<sup>2</sup> Here an 'exceptionally good looking young man'<sup>3</sup> approached William and made a sexual advance towards him. When William responded to his advance, he was arrested – the young man was an undercover police officer. William was charged and subsequently convicted of importuning and conspiring to incite the police officer to 'commit unnatural offences'.<sup>4</sup> He was given the option of imprisonment or to be remanded provided he was willing to undergo psychological treatment to "cure" his "condition". In the belief that the psychological treatment would be a 'better option'<sup>5</sup> than imprisonment, he chose to receive the treatment.

William was transferred to a local psychiatric hospital and was subjected to what he described as 'a barbaric torture scene by the Gestapo in Nazi Germany trying to extract information from me'<sup>6</sup> and he thought he 'was going to die'.<sup>7</sup> What William had agreed to was to undergo aversion therapy in a bid to cure him of his homosexuality. The behaviour of the police officer was not unusual and entrapment by undercover police officers during the 1950s and 1960s was common practice.<sup>8</sup> Moreover, nurses were

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<sup>1</sup> William Newman, (pseudonym) interviewed 29<sup>th</sup> April 2010. For a detailed discussion regarding anonymity of the participants, please see Chapter I; biographical details of all participants in the study can be found in Appendix B.

<sup>2</sup> William Newman, interviewed 29<sup>th</sup> April 2010.

<sup>3</sup> William Newman, interviewed 29<sup>th</sup> April 2010.

<sup>4</sup> William Newman, interviewed 29<sup>th</sup> April 2010.

<sup>5</sup> William Newman, interviewed 29<sup>th</sup> April 2010.

<sup>6</sup> William Newman, interviewed 29<sup>th</sup> April 2010.

<sup>7</sup> William Newman, interviewed 29<sup>th</sup> April 2010.

<sup>8</sup> For an exploration of the police regulation of London: see, e.g. Matt Houlbrook, *Queer London: Perils and pleasures in the sexual metropolis, 1918-1957* (Chicago, 2005), pp. 19-43; Patrick Higgins, *Heterosexual Dictatorship: Male homosexuality in Postwar Britain* (London, 1996); Jeffery Weeks, *The World We Have Won: The Remaking of Erotic and intimate Life* (London, 2007); Paul Jones, *Tales from Out in the City* (Manchester, 2009).

frequently involved in administering aversion therapies to cure such individuals of what were seen as their “sexual deviations”.<sup>9</sup>

This thesis is primarily focussed on such narratives, which will be used as a way of interrogating questions of experience, motivation, feeling and perception in relation to the use of aversion therapy to “cure” homosexuality and transvestism. In this way, it seeks to offer fresh insight into both patients’ and nurses’ perspectives on these treatments. It uses testimonies of patients and nurses to explore the subject in ways that have not been attempted before, and to texture more broadly focussed histories of these treatments and this period. This echoes recent moves towards micro histories particularly in the history of sexuality and nursing, as a way of framing and answering questions about everyday life, experience and thought in relation to discourse and the bigger narratives and cultural assumptions we make about sexuality and nursing.<sup>10</sup>

This introductory chapter outlines the aims, research questions, time scale and the geographical location of this study, and goes on to explore the concept of “deviance” and “sexual deviance”. The various names used in different historical periods to describe homosexuals, transvestites and mental health nurses, as we know them today, are explored. It provides an overview of the thesis and explores key moments in the history of sexuality and mental health nursing (1533-1929), which are relevant to this study. Finally, the chapter lays out the contribution this thesis makes to the history of sexuality and mental health nursing.

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<sup>9</sup> See, e.g. “A Nursing Sister’s Advice to Homosexuals”, *Johannesburg Star*, 25<sup>th</sup> November 1968.

<sup>10</sup> See, e.g. Carlo Ginzburg, John Tedeschi & Anne C. Tedeschi, ‘Microhistory: Two or Three Things That I Know about It’, *Critical Inquiry* 20 (1993), pp. 10-35; Matt Cook, ‘Gay Times’: Identity, Locality, Memory, and the Brixton Squats in 1970s London’, *Twentieth Century History* 9 (2011), pp. 1-26; Diana Gittins, *Madness in its Place: Narratives of Severalls Hospital, 1913-1997* (London, 1997); John Adams, *Challenge and Change in a Cinderella Service: A History of Fulbourn Hospital, Cambridgeshire, 1953 – 1995*. PhD thesis, The Open University (2009).



## Rationale

With the notable exception of the joint work of Glenn Smith, Michael King & Annie Bartlett,<sup>11</sup> there is a paucity of academic literature exploring the experiences of individuals who were subjected to treatments for their sexual deviations. Smith and his colleagues conducted oral history interviews with twenty-nine people who received treatments to change their sexual orientation in the United Kingdom (UK). The study concluded that the definition of same-sex attraction as an illness and the development of treatments to eradicate such attractions have had a negative long-term impact on the individuals who received them.<sup>12</sup> Anecdotal evidence of the testimonies of patients who received these treatments and medical attitudes towards them are scattered in the written and recorded testimonies of gay, lesbian, bisexual and transgendered (GLBT) people.<sup>13</sup>

King and his colleagues also conducted a study exploring the experiences of thirty health care practitioners caring for these individuals. They concluded that ‘social and political assumptions sometimes lie at the heart of what we regard as mental pathology and serve as a warning for future practice’.<sup>14</sup> However, their study mainly focussed on the testimonies of doctors and psychologists and only included one nurse. The role of the nurse in regard to nursing individuals receiving treatments for sexual deviations is a hitherto neglected aspect of nursing history.

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<sup>11</sup> Glenn Smith, Michael King & Annie Bartlett, ‘Treatments of homosexuality in Britain since the 1950s – an oral history: the experience of patients’, *British Medical Journal*, 1136 (2004), pp. 1-4.

<sup>12</sup> Smith, King & Bartlett, ‘Treatments of homosexuality in Britain since the 1950s’, p. 2

<sup>13</sup> See, e.g., Duncan Fallowell & April Ashley, *April Ashley’s Odyssey* (London, 1982), pp. 30-32; Pete Price, ‘Namesdropper’ (Liverpool, 2007), pp. 85-90; Alkarim Jivani, *It’s Not Unusual: A history of lesbian and gay Britain in the twentieth century* (London, 1997), pp. 122-128; Roger Davidson, *And Thus Will I Freely Sing: An analogy of gay and lesbian writings from Scotland* (Edinburgh, 1989), pp. 154-159; Bob Cant, *Footsteps and Witnesses: Lesbian and Gay Life Stories from Scotland* (Edinburgh, 1993), p. 49.

<sup>14</sup> Michael King, Glenn Smith & Annie Bartlett, ‘Treatments of Homosexuality in Britain since the 1950s – an oral history: The experience of professionals’, *British Medical Journal* 1136 (2004), pp. 187-201.

## Aims

This thesis aims to:

- A. Examine the experiences of and meanings that nurses and patients attached to certain “treatments” to change sexual deviation in the UK from 1935 to 1974.
- B. Explore why men received such treatments, how they experienced them, how they affected their lives, and their aftermath, to obtain a better understanding of the topic in question and claim a ‘history from below’ which allows us to see historical practice from a new perspective.<sup>15</sup>
- C. Focus on a hitherto neglected area of study by looking in detail at nurses’ perspectives on providing these treatments.

The following research questions will be addressed:

- A. In the period 1935 – 1974: under what circumstances did men who were attracted to other men or engaged in transvestism receive treatments to change their sexual deviations?
- B. What were the referral pathways and the processes of treatment?
- C. What were the perceptions of nurses administering these treatments to cure sexual deviations of men?
- D. What were nurses’ motivations, rationales and experiences of administering these treatments?
- E. How did the patients receiving these treatments experience them and how did these experiences impact on their lives?

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<sup>15</sup> Roy Porter warned that if patients’ views are ignored in the history of medicine, there is the potential for gross distortion: Roy Porter, ‘The Patients View: doing history from below’, *Theory and Society* 14 (2) (1985), pp. 175-198.

### Time scale and geographical location of this study

The period this thesis examines is 1935 to 1974. The period began with the publication of the first official report on aversion therapy being utilised to treat homosexuality. The report was by Louis Max, a psychiatrist, who required a homosexual patient to fantasize about an attractive same-sex sexual stimulus in conjunction with receiving an electric shock.<sup>16</sup> The period ends in 1974 with the seventh printing of the American Psychiatric Association (APA) *Diagnostic Statistical Manual* (DSM) version II, which removed homosexuality as a category of psychiatric disorder. Although published in the USA, this manual was widely utilised in the UK to aid healthcare practitioners to diagnose mental illness.<sup>17</sup>

This study is specifically about the treatments developed for sexual deviations in the UK. That is not to say that these treatments were not administered elsewhere: they were – not least in the United States of America (USA).<sup>18</sup> However, given the dearth of literature specifically discussing these treatments in the UK, the decision was made to focus the study on this geographical area. Nevertheless, the APA is based in the USA and this is where the majority of the rhetoric regarding the eventual removal of homosexuality from the DSM took place. Therefore, Chapter VI will explore this literature and the implications it had for the UK.

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<sup>16</sup> Louis W. M. Max, 'Breaking up a Homosexual Fixation by the Conditional Reaction Technique: A Case Study', *Psychological Bulletin* 32 (1935), p. 734.

<sup>17</sup> American Psychiatric Association, *Seventh Printing Diagnostic Statistical Manual Version II* (Arlington, 1974). It is important to note that the World Health Organisation only decided to drop the term "homosexuality" as a diagnosis in 1990. It was eventually removed from their diagnostic manual in 1992, with the introduction of the *International Classification of Diseases edition 10 Classification of Mental and Behavioural Disorders* (ICD-10). Nevertheless, there is a paucity of literature describing treatments for homosexuality after 1974, and the literature, which will be explored in Chapter VI, describes how the publication of the seventh printing of the DSM II, combined with a fresh gay liberation movement in the 1970s, was seminal in the curtailment of these treatments. Additionally, no participants in this study reported receiving treatments after this date. Therefore, the decision was made to end the study in 1974. However, the period, 1974 – 1992 will be discussed in the epilogue.

<sup>18</sup> See, e.g. Ronald Bayer, *Homosexuality and American Psychiatry: The politics of power* (Princeton, 1987); Jack Drescher & Joseph P. Merlino, *American Psychiatry and Homosexuality: An Oral History* (New York, 2007); "A Neurosis Is Just A Bad Habit", *New York Times*, 4<sup>th</sup> June 1967.

## Deviance

Given that the notions of what is considered appropriate and inappropriate result from complex interaction of institutionalised norms and laws, it is pertinent that the notion of “deviance” is explored. My main concern within this thesis is with shifting definitions of deviance, predominantly in relation to views of homosexuality, and the consequences of these changes. I am particularly interested in how nurses came to see the treatments they were administering for sexual deviation as appropriate and then inappropriate as the ideas of deviance shifted throughout the study period.<sup>19</sup>

There are many ways to study what sociologists call deviance. Peter Conrad and Joseph Schneider argue that there are two general orientations to deviance in sociology that lead in distinctive directions and produce altered, sometimes conflicting conclusions about what deviance is and how sociologists and others should conceptualise it.<sup>20</sup> These are the positivist and the interactionist approaches. Conrad and Schneider argue that the positivist approach accepts that deviance is real, that it occurs in the objective knowledge of the individuals who engage in deviant acts and those who respond to them. Essentially this view rests on a second important notion – ‘that deviance is definable in a basic manner as behaviour not within permissible conformity to social norms’.<sup>21</sup> The focus of positivists’ study of deviance has mainly been on searching for its causes. From a sociological point of view, such causes have been attributed to terms such as social and/or cultural environment and one’s socialization. However, Conrad

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<sup>19</sup> Due to the reflective nature of this thesis, I feel that it is appropriate that I write in the first person, as I will be reflecting upon personal incidents and discussing the process of my development using oral history as a method of historical research. Christine Webb suggests that there are many benefits of writing in the first person: these include the fact that this approach is appropriate to develop the personal and professional qualities of self-awareness, reflection, analysis and critique. It is also argued that it is acceptable to write in the first person when giving a personal opinion or when one has played a crucial role in shaping the data or ideas presented: Christine Webb, *Communication Skills* (London, 1992), pp. 11-12; Gert Rijlaarsdam, Huub Van den Bergh, & Michel Couzijn, *Effective Learning and Teaching of Writing: A Handbook of Writing in Education* (New York, 2005).

<sup>20</sup> Peter Conrad & Joseph W. Schneider, *Deviance and Medicalization: From badness to sickness* (Philadelphia, 1980), p. 1.

<sup>21</sup> Conrad & Schneider, *Deviance and Medicalization*, p. 2.

and Schneider suggest that positivists outside sociology typically search for causes in physiology and/or the psyche.<sup>22</sup> Moreover, it has been argued that the medical model of deviance is essentially a positivist one.<sup>23</sup>

Peter Aggleton argues that the interactionist orientation to deviance perceives that the morality of society is 'socially constructed and relative to actors, context and historical time'.<sup>24</sup> Of fundamental importance to this view is the assumption that moral codes do not just happen rather they are socially constructed and since they are socially constructed, there must be constructors. I would suggest, therefore, that morality, and hence definitions of deviance, is the product of certain people making claims based on their own vested interests, values, beliefs and views of the world. People who command comparatively more power within society are characteristically more able to impose their rules and sanctions on the less powerful.<sup>25</sup> Deviance, therefore, becomes the conditions that are defined as inappropriate to or in violation of certain powerful groups' ideals and moral codes. The interactionist view assumes that the behaviours defined as deviant are mainly voluntary and that people exercise some degree of 'free will' in their lives.<sup>26</sup> Therefore, it could be argued that deviance is socially defined, and that research should focus on how such definitions are constructed, how deviant labels are attached to particular behaviours and people and what the consequences are, both for those labelled as deviant and for the authors of such attributions. It is pertinent at this juncture to note, however, that it does not mean that positivist and interactionist approaches are never combined in research; according to Conrad and Schneider, some of the best studies have adopted elements of both.<sup>27</sup> However, as discussed above, given that the notions of what is deemed appropriate and inappropriate result from complex

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<sup>22</sup> Conrad & Schneider, *Deviance and Medicalization*, p. 2.

<sup>23</sup> Peter Aggleton, *Deviance* (London, 1987), p. 17; Conrad & Schneider, *Deviance and Medicalization*, p. 2.

<sup>24</sup> Aggleton, *Deviance*, p. 17

<sup>25</sup> Conrad & Schneider, *Deviance and Medicalization*, p. 2

<sup>26</sup> Conrad & Schneider, *Deviance and Medicalization*, p. 2.

<sup>27</sup> Conrad & Schneider, *Deviance and Medicalization*, p. 2.

interaction of institutionalised norms and laws, shared and internalised norms or mores, the main approach taken within this thesis is decidedly interactionist. My main concern is with the shifting of definitions of deviance, the explanations of such shifts, and the implications of these changes.

### *Sexual Deviance*

The definition of what is considered deviant sexual behaviour has slowly transformed within British society. This has not been a change in behaviour so much as a change in how behaviour is defined. Those deviant behaviours once defined as immoral, sinful or criminal were later interpreted as medical conditions, hence requiring treatment as opposed to punishment. I would argue that rehabilitation replaced punishment. However, it has been suggested that medical treatments became a new form of punishment and social control.<sup>28</sup> It has been proposed that these changes have not ensued by themselves; nor have they been the consequence of a “natural” evolution of society or the inevitable advancement of medicine. The roots of these changes lie deep within our social and cultural heritage.<sup>29</sup> This study presents an analysis of the historical transformation of the definitions of sexual deviance from a “crime” to “sickness” and finally on to “acceptance” and discusses the significances of these changes and the implications in terms of treatments administered for sexual deviance.

As awareness of the variability and multifariousness of sexual behaviour increased throughout the period examined in this study, the boundaries between normal and deviant sexual behaviour became more blurred. However, there were certain forms of sexual behaviour that were generally held to be deviant. Paul Scott adumbrated those

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<sup>28</sup> Michael King & Annie Bartlett, ‘British Psychiatry and Homosexuality’, *British Journal of Psychiatry*, 175 (1999), pp. 106 – 113; Aggleton, *Deviance*, p. 10.

<sup>29</sup> Conrad & Schneider, *Deviance and Medicalization*, p. 1.

features that characterized such behaviour as follows:

The elements of a comprehensive definition of sexual perversion should include sexual activity or fantasy directed towards orgasm other than genital intercourse with a willing partner of the opposite sex and of similar maturity, persistently recurrent, not merely a substitute for preferred behaviour made difficult by the immediate environment and contrary to the generally accepted norm of sexual behaviour in the community.<sup>30</sup>

This definition, which is taken from the 1960s, which is towards the latter part of this study period, emphasizes that it is the continued and habitual substitution of some other act for heterosexual genital intercourse which primarily characterized behaviours called sexual deviation. Sexual deviations were separated into categories according to the predominant or outstanding sexual behaviour. These categories included homosexuality, prostitution, sexual activity with immature partners of either sex (paedophilia), transvestism and sex with dead people (necrophilia), animals (bestiality) or inanimate objects (fetishism). Also included were sado-masochism, sexual violence, rape, incest, exhibitionism, voyeurism and transsexualism.<sup>31</sup>

Treatments were developed for all of these categories of sexual deviations.<sup>32</sup> However, homosexuality was the category which predominately received treatments and where we can see clear shifts in attitudes towards individuals.<sup>33</sup> Five participants in this study received treatments for homosexuality. Transvestism was also treated fairly widely; however, not to the same extent as homosexuality, and only two participants in this study received treatments for this.<sup>34</sup> Moreover, transvestism currently remains

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<sup>30</sup> Paul D. Scott, *Definition, Classification, Prognosis and Treatment of Sexual Deviation* (London, 1964), p. 34

<sup>31</sup> Ismond Rosen, *Sexual Deviation* (Oxford, 1979), p. 3.

<sup>32</sup> See, e.g. John Bancroft, *Deviant Sexual Behaviour: Modification and Assessment* (Oxford, 1974); Rosen, *Sexual Deviation*.

<sup>33</sup> Rosen, *Sexual Deviation*, p. 5.

<sup>34</sup> Bancroft, *Deviant Sexual Behaviour*, p. 29.

classifiable as a mental disorder.<sup>35</sup> While this thesis will explore the treatments developed for transvestism and the testimonies of the individuals who received treatment for this, it will predominantly explore the cultural and medical attitudinal shifts towards homosexuality, which initially led to treatments being developed for this “disorder”, and subsequently on to the eventual removal of homosexuality from psychiatric diagnostic manuals.

Further, this thesis is mainly about the treatments for sexual deviations in men. That is not to say that women were not subjected to psychiatric evaluation or advised to undergo these treatments; they were.<sup>36</sup> However, of all reported cases in the medical literature, only one published study discussed aversion therapy being administered to women.<sup>37</sup> Furthermore, no women came forward as research participants for this study. It is important to note that while female sexual deviation – predominantly prostitution – was inscribed within forms of investigation that mirrored the regulation of male sexualities, lesbianism remained invisible in the law.<sup>38</sup> When we consider that one of the main ways in which men were referred for these treatments was through a court order,<sup>39</sup> this could offer a context to explain the limited response from females to this study and their limited presence in the literature.

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<sup>35</sup> The current versions of the Diagnostic Statistical Manual and the International Classification of Diseases both classify transvestism as a mental disorder: ‘Transvestic Fetishism’ (DSM: 302.3) American Psychiatric Association, *Diagnostic Statistical Manual Version IV* (Washington, 1994); ‘Transvestism’ (ICD: F64.1) World Health Organisation, *The International Classification of Diseases version 10 Classification of Mental and Behavioural Disorders* (Geneva, 1992).

<sup>36</sup> See, e.g. Jennifer Terry, ‘Lesbians under the Medical Gaze: Scientists Search for Remarkable Differences’, *The Journal of Sex Research* 27 (1990), pp. 317-339; Jivani, *It’s Not Unusual*, p. 127; Henry L. Minton, ‘Community Empowerment and the Medicalization of Homosexuality: Constructing Sexual Identities in the 1930s’, *Journal of the History of Sexuality* 6 (1996), pp. 435-458.

<sup>37</sup> Michael J. McCulloch & Michael P. Feldman, ‘Aversion therapy in the management of 43 homosexuals’, *British Medical Journal* 4 (1967), p. 595

<sup>38</sup> See, e.g. Judith Walkowitz, *Prostitution and Victorian Society: Women, class and the State* (Cambridge, 1980), pp. 7-8; Houlbrook, *Queer London*, p. 10; Lillian Faderman, *Surpassing the Love of Man: Romantic Friendship and Love Between Women from Renaissance to the Present* (London, 1985).

<sup>39</sup> John Bancroft, ‘Aversion Therapy of Homosexuality: A pilot study of 10 cases’, *The British Journal of Psychiatry* 115 (1969), p. 1418.



## Terminology and definitions

### *Homosexuality*

Finding an appropriate vocabulary with which to discuss the historical organization of male sexual practices and identities is particularly challenging. The terms “gay”/“homosexual” and “straight”/“heterosexual” are contemporary terms, and position such practices within a specific interpretive framework that cannot be applied easily to the past.<sup>40</sup> Indeed, prior to the early 1970s, many men who had sex with other men did not consider themselves to be gay.<sup>41</sup> The word only came into popular usage in the UK with the advent of Gay Liberation during the 1970s.<sup>42</sup> Different labels were given to these men in the eighteenth, nineteenth and twentieth centuries, and included “mollies”, “sodomites”, “inverts”, “maryannes”, “homosexuals”, “queens”, “trade”, “gays”, “artistic”, “so” and “queers”. Matt Cook has argued that these labels were not necessarily synonymous, with each representing a different understanding of identity and desire.<sup>43</sup>

Donna Penn has suggested that this identity paradigm on scholarly as well as political imaginings has made it extremely difficult to address the issues of studying their history. She goes on to argue that the term “queer” provides new ways of thinking on the subject:

The challenge of queer to the hegemony of the “normal” might provide the space in which to begin retheorizing categories of inclusion and exclusion that guide our historical work. By reframing the project, [a] “queer” [project] it may provide an interpretative strategy that can free the historian from the bondage of rigid definitions that, necessarily if unintentionally, limit the historical imagination. Instead of organizing on behalf of a group defined variously as homosexuals, gays and lesbians, or gays, lesbians, and bisexuals, queers aim to destabilize the

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<sup>40</sup> Houlbrook, *Queer London*, p. xiii.

<sup>41</sup> Paul Baker & Jo Stanley, *Hello Sailor! The Hidden History of Gay Life at Sea* (London, 2003), p.11.

<sup>42</sup> Matt Cook, *A Gay History of Britain: Love and Sex Between Men Since the Middle Ages* (Oxford, 2007), p. xi.

<sup>43</sup> Cook, *A Gay History of Britain*, p. xi.

boundaries that divide the normal from the deviant and to organize against heteronormativity.<sup>44</sup>

Cook also goes on to suggest that “queer” is useful as a broader term, as it does not carry with it the same idea of a definitive and a singular identity that “gay” does.<sup>45</sup> However, for many men who suffered stigma in the last century – not least those whom I examine here, the term “queer” may have pejorative meanings. It would seem ironic – and for the subjects themselves, inappropriate – to re-use that term here, albeit with a difference in meaning. Following Paul Baker and Jo Stanley, I therefore use the labels of “gay” and “homosexual” (as appropriate in context) interchangeably throughout the thesis to describe men who self-identified as mainly being sexually and romantically attracted to other men.<sup>46</sup> However, I acknowledge that some of these men would not have used these words to describe themselves during the time they were receiving treatments for their sexual deviations, even though they do later.

### *Transvestism*

The term ‘transvestite’ was first coined by Magnus Hirschfeld in 1910.<sup>47</sup> Hirschfeld invented the word from Latin *trans*, ‘across, over’ and *vestitus*, ‘dressed’ to refer to the sexual interest in cross-dressing.<sup>48</sup> Nevertheless, the definition of transvestite has always been contentious – not least for the two participants in this study who received treatments for transvestism. Peter Ackroyd suggests that transvestism comprises at least two distinct aspects. The first consists of those who are exclusively fetishistic: they dress, in other words, to obtain some kind of sexual arousal. Others move out of the fetishistic stage; they cease to be sexually excited by the act of cross-dressing itself, and

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<sup>44</sup> Donna Penn, ‘Queer: Theorising Politics and History’, *Radical History Review* 63 (1995), pp. 30-31

<sup>45</sup> Cook, *A Gay History of Britain*, p. xi.

<sup>46</sup> Baker & Stanley, *Hello Sailor!*, p. 7.

<sup>47</sup> Magnus Hirschfeld, *Transvestites: The Erotic Drive to Cross Dress* (London, 1991).

<sup>48</sup> Marjorie Garber, *Vested Interests Cross-Dressing and Cultural Anxiety* (London, 1992), p. 24.

go on to a more comprehensive form of feminine ‘passing’.<sup>49</sup> Further, Jed Bland states that male transvestites are rarely effeminate or homosexual and that most are firmly heterosexual and cross-dressing often increases their heterosexual activities.<sup>50</sup>

The two participants in this study who received treatments for transvestism never identified themselves as homosexual and stated that they did not get any sexual gratification from cross-dressing. They expressed an obsessive desire to assume the genitals and body of the opposite sex. Indeed, both the participants subsequently underwent gender reassignment surgery (GRS) and are now living as females. However, the first GRS was not undertaken in the UK until 1969, when Dr. Philip Thomas began performing GRS at Charing Cross Hospital.<sup>51</sup> Consequently, most men who sought or were referred for medical help relating to cross-dressing were labelled as transvestites even though the majority of them would never have identified themselves with this label.<sup>52</sup> Therefore, in keeping with the terminology utilised during the period being discussed, I will use the term “transvestite” (as appropriate in context) to describe men who cross-dressed in the opposite sex’s clothes. However, I acknowledge that both the participants in this study and many other men would not have used this word to describe themselves at the time when they were receiving treatments.

### *Mental health nursing*

Mental health nurses have also been known by different names in the past. Initially, staff who worked within the early asylums were referred to as “keepers”, a title that applied to both male and female staff and dated back to medieval times.<sup>53</sup> Following the

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<sup>49</sup> Peter Ackroyd, *Dressing Up Transvestism and Drag: The History of an Obsession* (Norwich, 1979), p. 14.

<sup>50</sup> Jed Bland, *Transvestism and Cross-Dressing: Current Views* (London, 2004), p. 9.

<sup>51</sup> ‘Mistaken Identity.’ *The Guardian*, 31<sup>st</sup> July, 2004.

<sup>52</sup> Bancroft, *Deviant Sexual Behaviour*, p. 28; ‘Mistaken Identity.’

<sup>53</sup> Michael Arton, *The Professionalization of Mental Nursing in Great Britain, 1850-1950* Unpublished PhD Thesis University of London (London, 1998), p. 14; Claire S. Chatterton “*The weakest link in the chain of*

1845 Lunacy Act the term “attendant” became the norm. This also reflected a cultural shift within the asylums, as attendants were now expected to “attend” to the patients and the institution rather than simply “keep” them confined.<sup>54</sup> “Attendant” remained the preferred title for men, though “nurse” was increasingly utilised for female staff. However, gradually male staff were also being known as nurses towards the end of the nineteenth century.<sup>55</sup> This was compounded by and became the norm following the 1919 Nurses’ Registration Act and the title of “mental nurse” endured until the 1960s, when it was replaced by the term “psychiatric nurse”.<sup>56</sup> Chatterton argues, however, that this had no statutory basis and registered nurses were officially known as Registered Mental Nurses (RMNs) from the 1920s until the inception of Project 2000 in the late 1980s and early 1990s, when the term “mental health nurse” was embraced.<sup>57</sup>

Given that, for the majority of the period being explored in this thesis, the most commonly utilised term was “mental nurse”, this term will be used throughout the thesis for consistency. Furthermore, for the same reason, the term “patient” will be used. However, I recognise that many people today would use contemporary terms such as “service user”, “client” or “survivor”. Finally, I acknowledge that the terms “mental” “lunatic” and “mental hospital” that I will also utilise in this thesis can have pejorative connotations for individuals today. However, Duncan Mitchell argues that ‘using contemporary terminology would be to impose current categories on the past’.<sup>58</sup>

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*nursing?*” *Recruitment and Retention in Mental Health Nursing, 1948-1968* Unpublished PhD thesis, University of Salford (Salford, 2007), p. 5.

<sup>54</sup> Peter Nolan, *A History of Mental Health Nursing* (London, 1993), p. 6.

<sup>55</sup> Chatterton “*The weakest link in the chain of nursing?*”, p. 6.

<sup>56</sup> Arton, *The Professionalization of Mental Nursing*, p. 16; Chatterton “*The weakest link in the chain of nursing?*”, p. 6.

<sup>57</sup> Chatterton “*The weakest link in the chain of nursing?*”, p. 6.

<sup>58</sup> Duncan Mitchell, “*No claim to be called sick nurses at all*”. *An Historical Study of Learning Disability Nursing*. Unpublished PhD thesis, South Bank University (London, 2000), p. 15.

Therefore, in accord with Chatterton and Mitchell, the language of the past will be utilised to preserve clarity.<sup>59</sup>

### **Organisation of the thesis**

This thesis will shuttle between two levels of discussion throughout. The first part of the thesis – here in the introduction and in Chapters I and II – sketches out and discusses some broader histories and approaches which couch the detailed oral history work that follows. The main Chapters (III-V) deliberately focus on the oral history interviews conducted as part of this study. However, I fully recognise the significance of the documentary, printed and published sources. Indeed, a number of the “published sources” in the bibliography are, in fact, primary sources, which demonstrates the wealth of primary sources upon which this study is based.

In Chapter I, I critically analyse and reflect upon the use of oral history as the main source of primary data within this thesis. Ethical implications will be considered, along with issues around the anonymity of the participants in this study.

The oppression and suppression of the sexual deviant will be examined in Chapter II. The narrative of the ways in which homosexuals and transvestites have been regarded and treated by British society will be explored and the introduction of aversion therapies for “sexual deviance” will be considered. The mixed and muddled messages nurses were receiving about these individuals are also explored.

During the 1930s to the 1950s, mental health care witnessed a spirit of “therapeutic optimism” as new somatic treatments and therapies were introduced in mental hospitals. Chapter III examines the impact these had on the role of mental nurses and explores how such treatments may have essentially normalised nurses to implement painful and

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<sup>59</sup> Chatterton “*The weakest link in the chain of nursing?*”, p. 6; Mitchell, “*No claim to be called sick nurses at all*”, p. 15.

distressing “therapeutic” interventions to patients in their care. Attention is also given to investigating the effect of hospital conditions, as despite these new therapeutic approaches the nurses were still working within asylum type conditions. Overcrowding, lack of resources and understaffing all contributed and influenced the work of mental nurses.

Some nurses in this study appeared to have behaved in a subservient, unenquiring and unquestioning manner that resulted in, or at least contributed to, their behaviour and participation in what could now be perceived as professionally incongruent activities. Chapter IV deconstructs and offers some possible interpretations for why these nurses may have behaved in this way.

There were some nurses in this study, albeit very few, who conscientiously objected to the medical treatments for sexual deviations. These nurses engaged in some fascinating subversive behaviours in order to avoid participating in this aspect of clinical practice. Chapter V examines and interprets the testimonies of the “subversive nurses” in this study.

By the 1970s, individuals were beginning to question the definition of “difference”. Gay men and women were starting to unite and promote sexual and subcultural difference as positive and life-enhancing as gay liberation emerged – individuals were actively and vocally refuting the sickness label and the treatment that had come to accompany it. This eventually led the APA to remove the term “homosexuality” from its DSM. Chapter VI explores the implications of these changes and examines how nurses began to view medical treatments for sexual deviation as inappropriate as ideas of deviance shifted. The chapter will also explore the inception of “nurse therapists” and examine their role in administering aversion therapy.

In Chapter VII, I offer some concluding remarks to the thesis. Ideas are drawn together in order to cast light on the possible meanings that nurses attached to the treatments for sexual deviations. The final section serves as an epilogue. In spite of the treatments for sexual deviations appearing to peter out in the mid to late 1970s, following the decision by the APA to remove homosexuality as a diagnosis and a growing gay liberation movement, it was not until 1992 that the World Health Organisation (WHO) removed “homosexuality” from its diagnostic manual. Therefore, the period 1974 – 1992 will be explored to offer a context to help interpret why the WHO did not follow the example of the APA and remove “homosexuality” from its diagnostic manual until 1992.

## **Background**

### *Gay history*

Given that this thesis is predominantly about the pathologisation of sexual deviation, I do not intend to undertake a rigorous history of sexuality within this section. Instead, I will explore key moments in the medicalization and identity of homosexuality and transvestism, which are relevant to this study. According to Jeffery Weeks, homosexuality was first incorporated into English law in the 1533 Act of Henry VIII. The law defined sodomy as an illegal act between man and woman, man and man, or man and beast. The law was re-enacted in 1563, and formed the basis for all male homosexual convictions until 1885, when the Labouchère Amendment to the Criminal Law Amendment Act was passed. This Act brought all practices of homosexuality between men under the auspices of the criminal law, and these were made illegal, whether conducted in private or in public.<sup>60</sup>

The homosexual and transvestite were rarely out of the public eye during the course of the late nineteenth century as headlines regarding these individuals were ever present in

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<sup>60</sup> Weeks, *Coming Out: Homosexual Politics in Britain from the Nineteenth Century to Present* (London, 1990), p. 35

the press.<sup>61</sup> The influential press made it more obvious than ever that the sexual deviant was a matter of national and imperial interest, as they were seen to threaten the strength of the empire.<sup>62</sup> Therefore, this section will also explore how the media played a part in shaping public perceptions regarding these individuals in the late nineteenth century. It is important to explore the impact the media had on shaping societal perceptions of same-sex desire during this period, as the media had a similar influence on the public's conscience regarding sexual deviation and its medicalization in the 1950s and 1960s. This will be explored in Chapter II.

The second half of the nineteenth century saw significant changes in the newspaper press.<sup>63</sup> Technological advances meant that newspapers could be produced more quickly than before, whilst the earlier abolition of advertisement, stamp and paper duties – in 1853, 1855 and 1862 respectively – and improved national and local transport infrastructures meant that more newspapers were on the market and were more widely available.<sup>64</sup> Cook argues that there was also a change in style within the press during the late 1800s, and the articles published were more direct and headlines and sub-headings became more descriptive, delivering mini-narratives at a glance. The new style press often took on a crusading mantle; they did not merely report on parliamentary, court and police action but also highlighted inaction and corruption.<sup>65</sup>

This could be said for a series of articles entitled “A Night in a Workhouse”, written by James Greenwood but reprinted under the pseudonym “The Amateur Casual”, which appeared in the *Pall Mall Gazette* in 1866.<sup>66</sup> Within these articles, Greenwood

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<sup>61</sup> See, e.g. Matt Cook, *London and the Culture of Homosexuality, 1885-1914* (Cambridge, 2003), pp. 42-55.

<sup>62</sup> Harry Cocks, ‘Secrets, Crimes and Diseases, 1800-1914’, in Matt Cook (ed.) *A Gay History of Britain: Love and Sex Between Men Since the Middle Ages* (Oxford, 2007), p. 110

<sup>63</sup> Cook *London and the Culture of Homosexuality*, p. 49.

<sup>64</sup> Matt Cook, “A New City of Friends”: London and Homosexuality in the 1890s’, *History Workshop Journal* 56 (2003), pp. 33-58; Cook, *London and the Culture of Homosexuality*, p. 49.

<sup>65</sup> Cook, *London and the Culture of Homosexuality*, p. 49.

<sup>66</sup> “A Night in a Workhouse”, *Pall Mall Gazette*, 4<sup>th</sup> January 1866.



masqueraded as one of the poor to experience first-hand what it meant to be an inmate in a workhouse for indigent wayfarers, tramps and other homeless people.<sup>67</sup> Greenwood's writing had a sodomitical subtext, and suggested that sodomy was so contagious within the wards of these workhouses that it threatened to corrupt even innocent bystanders compelled by circumstances to witness it. This in turn fuelled its Victorian readers because it both helped to create and drew upon widely held fantasies and anxieties about poor men and their sexuality.<sup>68</sup> The publication of "A Night in a Workhouse" made visible the complex intersection of sexual and social politics in Britain at the time. These articles are important in relation to this study, as they demonstrate how the media began to reinforce the perception that homosexuals were a contagious risk who essentially polluted society. This notion prevailed until the 1970s, which I will explore in Chapters II and VI. This perception appeared to re-emerge with the AIDS crisis in the 1980s, which I will discuss in the epilogue.

Conversely, men had cross-dressed for the English stage for centuries, and as a result of this, cross-dressing was more accepted by society. Rictor Norton argues that cross-dressing men and their associates have formed and retained their own set of customs and institutions since the early eighteenth century.<sup>69</sup> These men developed an identity amongst themselves in the eighteenth century as "mollies" or "mary-annes", and they established an intricate system of safe spaces and supportive relationships that enabled their connection with similar men to satisfy their sexual and emotional needs. These men were intermittently "discovered" and prosecuted throughout the eighteenth and nineteenth centuries for same-sex sexual activity, as were those men who took advantage of casual opportunities for sex with other men in toilets and well-known

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<sup>67</sup> Seth Koven, *Slumming, Sexual and Social Politics in Victorian London* (Princeton, 2004), p. 26.

<sup>68</sup> Koven, *Slumming*, p. 57.

<sup>69</sup> Rictor Norton, *Mother Clap's Molly House: The Gay Subculture in England, 1700-1830* (London, 1992), p. 35.

cruising<sup>70</sup> areas primarily in cities. However, Charles Upchurch argues that the state lacked either the means or the predisposition to mount a continued and pervasive campaign against them.<sup>71</sup>

However, an arraignment in 1870 would bring two cross-dressing men into intimate contact with the law, media and medicine. This indictment was the case of the Queen vs. others, which involved the arrest and trial of Boulton and Park for ‘a misdemeanour related to their public cross-dressing’.<sup>72</sup> Ernest Boulton and Fredrick Park – known popularly as “Stella” and “Fanny” respectively – were arrested outside the Strand Theatre on 28 April 1870. They were dressed completely in women’s clothes, and it was in this attire that they were brought before the Bow Street magistrates for ‘conspiracy to commit a felony’.<sup>73</sup>

The prosecution in this case included the testimony of doctors who claimed to have ‘medical proof’ that the defendants had engaged in recurrent acts of anal intercourse.<sup>74</sup> This medical evidence cast doubts over the distinctions between “cross-dresser” and “sodomite”, and Upchurch argues that this medical testimony essentially ‘collapsed these two categories of individuals into each other’.<sup>75</sup> Ackroyd argues that the cross-dressing of Boulton and Park had no malice and was not fetishistic, but ‘outrageous and exhibitionistic’, yet their behaviour merited public condemnation and the threat of vengeance. He goes on to argue that the reasons for this was that their appearance explicitly defied the fundamental ethos of their society; by refusing to adopt the ‘phallic and utilitarian model’ of male clothing, and by asserting instead the primacy of ‘pleasure

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<sup>70</sup> Cruising areas are public places where gay men search for a sexual partner and sometimes engage in sexual acts.

<sup>71</sup> Charles Upchurch, ‘Forgetting the Unthinkable: Cross-Dressers and British Society in the Case of the Queen vs. Boulton and Others’, *Gender and History*, 12 (2000), p. 127; see also Randolph Trumbach, ‘London’s Sodomites: Homosexual Behaviour and Western Culture in the Eighteenth Century’, *Journal of Social History* 11 (1977), pp.4-5.

<sup>72</sup> Upchurch, ‘Forgetting the Unthinkable’, p. 127.

<sup>73</sup> Ackroyd, *Dressing Up*, p. 83.

<sup>74</sup> Norton, *Mother Clap’s Molly House*, p. 47; Upchurch, ‘Forgetting the Unthinkable’, p. 140.

<sup>75</sup> Upchurch, ‘Forgetting the Unthinkable’, p. 140.

and ornamentation, they inverted the codes of a society, which had created its sexual and social images in the name of economic progress and material acquisition'.<sup>76</sup>

This arraignment was heavily publicised by the British press, with *The Times* referring to the proceedings as 'the most extraordinary case we can remember to have occurred in our time'.<sup>77</sup> Meanwhile the *Pall Mall Gazette* warned of the serious threat that the Boulton and Park case posed to the empire's reputation, and advocated that fathers might feel obligated to keep their newspapers under lock and key for the duration of the arraignment.<sup>78</sup> The media were keen to express that there was a threat to British morality and manhood if sodomites such as Boulton and Park were living in central London. Upchurch argues that the mainstream press from the 1820s onwards heavily influenced societal perceptions of sexual deviations. He proposes that newspapers did not simply provide information about sex acts and offences but also offered readers normative judgements about appropriate and inappropriate male social identities and same-sex behaviour.<sup>79</sup> They were instrumental in shaping images of deviance and therefore controlling and regulating it.<sup>80</sup> This arraignment is important in relation to this study because it not only demonstrates the way that pathology starts to be written into accounts of sexual deviation, but also displays the influence that the media had in regard to shaping public perceptions of transvestism and homosexuality. In essence, the media were making the concept of effeminacy and cross-dressing more broadly somewhat threatening.

With each of these publicised sensations, Britons came closer to developing a vocabulary and an intellectual framework within which to place their understanding of the relationship between same-sex desires and behaviours on the one hand and

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<sup>76</sup> Ackroyd, *Dressing Up*, p. 85.

<sup>77</sup> *The Times*, 31<sup>st</sup> May 1870.

<sup>78</sup> *Pall Mall Gazette*, 8<sup>th</sup> June 1870.

<sup>79</sup> Upchurch, 'Forgetting the Unthinkable', p. 137.

<sup>80</sup> Cook, *London and the Culture of Homosexuality*, p. 50.

homosexual identity on the other. It was within this highly charged atmosphere that a variety of enquiries began into such sexually ‘perverse’ behaviour.<sup>81</sup> This included the medicalisation of sexual behaviour; with the publication of Richard von Krafft-Ebing’s *Psychopathia Sexualis*, in 1892.<sup>82</sup> This was the first time that an exhaustive list of sexual transgressions defined as medical conditions had been delineated. In 1897, Havelock Ellis and John Addington Symonds extended the terminology to include homosexuality and paedophilia in their masterwork *Sexual Inversion*.<sup>83</sup> This was one of the many terms developed by sexologists to refer to same-sex desire. Harry Cocks argues that *Sexual Inversion* was the first British attempt to synthesize biological, anthropological and psychological knowledge on the subject.<sup>84</sup>

Sexology was the study and classification of sexual behaviours, identities and relations, and had a dual character. Firstly, it developed an apparatus of treatment for the “perverted”, and secondly, according to Robert Nye, it formed a group of medical and legal specialists devoted to studying, curing or punishing them.<sup>85</sup> Lucy Bland and Laura Doan argue, however, that the aim of sexologists was positive in that they wanted to stop discrimination and show that sexual difference was based on biology rather than perversion.<sup>86</sup> Ellis and Symonds employed the methods of sexology in order to show that “perversity” of all kinds was merely one aspect of human sexuality and should be

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<sup>81</sup> Ivan Crozier, ‘Philosophy in the English Boudoir: Havelock Ellis, Love and Pain, and Sexological Discourses on Algophilia’, *Journal of the History of Sexuality* 13 (2004), pp. 275-305; Cocks, ‘Secrets, Crimes and Diseases, 1800-1914’, pp. 134-135.

<sup>82</sup> Richard von Kraft-Ebing, *Psychopathia Sexualis* (Philadelphia, 1892).

<sup>83</sup> Havelock Ellis & John Addington Symonds, *Studies in the Psychology of Sex, Vol. 1: Sexual Inversion* (London, 1897).

<sup>84</sup> Cocks, ‘Secrets, Crimes and Diseases, 1800-1914’, pp. 134-135.

<sup>85</sup> Robert Nye, *Sexuality* (Oxford, 2000), p. 37

<sup>86</sup> Lucy Bland & Laura Doan, *Sexology Uncensored: The Documents of Sexual Science*, (Cambridge, 1998), p. 1; Despite fundamental differences in their approach to the subject and their attitudes towards sexology as a science, Symonds and Ellis both sought to use their study to challenge the 1885 Labouchere amendment, which had made sexual contact between men subject to harsh criminal punishment. Their study drew heavily on case histories written by “inverts” who attempted to make sense of their own sexual histories. To avoid legal obstacles in Britain, *Sexual Inversion* first appeared under joint authorship in German in 1896, three years after Symonds’ death. The Symonds family later strove to have their name removed from the publication, which has subsequently been ascribed simply to Havelock Ellis; see also Faderman, *Surpassing the Love of Man*, p. 67.

judged accordingly. They and other sexologists advocated that sexual behaviour, and hence homosexuality, was inherent to the personality, as something inborn and congenital, either physiologically or psychologically.<sup>87</sup> Sexology is important in relation to this study as it was the first attempt to mark out a specialism and a specialist discourse in relation to the medicalization of sexual deviation, and it remained in vogue as the main method of classifying sexual behaviours, identities and relations until the early twentieth century.<sup>88</sup>

In 1898, with virtually no debate, Parliament passed an amendment to the 1824 Vagrancy Act. The main impetus of the 1898 amendment was to expand the state's capacity to imprison bullies or pimps who lived on the earnings of female prostitution; however, it soon also became the Victorian state's draconian regulation of all forms of sex between men.<sup>89</sup> According to the Act, 'every male person who in any public place persistently solicits or importunes for immoral purposes shall be deemed a rogue and a vagabond and may be dealt with accordingly'.<sup>90</sup> Seth Koven posits that in practice, the law was applied only to men who 'importuned' or 'solicited' other men for sex.<sup>91</sup> However, Cook argues that the 1898 provision of the Vagrancy Act heightened the significance of behaviour that was not explicitly sexual (such as the use of cosmetics and the way a man walked). The police did not simply arrest because homosexual acts had actually been committed, but also on the basis of a judgement they had made about the predilection of an individual to commit such acts.<sup>92</sup>

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<sup>87</sup> Cocks, 'Secrets, Crimes and Diseases', 1800-1914, p. 135; Crozier, 'Philosophy in the English Boudoir', p. 300.

<sup>88</sup> See, e.g. Crozier, 'Philosophy in the English Boudoir', pp. 275-305; Bland & Doan, *Sexology Uncensored: The Documents of Sexual Science*.

<sup>89</sup> Koven, *Slumming*, p. 73; see also Angus McLaren, *The Trials of Masculinity: Policing Sexual Boundaries, 1870-1930* (Chicago, 1997), p. 16.

<sup>90</sup> Cocks, 'Secrets, Crimes and Diseases', 1800-1914, p. 110.

<sup>91</sup> Koven, *Slumming*, p. 73.

<sup>92</sup> Cook, *London and the Culture of Homosexuality*, p. 57.

Michel Foucault has suggested that the period between 1870 and 1900 was significant in relation to the medicalization of sexual behaviour, as this is where the sexological categories and lived social identities of both the “homosexual” and the “heterosexual” first came into being.<sup>93</sup> Koven concurs and argues that the period between the 1860s and 1890s irrefutably constituted a watershed in the histories of sexualities and the medicalization of sexually deviant behaviour in Great Britain.<sup>94</sup>

As mentioned above, sexology was utilised as the main method to classify sexual behaviours, identities and relations until the early twentieth century. However, this approach began to be challenged with the publication of Sigmund Freud’s influential work.<sup>95</sup> In 1905, Freud’s *Three Essays On The Theory Of Sexuality* were published in German. This was his seminal work where he first described his ‘theories on the development, aberrations, and transformations of the sexual instinct from its earliest beginnings in childhood’.<sup>96</sup> In 1924, the Hogarth Press<sup>97</sup> became the publisher for the papers of the International Psycho-Analytical Institute. In doing so, the Press became the official publisher for Sigmund Freud in England and was the first publisher to make psychoanalytic theory available in English.<sup>98</sup>

Following translation, Freud’s work began to have a pioneering influence in the treatment and understanding of sexual deviation in Britain. Indeed, by the 1920s, the mapping of homosexual identities by sexologists was being challenged by the advent of Freud’s new psychoanalytical understandings of sexual development.<sup>99</sup> He opposed the work of those sexologists who believed that homosexuals needed to be studied as a

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<sup>93</sup> Michel Foucault, *The History of Sexuality, Vol. 1: An Introduction* (Oxford, 1990), pp. 57-68.

<sup>94</sup> Koven, *Slumming*, p. 74.

<sup>95</sup> See, e.g. Laura Doan & Chris Waters, ‘Homosexuality’s’. In Lucy Bland & Laura Doan (eds.) *Sexology Uncensored: The Documents of Sexual Science* (Cambridge, 1998).

<sup>96</sup> Sigmund Freud, *Three Essays On The Theory Of Sexuality* (Vienna, 1905).

<sup>97</sup> The Hogarth Press had already achieved a reputation for original translations of seminal works of foreign literature.

<sup>98</sup> Nye, *Sexuality*, p. 56; Doan & Waters, ‘Homosexuality’s’, p. 61.

<sup>99</sup> Doan & Waters, ‘Homosexuality’s’, p. 43.

special category of person. Freud believed that ‘homosexual and heterosexual object choices were simply two outcomes of each person’s unique development, a process that began in a shared, polymorphous, infant bisexuality’.<sup>100</sup> Freud purported that ‘every male had to pass through a phase of homosexuality as a way of delivering himself from the Oedipus complex’.<sup>101</sup> Freudian arguments of homosexuality in Britain had made considerable headway by the 1930s, and for many students of the subject, Havelock Ellis’s work already seemed discredited.<sup>102</sup> Indeed, Freud stated that:

[...] homosexuality is nothing to be ashamed of, no vice, no degradation; it cannot be classified as an illness; we consider it to be a variation of the sexual function, produced by certain arrest of sexual development.<sup>103</sup>

Chris Waters argues that optimism regarding psychiatric treatment of the homosexual offender, and other psychiatric conditions was widespread in the 1930s, and this will be explored in Chapter III. Though in that decade few of the suggestions pertaining to treatment of the former were implemented, doctors, magistrates and barristers began calling for institutions where homosexuals could be isolated and treated, as psychological explanations for sexual behaviour were more frequently cited in court cases.<sup>104</sup> Such ideas were indebted to Freud in so far as they developed from the idea that, as one medical officer put it, homosexuality was a mental disorder that arose ‘from repressive influences in infancy and childhood which retard or distort the normal development of the sex instinct’ – a state of arrested development that required

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<sup>100</sup>Doan & Waters, ‘Homosexuality’s’, p. 43.

<sup>101</sup> Sigmund Freud, Some Neurotic Mechanisms in Jealousy, Paranoia, and Homosexuality. Reprinted (1953-1974) in *The Standard Edition of Complete Psychological works of Sigmund Freud* (London, 1923), p. 145-172; Doan & Waters, ‘Homosexuality’s’, p. 43.

<sup>102</sup> Chris Waters, ‘Havelock Ellis, Sigmund Freud and the State: Discourses of Homosexual Identity in Interwar Britain’. In Lucy Bland & Laura Doan (eds.) *Sexology in Culture Labelling Bodies and Desires*. (Cambridge, 1998), pp. 170-171.

<sup>103</sup> Sigmund Freud, Anonymous (letter to an American Mother) Reprinted in *The Letters of Sigmund Freud* (New York, 1935).

<sup>104</sup> Chris Waters, ‘Havelock Ellis, Sigmund Freud and the State’, pp. 173-174; for psychological explanations in court cases, see e.g. “Porter’s Punishment.” *News of the World*, 30<sup>th</sup> October 1932.

therapeutic intervention.<sup>105</sup> However, one Dorset doctor had a more antipathetic view of how to manage these individuals, advocating that special gas chambers should be attached to courts for the immediate execution of such ‘sex perverts’ post-prosecution.<sup>106</sup>

Nevertheless, with the outbreak of World War II, there appeared to be a relaxing of attitudes towards homosexuality; this will be explored further in Chapter II. Indeed, it was not until the 1950s and 1960s that Freud’s discourses of homosexuality actually came into the wider public domain, and treatments for sexual deviations really came to the fore. The narrative of the ways in which homosexuals and transvestites have been regarded and treated by British society will be taken further in Chapter III when the introduction of aversion therapies for “sexual deviance” will be considered.

#### *International history of mental nursing*

Not only were there changes and developments in the ways that homosexuals and transvestites were viewed by society and the treatment they received: the profession of mental nursing has also seen considerable changes and developments over the years. Since this study is exploring the role nurses played in the treatment of sexual deviants, and given the nature of newness of this study in relation to the history of nursing, it is pertinent that the wider history of the profession is also explored.

Prebble shows that histories of mental nursing have proliferated since the 1980s. She goes on to posit that in the first instance, they were add-on aspects of broader nineteenth-century asylum studies, but they later shifted to consider the workers themselves.<sup>107</sup> Historians such as Michael Arton, Diane Carpenter, Patricia D’Antonia,

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<sup>105</sup> Chris Waters, ‘Havelock Ellis, Sigmund Freud and the State’, pp. 173-174.

<sup>106</sup> ‘If Guilty They Would be Gassed While in Court.’ *Reynold’s News*, 18<sup>th</sup> December, 1938.

<sup>107</sup> Kate Prebble, *Ordinary Men and Uncommon Women: A history of psychiatric nursing in New Zealand public mental hospitals* (Unpublished PhD thesis University of Auckland, 2007), p. 2.



Anne Digby, John Hopton, Nancy Tomes, Ellen Dwyer, Olga Church, Peter Nolan, Geertje Boschma, Veryl Tripisk, John Adams, Angela Martin, Kate Prebble, Claire Chatterton and Philip Maude have produced some seminal accounts of the life and work of attendants and nurses.<sup>108</sup> As a leading scholar in the field, Peter Nolan argues that the history of mental nursing has at best been considered an appendage either to general nursing or to medicine and, at worst, an insignificance meriting minimal or no credit in the history of care.<sup>109</sup> He goes on to explain: ‘having a history confirms the legitimacy of the services one provides’.<sup>110</sup>

#### *United Kingdom history of mental nursing*

Basil Clarke argues that the Celtic Church could be seen as the initial forerunners for providing mental health care in early Britain.<sup>111</sup> Attached to each monastery were a number of itinerant monks known as “soul friends” who made mental health their main concern. Their role was to befriend the disenchanted and melancholic and to form

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<sup>108</sup> Michael Arton, *The Professionalization of Mental Nursing in Great Britain* (Unpublished PhD Thesis, University College London, 1998); Diane Carpenter, *Above All a Patient Should Never Be Terrified: An Examination of Mental Health Care and Treatment in Hampshire* (Unpublished PhD Thesis, University of Portsmouth, 2010); Patricia D’Antonio, *Negotiated Care: A Case Study of the Friends Asylum, 1800-1850* (Unpublished PhD thesis, University of Pennsylvania, 1992); Anne Digby, *Madness, Morality and Medicine: A study of the York Retreat, 1796-1914*, (Cambridge, 1985); John Hopton, ‘Prestwich Hospital in the Twentieth Century: A case study of slow and uneven progress in the development of psychiatric care’, *History of Psychiatry* (1999), p. 351; Nancy Tomes, *A Generous Confidence: Thomas Story Kirkbride and the Art of Asylum-Keeping, 1840-1883*, (Cambridge, 1984); Ellen Dwyer, *Homes for the Mad: life inside two nineteenth-century Asylums* (New Brunswick, 1987); Olga Church, *That Nobel Reform: The emergence of psychiatric nursing in the United States, 1882-1963* (Unpublished PhD thesis, University of Illinois, 1982); Peter Nolan, *Psychiatric Nursing Past and Present: The Nurses’ Viewpoint*, Unpublished PhD Thesis University of Bath (Bath, 1989); Peter Nolan, *A History of Mental Health Nursing*, (London, 1993); Geertje Boschma, *The Rise of Mental Health Nursing: A history of psychiatric care in Dutch asylums, 1890-1929* (Amsterdam, 2003); Veryl Tipliski, *Parting in the crossroads: The development of education in psychiatric nursing in three Canadian providences, 1909-1955* (Unpublished PhD thesis, University of Manitoba, 2003); Adams, *Challenge and Change in a Cinderella Service*; Angela Martin, *Determinants of Destiny: The professional development of psychiatric nurses in Saskatchewan* (Unpublished MA thesis, University of Regina, 2003); Prebble, *Ordinary Men and Uncommon Women*; Chatterton “*The weakest link in the chain of nursing?*”; Philip Maude, *The Development of the Community Mental Health Nursing Services in Western Australia: A history (1950 to 1995) and population profile* (Unpublished Master of Nursing thesis, Edith Cowan University, 1996).

<sup>109</sup> Nolan, *A History of Mental Health Nursing*, p. 22.

<sup>110</sup> Nolan, *A History of Mental Health Nursing*, p. 1.

<sup>111</sup> Basil Clarke, *Mental Disorder in Early Britain*. (Cardiff, 1975), p. 5.

intimate spiritual relationships with the afflicted so as to ‘steer them back’ into social harmony.<sup>112</sup>

Workhouses were established in the 1630s to cater for the poor; many of these people were also “insane”. By the middle of the 18<sup>th</sup> century, the insane were increasingly being brought under surveillance. If they were unable to work, the Poor Law confined them as “pauper lunatics” in workhouses under the supervision of the parish overseer. However, by the beginning of the 19<sup>th</sup> century, the number of paupers was increasing drastically.

In light of this, the first House of Commons Select Committee to investigate the lunacy problem reported in 1807. The report produced from this investigation led to the County Asylums Act (1808), which recommended the provision of public asylums. The Act stated that asylums should be built outside the towns but should remain accessible to visiting doctors who should not be expected to travel more than a few miles on horseback or by pony and trap. The asylums were to have separate wards for male and female patients, wards for “incurables”, day rooms and airing grounds for the convalescents and ‘dry and airy cells for lunatics of every description’.<sup>113</sup> However, in 1844, the Report of the Metropolitan Commissioners in Lunacy confirmed that a rapid rise in the total number of insane persons had taken place and that the number of afflicted was almost six times that reported in 1807. In essence, in less than 30 years, insanity had become a serious social problem, and the report concluded that it was high time to address the problem of funding properly-built asylums on a national scale.<sup>114</sup>

This echoes the earlier discussion regarding “A Night in a Workhouse” and highlights

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<sup>112</sup> Nolan, *Psychiatric Nursing Past and Present*, p. 62; Nolan, *A History of Mental Health Nursing*, p. 23.

<sup>113</sup> Nolan, *A History of Mental Health Nursing*, p. 32.

<sup>114</sup> Alexander Walk, ‘The History of Mental Nursing’, *The Journal of Mental Science* 107 (1961), p. 10.

the idea of traditions of institutionalisation of all categories of individuals deemed to be “deviants”.

Anne Digby suggests that the asylum system was not simply the product of necessity due to overcrowding in the workhouses, but also of a heightened public awareness.<sup>115</sup> As with discourse regarding sexual deviation described above, the media were a central force driving this awareness. For example, on 5<sup>th</sup> April 1877 *The Times* remarked, ‘If lunacy continues to increase as at present, the insane will be in the majority and, freeing themselves, will put the sane in asylums’.<sup>116</sup> Parliamentary and media activity constantly brought the problems of insanity into the public domain throughout the 19<sup>th</sup> century, and according to Nolan, this was partly responsible for the 1845 Lunacy Act and the asylum system to which it gave birth. Nolan goes on to argue that the Lunacy Act, passed on 4<sup>th</sup> August 1845, ‘heralded a new era in the care of psychiatric patients’.<sup>117</sup>

Lord Shaftesbury, a great humanitarian reformer was mainly pioneering these changes. In his discourses on the subject, he repeatedly made reference to “patients”, “hospitals”, “doctors” and “nurses”, seemingly associating the proposed asylum system with a hospital system and inferring that mental and physical illnesses were largely similar.<sup>118</sup> However, the political and humanitarian pioneers driving such changes paid little attention to the actual logistics and practicalities of funding such a system, or to the numbers and kind of personnel who would be required to staff it.<sup>119</sup>

The new asylums were almost immediately overwhelmed by large numbers of ex-workhouse inmates with chronic illnesses: within a short period of time, 90% of the

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<sup>115</sup> Digby, *Madness, Morality and Medicine*, p. 56

<sup>116</sup> “The Lunacy Problem.” *The Times*, 5<sup>th</sup> April, 1877.

<sup>117</sup> Nolan, *A History of Mental Health Nursing*, p. 34.

<sup>118</sup> Nolan, *A History of Mental Health Nursing*, p. 34.

<sup>119</sup> Peter Nolan & Cheung Chung, ‘Science and Early Development of Mental Health Nursing’, *Nursing Standard* 10 (48) (1996); Nolan, *A History of Mental Health Nursing*, p. 35.

asylum population were classified as paupers.<sup>120</sup> The asylums were expected to be self-financing and self-sufficient; this meant that labour costs had to be kept to a minimum. Therefore, staff and patients were expected to undertake a wide variety of duties, which included maintaining the buildings and farming duties.<sup>121</sup> The large majority of the workforce was made up of male attendants who, it has been suggested, occupied the middle ground between doctors and the patients. Their status was considered very much inferior to that of the medical staff. However, their closeness to the patients made them extremely pertinent in the patients' lives.<sup>122</sup> The majority of asylums, like general hospitals, referred to the female attendants as "nurses".<sup>123</sup> Nolan argues, however, that these attendants and nurses were all pioneers and laid down the foundations of contemporary mental health nursing. They represented cheap labour, and in the majority of asylums during the 1850s and 1860s, they received no training; nor was there any career structure for them.<sup>124</sup>

Initially, the attendants' role was not clearly defined; this largely depended on the way the medical superintendent of the asylum saw it. Some viewed the attendants as obedient servants of the institution to keep and enforce rules; others saw them as principally servants to the patients; others again saw their role as that of spiritual guides. There was also the view that the attendants were simply intermediaries between doctors and patients.<sup>125</sup> Moreover, these individuals did not have a body of knowledge upon which to base a coherent system of care and treatment.

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<sup>120</sup> Nancy Korman & Howard Glennerster, *Hospital Closure* (Milton Keynes, 1990), p. 75.

<sup>121</sup> Walk, 'The History of Mental Nursing', p. 12

<sup>122</sup> Nolan, *A History of Mental Health Nursing*, p. 47.

<sup>123</sup> Carpenter, *Above All a Patient Should Never Be Terrified*, p. 57; Nolan, *A History of Mental Health Nursing*, p. 47.

<sup>124</sup> Nolan, *Psychiatric Nursing Past and Present*, p. 67; Nolan, *A History of Mental Health Nursing*, p. 47; Walk, 'The History of Mental Nursing', p. 12.

<sup>125</sup> Peter Nolan, 'A History of the Training of Asylum Nurses', *Journal of Advanced Nursing*, 18 (1993), p. 1197; Nolan, *A History of Mental Health Nursing*, p. 53.

It was not until 1884 that the Medico-Psychological Association (MPA), which was run by doctors, finally accepted that there was some advantage in training attendants, and Drs Campbell Clark, McIvor Campbell, Turnball and Urquart were commissioned to prepare a handbook which would help attendants ‘to a due understanding of their work in which they were engaged’.<sup>126</sup> In 1885, they completed their task and *The Handbook for the Instruction of Attendants on the Insane* was published.<sup>127</sup>

Nolan has argued that this handbook was a milestone in the history of educating mental health nurses, as it gave the attendants a semblance of scientific credibility and the beginning of a literature base. Nurses who wanted to advance had to be able to read and quote from it.<sup>128</sup> By 1889, the MPA had decided that a national training scheme was required for attendants. Therefore, the decision was made that attendants would undergo a two-year training course, following a three-month probation period. At the end of this, the attendants would sit an exam, with successful completion leading to a Certificate in Nursing the Insane and registration with the MPA. Once attendants’ names were entered on the Association Register, their Superintendents were held responsible for their conduct and anyone found guilty of misconduct was to be reported to the Registrar, who could remove his/her name from the Register and advise dismissal.<sup>129</sup> Nevertheless, despite a new education system, nursing was still based on “common sense” assumptions and concern with neatness rather than on research-based

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<sup>126</sup> Henry R. Rollin, ‘The Red Handbook: An Historic Centenary’, *Bulletin of the Royal College of Psychiatrists*, 10 (1986), p. 279; Nolan, ‘A history of the training of asylum nurses’, p. 1197.

<sup>127</sup> Medico-Psychological Association, *The Handbook for the Instruction of Attendants on the Insane* (London, 1885).

<sup>128</sup> Carpenter, *Above All a Patient Should Never Be Terrified*, p. 61; Nolan, *A History of Mental Health Nursing*, p. 64.

<sup>129</sup> Walk, ‘The History of Mental Nursing’, p. 17; Nolan, ‘A history of the training of asylum nurses’, p. 1199; Nolan, *A History of Mental Health Nursing*, p. 67.

theory'.<sup>130</sup> This has important implications for this study and will be explored further in Chapters IV and V.

In 1890, the Lunacy Act came into force, and confirmed that the practice of psychiatry was firmly established within the confines of mental institutions.<sup>131</sup> Nevertheless, there were very few developments in mental nursing between 1890 and 1918. The First World War was a critical period in the history of psychiatry. The mental hospitals were depleted of able-bodied staff called up for military service, while the patient population of certain hospitals increased immensely as patients were transferred from other hospitals that had been commissioned to treat wounded soldiers.<sup>132</sup>

At the end of 1919, the Nurses' Registration Act for England, Scotland, Wales and Ireland received Royal assent. This established a Register for general nurses with supplementary sections for other groups, including mental nurses, and at the end of 1919, nursing registration became enshrined in law.<sup>133</sup> Then, in 1920, the General Nursing Council (GNC) agreed to accept holders of the MPA's Certificate in Nursing the Insane as eligible for admission to the supplementary Register for a 'period of grace'.<sup>134</sup> In the early 1920s, the GNC also set up their own alternative qualification, and the first cohort of mental nurse trainees sat the GNC's examination in 1922.<sup>135</sup>

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<sup>130</sup> Hopton, 'Prestwich Hospital in the Twentieth Century', p. 360.

<sup>131</sup> Nolan, *A History of Mental Nursing*, p. 8.

<sup>132</sup> Psychiatry's contribution to the war effort was acknowledged in 1926 when the Medico Psychological Association was awarded a Royal Charter and became the Royal Medico Psychological Association (RMPA). See also Peter Nolan, 'Mental Health Nursing – origins and developments', in Monica E. Baly (ed), *Nursing & Social Change* (New York, 1995), p. 254.

<sup>133</sup> Claire Chatterton, "'Caught in the middle"? Mental nurse training in England 1919-51', *Journal of Psychiatric and Mental Health Nursing* 11 (2004), p. 32.

<sup>134</sup> Chatterton, "'Caught in the middle"?', p. 32.

<sup>135</sup> The number of mental nurses registering with the GNC rose steadily until 1930, and thereafter, approximately 5000 nurses registered annually. Each year the number of female mental nurses increased, resulting in there being far more qualified female nurses than males: Nolan, *A History of Mental Health Nursing*, p. 81. See also Valerie Harrington, *Voices Beyond the Asylum: A post war history of mental health services in Manchester and Salford* (Unpublished MPhil/PhD Transfer report, University of Manchester, 2005). See, also Chapter III for a fuller exploration of mental health nurse education.

New honours, however, could not disguise the confusion which was widespread among doctors, nurses and Boards of Governors as to the role of mental hospitals. Meanwhile the staffing levels were reducing yet patient numbers were increasing, and the country was in an economic depression which deprived health services of resources.<sup>136</sup> A similar incident happened after the Second World War, and the effects of this will be explored in Chapter III, as it contributed and influenced the work of mental nurses caring for patients receiving treatments for their sexual deviations.



**Figure 1. Female nurses in the ballroom at Bristol Lunatic Asylum, circa 1920s.**  
Source: Reprinted with permission from the Glenside Hospital Museum, Bristol.

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<sup>136</sup> Nolan, 'Mental Health Nursing – origins and developments', p. 254.



**Figure 2. Male attendants at Bristol Lunatic Asylum, circa 1920s. The Head Attendant is wearing the peaked cap.**

**Source: Reprinted with permission from the Glenside Hospital Museum, Bristol.**

In response to these pressures, in the 1920s, psychiatry began to look to community care as a way of relieving the pressure on hospitals. The very early moves towards community care were consolidated in the Mental Treatment Act, 1930, and with this new Act, asylums formally became hospitals.<sup>137</sup> Although asylum doctors had long been talking about “patients” with “mental illness”, and had constantly sought closer contact with general medicine, it was not until the passing of the Act that the concept of mental disorder as illness was cautiously accepted.<sup>138</sup> This was the first major revision of mental health policy since the 1890 Lunacy Act and brought to the fore new and innovative ideas such as observation wards, outpatient clinics and aftercare facilities. It also

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<sup>137</sup> Harrington, *Voices Beyond the Asylum*, p. 4; Nolan, ‘Mental Health Nursing – origins and developments’, p. 254.

<sup>138</sup> Karen Jones, *The Culture of the Mental Hospital*. In German E. Berrios & Hugh Freeman (eds.) *150 Years of British Psychiatry 1841-1991* (London, 1991), p. 121.



provided for the voluntary admission of patients to mental hospitals and placed a new emphasis on model of treatment. The implications of the introduction of this new Act of 1930 will be explored in Chapter III.

### **Thesis contribution**

This thesis enhances our understanding of sexuality in relation to nursing as a profession by revealing a hitherto undiscovered history of gay life in mental hospitals, and sits at the nexus of memory studies, histories of subjectivities, and histories of post-war Britain. In doing so, it offers a fresh understanding of the draw of mental nursing to gay men and supplements previous work regarding gay life at sea and within the military during World War II.<sup>139</sup> By identifying this previously hidden and multifaceted homosexual male sub-culture within the mental hospitals and discovering that, different types of gay male nurses within these hospitals had their own implicit rules and behaviours, which included status distinctions between the lower ranking SENs and the nursing officers in the higher ranks. It relates to Matt Houlbrook's seminal work regarding camp 'queans'<sup>140</sup> and the 'respectable middle class queer men'.<sup>141</sup> Therefore, it adds to this debate and contributes to our understanding in relation to status, class and sexual identity among gay men.

This thesis also contributes to a relatively new body of literature regarding the work and practice of mental nurses in the UK. In doing so, my thesis adds fresh material and a new perspective to the documented history of experiences of individuals "diagnosed" as mentally ill due to sexual deviance as well as mental nurses' experiences and perceptions

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<sup>139</sup> See, e.g. Baker & Stanley, *Hello Sailor!*; Cook, *A Gay History of Britain*. p. 187.

<sup>140</sup> Houlbrook uses this term to describe a flamboyant and striking figure in London's streets and commercial venues who was, for many Londoners, the very epitome of sexual difference. While the spellings "queen" and "quean" were used interchangeably in the first half of the twentieth century, Houlbrook followed Eric Partridge's *Dictionary of the Underworld* (Wordsworth, 1995), pp. 545-549, and used "quean" as the standard spelling in his book *Queer London*.

<sup>141</sup> For a more detailed exploration of class within homosexual urban culture: see, e.g. Houlbrook, *Queer London*, pp. 167-195.

of the “management” of individuals belonging to stigmatised groups. Overall, this thesis displays how histories of discourse do not map straightforwardly onto histories of everyday life. It exposes the tensions in relations between the two, and the equivocal way in which nurses read and listened to influential cultural outputs and acted in accordance with these. In order for practitioners to be able to critically reflect, they must have an understanding of the past. Therefore, it is envisaged that this study might also act to reiterate the need for nurses to ensure their interventions have a sound evidence base, and that they constantly reflect on the moral and value base of their practice and the influence that science, societal norms and contexts can have on changing views of what is regarded as “acceptable practice”.

# CHAPTER I

## METHODOLOGY

### Introduction

This chapter aims to outline the methodology of the study and critically analyse and reflect upon the use of oral history as the main source of primary data within this thesis.

It will also give consideration to the use of documentary, printed and published sources.

Oral history can be defined as:

A systematic collection, arrangement, preservation and publication...of recorded verbatim accounts and opinions of people who were witnesses to or participants in events.<sup>1</sup>

Plummer argues that there are merits to this particular research method when scholars wish to explore hidden or taboo subjects.<sup>2</sup> Advantages of oral evidence to the history of nursing are that it can reveal the voices of women, ethnic and other minority groups, working people and sections of the middle classes who did not write autobiographies and who have been essentially hidden from history.<sup>3</sup> Further, official written records rarely cover the private yet crucial areas of family relationships, influences in childhood and episodes that prompted career decisions. This is pertinent to nursing, as so much nursing practice has been transmitted through the oral tradition, and it supplements the domains that have existing written and official material. Indeed, Kirby has argued:

The conversations in the corridors on the way to meetings, or the chance remark when the committee had closed its business,

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<sup>1</sup> Winnifred W. Moss, *Oral History Programme Manual* (New York, 1974), p. 7; see, also, Paul Thompson, *The Voice of the Past: Oral history* (Oxford, 2000), p. 2.

<sup>2</sup> Ken Plummer, *Telling Sexual Stories: Power, Change and Social World* (London, 1995), p. 35.

<sup>3</sup> Gina Safier, 'What is Nursing History? What are the advantages and disadvantages of oral history? How can it be used in nursing history?', *Nurse Researcher* 25 (5) (1976), p. 384; Moss, *Oral History Programme Manual*, p. 35.

add to the composite picture of negotiations around significant nursing legislation and policy making.<sup>4</sup>

Furthermore, there is little written or published material that explores the perceptions of former patients' views in the history of nursing. It has been proposed that the omission of the patient perspective may lead to the continued silencing of 'those who travel in silence' through the mental health system.<sup>5</sup> Therefore, by using the experiences of former patients, as told through their own accounts, the researcher can obtain a better understanding of the topic in question and claim a 'history from below' which allows us to see historical practice from a new perspective.<sup>6</sup>

### **Advantages of oral history**

Examining the advantages of oral history first, as they perhaps give clues as to why oral histories can be critical evidence in determining the nature of events, there are several major reasons why they should be taken into consideration. Firstly, oral history gives a historian the ability to '[...] pin down evidence just where it is needed'.<sup>7</sup> This suggests that oral histories allow historians to find the answers to highly specific questions that may otherwise be impossible to locate in the myriad of other primary sources that might be available.

Oral accounts are indeed very effective primary sources: for example, a census will give dates, names and occupations but it will not answer questions about elements of the lives of those people from their own perspective as lived, experienced and given meaning. However, oral histories may give these answers. As such, oral histories

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<sup>4</sup> Stephanie Kirby, 'The Resurgence of Oral History and the New Issues it Raises', *Nurse Researcher* 5 (1997), p. 47.

<sup>5</sup> Kerry Davies, 'Silent and Censored Travellers? Narratives and Patients Voices: Perspectives on the History of Mental Health since 1948', *Social History of Medicine*, 14 (2) (2001), p. 271.

<sup>6</sup> Porter, 'The Patient's View', pp. 175-198.

<sup>7</sup> Robert Perks & Alistair Thomson, *The Oral History Reader* (London, 1998), p. 26.

complement other primary documentary sources because they fill in many of the gaps left behind and create ‘community histories’.<sup>8</sup>

In relation to the above benefit of complementing other sources that historians may use, there is a benefit that goes above and beyond filling in the blanks. Oral histories allow individuals to challenge previously held misconceptions of a given era, event or place:

The benefits that oral history can provide depend on whether the area of research contains full documentary evidence or whether documentary evidence is poor, non-existent, or simply not available. In the latter case both fact and interpretation are required; in the former often interpretation alone – of events personalities and documents.<sup>9</sup>

Until recently the sources for gay history have been largely based on the writings of experts, writers and stars, with the “ordinary” world of lesbians and gay men essentially hidden.<sup>10</sup> Oral history, therefore, gives a voice to those who have been most marginalised within historical accounts so far. This study is essentially about the history of variance. It is the history of a description of “other”, of the ascription of characteristics that differentiate groups of people from a supposed (and typically unspecified) norm.

This implies that oral histories can go further than supplementing other available information sources: they can also allow individuals varied interpretations of history from eyewitnesses that can stand alone. Subjects do not have a wide-ranging agenda that has the potential to influence generations to come. Instead, they can interpret events as they saw them and thus provide historians with the ability to use them in the way they

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<sup>8</sup> Moss, *Oral History Programme Manual*, p. 17.

<sup>9</sup> Anthony Seldon & Joanna Pappworth, *By Word Of Mouth: “Elite” Oral History* (New York, 1983), p. 36.

<sup>10</sup> Jeffery Weeks & Kevin Porter, *Between the Acts: Lives of Homosexual Men 1885-1967* (London, 1998), p. viii.

see fit. Scott argues:

Knowledge is gained through vision; vision is a direct apprehension of a world of transparent objects. In this conceptualization, the visible is privileged; writing is then put at its service. Seeing is the origin of knowing. Writing is reproduction, transmission – the communication of knowledge gained through (visual, visceral) experience.<sup>11</sup>

## Challenges

There are, however, several challenges that should be considered before such accounts are taken into consideration. The first is perhaps the most important, and that is the bias of the account itself.<sup>12</sup> Oral histories face numerous difficulties that may be impossible to overcome by even experienced historians because there are several facets to this particular disadvantage. For example, faulty memory is a common problem, as is the fact that many individuals are prone to embellishment for a number of reasons, with the most common being to prove a point, to alter the perspective, to place an individual in a better light or even as a result of a pre-determined perspective that is set by any number of factors. Furthermore, embellishment can be either deliberate or accidental. A prime example of the latter is the stories that are handed down from generation to generation, as details are often lost or altered in the recounting of tales over centuries as societal perspectives change and the importance of elements is lost.<sup>13</sup> Whether memories and perspectives alter over time and thus accidentally deviate from the truth or tales are deliberately changed for another specific purpose, the fact remains that oral accounts are not always completely accurate, and are thus perhaps unreliable when taken alone. Nevertheless, over the years, oral historians have come to view this “unreliability” of memory as a resource rather than a flaw, which can provide vital clues to the meaning

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<sup>11</sup> Joan W. Scott, ‘The Evidence of Experience’, *Critical Inquiry* 17 (4) (1991), p. 776.

<sup>12</sup> Stacy Erickson, *Field Notebook For Oral History*. 2<sup>nd</sup> Edition (Boise, 1993), p. vii.

<sup>13</sup> Charles Kahn, *World Histories: Societies Of The Past*. 2<sup>nd</sup> Edition (Winnipeg, 2005) p. 14.

people attach to certain events.<sup>14</sup> This notion will be explored further in the “memory and subjectivity” section of this chapter.

Furthermore, in spite of unreliable memory being a potential problem for some, associated studies on the effect of trauma and positive and negative stresses on the human psyche reveal that memories of very distressing events tend to be more accurate than those of ordinary ones – at least in a broad sense.<sup>15</sup> Daniel Schacter, a Harvard psychologist, argues that when an individual experiences trauma, it is almost always well remembered, and if there is any distortion, it is frequently in specific details. Schacter proposes that this remarkably accurate recall, can be traced to the release of stress-related hormones, signalled by the brain’s ‘emotional computer’, the amygdala.<sup>16</sup> This thesis suggests that the treatments for sexual deviation could be classed as traumatic for the patient. This could, therefore, indicate that accurate recollections by the participants in the study are likely.

Further, where it is possible to compare the personal testimony of an individual with other sources, this implies no disrespect to that individual. Indeed, such an exercise does not imply a wish to or an expectation of challenging the fundamental reliability of their testimony. However, it helps to ‘elucidate the very process of the memory that we are seeking to understand’.<sup>17</sup> Therefore, I have also made use of archival materials, largely from the records of the National Archives, London; the Wellcome Trust, London; the Royal College of Nursing Archives, Edinburgh; and the Hall Carpenter Archives, London. Journals published during this period also provided a rich source of

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<sup>14</sup> On this point see, e.g. Alistair Thomson, ‘Fifty Years On: An International Perspective on Oral History’, *The Journal of American History* September (1998), pp. 584-588; Cook, ‘Brixton Squats in the 1970s’, p. 25.

<sup>15</sup> Jonathan Friedman, ‘Togetherness and Isolation: Holocaust Survivor Memories of sexuality and intimacy in the ghettos’, *Oral History Review* 28 (1) (2001), p. 57.

<sup>16</sup> Daniel Schacter, *Searching for Memory: The Brain, the Mind, and the Past*. (New York, 1996), p. 205, 209, 216

<sup>17</sup> Mark Roseman, ‘Surviving Memory’, in Robert Perks & Alistair Thompson (eds.) *The Oral History Reader* (London, 1998) p. 242.

primary data. I also consulted daily newspapers held at the Lesbian and Gay News Media Archive, London, as a source of public comment on events relating to homosexuality and transvestism.

It is not uncommon to have several competing versions of events, with one community's perspectives often directly contrasting with those of another community as a result of established biases, prejudices and pre-conceived notions of who is wrong and who is right: 'Local history drawn from a more restricted social stratum tends to be more complacent, a re-enactment of community myth'.<sup>18</sup> As a result of limiting or expanding the scope of social accounts taken, it is possible to reinforce myths or provide evidence to dispel them. Furthermore, Weeks highlights the lack of research in the history of sexuality in the UK beyond London.<sup>19</sup> Therefore, I am deliberately taking a broader approach and participants in the study were recruited from throughout the UK. Moreover, this is what this study offers: a broader history of sexuality across the UK.

However, even if oral histories do offer a broader history, collecting different versions of events can cause problems when it comes to establishing the correct version to work with, and that could depend on the influence of the interviewer as much as the interviewee: 'The perspective of the interviewer cannot help but influence, even subtly, the content of the material – particularly what the interviewee will judge as "important"'.<sup>20</sup> The interviewer has more of an influence on oral history than one may imagine as a result of this. For example, the questions asked may be tailored to suit a particular perspective or indeed to elicit a specific answer. In many cases, interviewers

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<sup>18</sup> Perks & Thomson, *The Oral History Reader*, p. 27.

<sup>19</sup> Weeks, *The World We Have Won*, p. 57.

<sup>20</sup> Sherna Berger Gluck, What's So Special About Women?: Women's Oral History. In Susan Hodge Armitage, Patricia Hart & Karen Weathermon (eds.) *Women's Oral History: The Frontiers Reader* (Lincoln, 2002), p. 7.



will also edit oral histories and thus further control the information given, providing facts that support their perspective alone.<sup>21</sup>

### *Sampling*

Moss argues that an additional challenge of oral history is the fact that we are interviewing survivors and therefore cannot be sure that a representative sample is obtained.<sup>22</sup> However, Fred Allison argues that the quest for a representative sample is not as important as the value of an in-depth study on a particular issue, which might identify issues and themes that resonate with wider histories without representing them.<sup>23</sup> Nevertheless, the nature of this study decided the nature of the sample, in that individuals to be interviewed had to have received or administered treatments for sexual deviation. Therefore, I used purposeful sampling when selecting participants for this study.<sup>24</sup>

Purposeful sampling includes individuals on the basis of personal knowledge of the event or phenomenon, as well as the ability and willingness to communicate this experience to others.<sup>25</sup> Snowball sampling was also utilised in the study, where subjects put the researcher in contact with other colleagues they knew who may have had similar stories to tell.<sup>26</sup> However, these treatments did not become mainstream within UK mental health services and it is estimated that only about 1000 patients received them.<sup>27</sup>

Therefore, obtaining participants proved difficult. It is also important to acknowledge

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<sup>21</sup> James E. Fogerty, Oral History And Archives: Documenting Context. In Thomas L. Charlton, Lois E. Myers & Rebecca Sharpless (eds.) *History Of Oral History: Foundations And Methodology* (Lanham, 2007), p. 208.

<sup>22</sup> Moss, *Oral History Programme Manual*, p. 19.

<sup>23</sup> Fred, H. Allison, 'Remembering a Vietnam War Fire Fight: Changing Perspectives over Time', in Robert Perks & Alistair Thompson (eds.), *The Oral History Reader* 2<sup>nd</sup> ed. (London, 1998), p. 212.

<sup>24</sup> Geertje Boschma, Margaret Scaia, Nerrisa Bonifacio & Erica Roberts, 'Oral History Research', in Sandra, B. Lewenson & Eleanor, K. Herrman (eds.) *Capturing Nursing History: A Guide to Historical Methods in Research* (New York, 2007), p. 85.

<sup>25</sup> Marguerite Sandelowski, 'Focus on Qualitative Methods: Sample Size in Qualitative Research', *Nursing and Health* 18 (1999), pp. 179-183.

<sup>26</sup> Kirby, 'The Resurgence of Oral History and the New Issues it Raises', p. 48.

<sup>27</sup> Smith, King & Bartlett, 'Treatments of Homosexuality in Britain', p. 1.

that this also limited the extent to which the sample could actually be purposive.

I recruited twenty-two participants in total: fifteen former nurses and seven former patients. Five participants were recruited from flyers posted on notice boards of various gay bars, and seven participants were recruited from an article I wrote in a mental health nursing journal (see Appendix C).<sup>28</sup> One participant was recruited following an interview I conducted on local radio regarding the study. The remaining participants were recruited by means of snowball sampling, as mentioned above: the initial participants put me in contact with other participants. Eve Sedgwick posits that sampling in historical research can rely on small numbers of people, as depth rather than breadth in data collection is sought.<sup>29</sup> Further, Patton goes on to state that ‘the validity, meaningfulness and insights of qualitative research have more to do with the richness of cases selected and the observational/analytical capabilities of the researcher than the sample size’.<sup>30</sup>

Of the fifteen mental nurses interviewed, there were eight men and seven women. At the time of their interviews, their ages ranged from sixty-three years to ninety-eight years. Two commenced nursing in the 1930s, five in the 1950s and eight in the 1960s. All the nurses had worked in NHS hospitals. All of the nurses identified themselves as having Caucasian ethnicity. One was originally from France and three were originally from the Republic of Ireland; the rest were from the UK. The seven patients were male at the time they received treatments for their sexual deviations; however, two later underwent gender reassignment surgery and are now living as females. At the time of their interviews they ranged from sixty-five years to ninety-seven years. Six of the former patients identified themselves as Caucasian and one as having African Caribbean

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<sup>28</sup> Tommy Dickinson, ‘Nursing History: Aversion Therapy’, *Mental Health Practice* 13 (5) (2010), p. 13.

<sup>29</sup> Eve K. Sedgwick, *Epistemology of the Closet* (London, 1990), p. 29.

<sup>30</sup> Michael Patton, *Qualitative Research and Evaluation Methods* (Oxford, 2002), p. 245.

ethnicity. One was originally from Jamaica; the remaining former patients were all from the UK (see Appendix B for brief biographical details of the participants).

### **Intersubjectivity and composure**

The intersubjectivity between the interviewer and interviewee and how this may have affected the “composure” of the individuals in the study is a pertinent factor and needs exploration. However, to discuss the nature of intersubjectivity in oral history, one must initially be aware of the nature of the subjective and the objective within history and also of the concept of composure. Summerfield argues that the ‘concept of composure refers to the process by which subjectivities are constructed in life-story telling’. It occurs when an interviewee composes a story about themselves. It also refers to the way in which the interviewee seeks a sense of ‘composure’ from establishing themselves as the subject of their story.<sup>31</sup> Further, concerning intersubjectivity in psychoanalysis, Stolorow and Atwood suggest that:

The perspective of intersubjectivity is, in its essence, a sweeping methodological and epistemological stance calling for a radical revision of all aspects of psychoanalytic thought. An intersubjective field exists at a higher level of generality and this can encompass dimensions of experience - such as trauma, conflict, defence, and resistance - other than the self-object dimension.<sup>32</sup>

Therefore, using this definition of intersubjectivity, we can begin to understand that subjectivity from the point of view of the interviewee involves a deeper analysis of the story being told than can be seen from a purely objective standpoint. Once intersubjectivity is brought into play, which involves the subjective nature of both

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<sup>31</sup> Penny Summerfield, ‘Culture and Composure: Creating Narratives of the Gendered Self in Oral History Interviews’, *Cultural and Social History* 1 (2004), p. 69.

<sup>32</sup> Robert, D. Stolorow & George, E. Atwood, *Context of Being: The Intersubjective Foundations of Psychological Life* (Hillsdale, 1992), pp. 18-42.

interviewee and interviewer, it is a story told which involves the lives of both parties. I would argue that, in this study, the fact that I am gay helped to put the former patient interviewees at ease in terms of their confidence in telling their own personal stories. This concurs with the writings of James Sears.<sup>33</sup> Further, it aided in the ability of the individuals to compose their narrative, in that I was able to identify and empathise with elements of their story. Conversely, it could also have been counterproductive in some cases, particularly when interviewing the nurses, as they may not have wanted to tell me the whole truth about the treatments for fear that it might offend me.

However, as I am also a mental health nurse, I was also in some respects an ‘insider’ in relation to the mental nurses I interviewed.<sup>34</sup> For the same reason, Prebble also believed she was an ‘insider’ to the mental nurses she interviewed. I would concur with her in that this status created a level of trust with the interviewees. She argues that this was mainly due to many mental nurses often experiencing the effect of stigma by association with mental illness and feeling misunderstood by other nurses and by the general public.<sup>35</sup> Nevertheless, my sexuality meant that I was in other respects an “outsider” who had to demonstrate trustworthiness as a researcher. In spite of having an understanding of the practice, concepts and language of mental health nursing, I had to be aware that in relation to my interviewees’ lived experience of providing these treatments, I was indeed an outsider.<sup>36</sup> In this context, Haravan notes that:

The subjective reconstruction of life histories is shaped by a variety of factors, most notably by individuals' interactions with their interviewers, by the life stage at the time they are interviewed, and by the social-structural conditions and historical

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<sup>33</sup> James, T. Sears, *Edwin and John: A Personal History of the American South* (New York, 2009).

<sup>34</sup> Perks & Thomson, *The Oral History Reader*, p. 67.

<sup>35</sup> Prebble, ‘*Ordinary Men and Uncommon Women*’, p. 23.

<sup>36</sup> Prebble, ‘*Ordinary Men and Uncommon Women*’, p. 23.

events that shape their lives.<sup>37</sup>

Debates between the subjective and objective nature of various elements of the telling of history are not new, and this is certainly the case in terms of oral history. In recent years, in a variety of disciplines, there has been a move towards recognising and accepting the subjective nature of oral history, whereby ‘what the informant believes is indeed a fact (that is, the fact that he or she believes it) just as much as what “really” happened’.<sup>38</sup> A key feature of this subjectivity, therefore, is the role of the interviewer, who is helping the interviewee in their interpretation of their oral history, which has been described as the ‘self-conscious analysis of the intersubjectivity of the interview.’<sup>39</sup> The authors place this analysis within modern ethnographic theory, whereby intersubjectivity is acknowledged rather than ignored, and whereby, through other people’s stories, we become aware of our own story.

In this analysis, therefore, and referring back to the main example of both the interviewer and interviewee being gay, intersubjectivity is present in the story of the interviewer being freshly interpreted through the oral history revelations of those being interviewed. This comes along with recent understandings about the inevitability of subjectivity, whereby as Grele says, a purely objective view is ‘a view from nowhere’.<sup>40</sup>

The rise of interest in intersubjectivity in oral history (and in many other disciplines) can therefore be seen as a consequence to a challenge to the reality of a supposedly objective

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<sup>37</sup> Tamara Haravan, ‘From Amoskeag to Nishijin: Reflections on Life History Interviewing in Two Cultures’, in Ronald, K Grele (ed.), *International Annual of Oral History, 1990: Subjectivity and Multiculturalism in Oral History* (New York, 1992), pp. 9-42.

<sup>38</sup> Perks & Thomson, *The Oral History Reader*, p. 178.

<sup>39</sup> Michelle Palmer, Marianne Esolen, Susan Rose, Andrea Fishman & Jill Bartoli, “I haven’t anything to say”: Reflections of Self and Community in Collecting Oral Histories, in Ronald, K Grele (ed.), *International Annual of Oral History, 1990: Subjectivity and Multiculturalism in Oral History* (New York, 1992), pp. 9-42.

<sup>40</sup> Ronald K. Grele, *International Annual of Oral History, 1990: Subjectivity and Multiculturalism in Oral History* (New York, 1992), p.2.

viewpoint, which has also been influenced by a marked shift from quantitative to qualitative methods of information-gathering in history.<sup>41</sup> This move away from a putatively objective and quantitative standpoint to a more subjective and qualitative standpoint, allied with a recognition of the difficulty of the interviewer to be fully objective, has increased the validity of intersubjectivity in oral history.

This has particularly been the case, as we shall now see in the example of Sears, in terms of oral histories from a gay perspective. In *Edwin and John: A Personal History of the American South*, Sears sees not only the story of Edwin and John but also readily identifies with his own homosexuality as he enters the world of their story.<sup>42</sup> There is, therefore, an interaction of intersubjectivity taking place within the narratives of John, as he tells his story, and Sears as he relates to the story and as it brings his own story into stark relief. This echoes Palmer's earlier comments about how as we become more aware of the stories of others, we also become more aware of our own stories. Sears himself suggests that the issue is not about subjectivity or objectivity, but that

In modernist scholarship, the interpretive hand is hidden behind passive verbs, third-person voice, detached narrative, and scholarly footnotes. Research, however, is subjective. [...] The critical test, I believe, is not objectivity but authenticity.<sup>43</sup>

### *Memory and subjectivity*

The debate over the "reliability" of memory has generated a great deal of contention in the historical literature. Alessandro Portelli argues that memory 'functions as an incessant work of interpretation and re-interpretation, and organisation of meaning'.<sup>44</sup>

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<sup>41</sup> Donald A. Ritchie, *Doing Oral History: A Practical Guide* (New York, 2003), pp. 103-104.

<sup>42</sup> Sears, *Edwin and John: A Personal History of the American South*, p. xv.

<sup>43</sup> Sears, *Edwin and John: A Personal History of the American South*, p. xvi.

<sup>44</sup> Alessandro Portelli, 'What makes oral history different?', in Robert Perks & Alistair Thompson (eds.), *The Oral History Reader* 2<sup>nd</sup> ed. (London, 1998), p. 33.

Geertje Boschma and her colleagues argue that memories are very rarely a precise account of what happened, but are always a reconstruction of events and experiences. These change over time and through the process of selection, recollection and connection with other memories.<sup>45</sup> Indeed, some participants' memories of dates and details of events did not always concur with written historical records. Nevertheless, over the years oral historians have come to view this "unreliability" of memory as a resource rather than a flaw, which can provide vital clues to the meaning people attach to certain events.<sup>46</sup> As I analysed and interpreted the participants' testimonies, it became apparent that there were times when their memories were more important as an indication of personal meaning than as a source of empirical data.

Delroy Heath, for example, when recalling his time in hospital receiving aversion therapy, stated, 'it was a miserable chapter of my life...the weather was always dark, cold and gloomy when I was in there too'.<sup>47</sup> I would argue that his particular experience of the weather was coloured by his unhappy memories of his time in hospital. As I scanned for the incidence of internal and external discrepancies and incongruities, I was able to gain an understanding of the subjective experience and the numerous constructed identities, especially in relation to the meanings that nurses placed on aversion therapies. Indeed, Elizabeth Kenny argues that to supplement the authenticity of the data, one must learn from the subjective nature of oral history interviews.<sup>48</sup>

Perhaps, then, in examining intersubjectivity, we can see a move from the modern to the post-modern: a change from a modernist perspective, where there are grand narratives

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<sup>45</sup> Boschma, Scaia, Bonifacio & Roberts, 'Oral History Research', p. 84; on this point, see also Cook, *Brixton Squats in 1970s London*; Paul Connerton, *How Societies Remember* (Cambridge, 1989); Mary Evans, *Missing Persons: the impossibility of Auto/Biography* (London, 1998).

<sup>46</sup> Thomson, 'Fifty Years On: an international perspective on oral history', pp. 584-588.

<sup>47</sup> Delroy Heath interviewed 28 April 2010.

<sup>48</sup> Elizabeth Lapovsky Kennedy, 'Telling Tales: oral history and the construction of pre-Stonewall Lesbian History', Robert Perks & Alistair Thomson (eds.), *The Oral History Reader*, 2<sup>nd</sup> Ed (New York, 2006), p. 281.

that can be observed and detailed from an objective perspective, to a series of narratives where the subject, and therefore the intersubjective, are much more important, with objectivity less important than (as Sears suggests) authenticity. For Sears in this analysis, his own homosexuality is a key part of the ability to tell the story of Edwin and John, as it is in his earlier oral history of Southern life, whereby:

[...] documenting, writing, and reading narratives of *our* communities provide lesbians and gay men with a collection of sacred, communal stories that for too long have been lost or devalued in the larger canon of heterosexist history - presented to us as fact.<sup>49</sup>

There is, however, a flip side to this insofar as researchers may only interview and include people who say what the researcher wants to hear. To alleviate this, Frankfort-Nachmias and Nachmias discuss the concept of 'bracketing'.<sup>50</sup> They argue that before researchers commence any project, and especially during the data collection and analysis phase, they must 'bracket away' any preconceived ideas, notions or beliefs about the topic they are about to investigate. Some have even gone so far as to suggest that an initial literature review is not required before commencing the study, as this does not lend itself to the bracketing process.<sup>51</sup> However, Summerfield argues that the preparation before the interview is paramount; this includes reading around the topic and gaining background information: 'The more one knows, the more likely one is to elicit significant historical information from the interview'.<sup>52</sup> Whether bracketing can really be achieved is, moreover, questionable. Holloway suggests that if there is a dearth of literature related to the phenomenon being studied, which could be argued is the case in this study, then the initial literature review is likely to have little influence on the

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<sup>49</sup> James Sears, *Lonely Hunters: An oral history of Lesbian and Gay Southern Life, 1948-1968* (Boulder, 1997), p. 1.

<sup>50</sup> Chava Frankfort-Nachmias and David Nachmias, *Research Methods in the Social Sciences* (London, 1996), p. 87.

<sup>51</sup> Patton, *Qualitative Research and Evaluation Methods*, p. 147.

<sup>52</sup> Penny Summerfield, 'Reconstructing Women's Wartime Lives' (Manchester, 1998), p. 26.



outcome.<sup>53</sup> This is clearly a contentious topic and it is not within the scope of this chapter to engage more extensively with the issue.

### **Equality between researcher and participant**

Returning to the above discussion on how my sexuality came into play within the study, I was able to identify with Oscar Mangle when he asked: 'I'm sure you can identify with me that it is not easy growing up gay'.<sup>54</sup> My simple and empathetic response of 'Yes, it was not easy; however, I am sure it would have been even more difficult in the 1950s' displayed to the interviewee that I could identify with him and wanted to know more about his experience. However, on reflection, it may have shaped his response by presenting the 1950s as a particularly challenging time for gay people. A slightly less leading reply could have been: 'Yes, it was not easy; however, some people say it was more difficult in the 1950s'.

Despite the possibility that having a shared sexuality aided in the ability of individuals to achieve composure, by enabling them to see me as someone equal to themselves, Judith Stacey has gone so far as to state that the ideal of equality between academic researchers and their subjects is impossible to achieve.<sup>55</sup> This possible power imbalance between academic researchers and their subjects may have affected the composure in Albert Holliday. When describing his upbringing, he was able to articulate a very detailed picture of growing up in a working-class mining town where money was scarce, with his parents having six other brothers and sisters to feed. However, he commented:

Although, I suppose your upbringing was very different and you didn't have to worry about such things. I imagine you are from a very middle class background.<sup>56</sup>

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<sup>53</sup> Immy Holloway, *Qualitative Research in Health Care* (New York, 2005), p. 150.

<sup>54</sup> Oscar Mangle, interviewed 21<sup>st</sup> June 2010.

<sup>55</sup> Judith Stacey, 'Can There Be a Feminist Ethnography?', in Sherna Gluck & Dephne Patai (eds) *Women's Words* (New York, 1991), pp. 111-119.

<sup>56</sup> Albert Holliday interviewed 27 June 2010.

This comment clearly displays that the participant did not perceive me to be someone “level” with himself in terms of social class, education and occupational identity. It is difficult to determine the extent to which this complex interplay between the interviewer and interviewee affected the “composure” in the interviewee. However, I would argue that it affected the readiness of the interviewee to develop a relationship with me, as he may have believed that the perceived class difference made it difficult to relate to me; this would in turn impinge on the interviewee’s ability to compose a story. On reflection, though, I was dressed very smartly, as I had been lecturing earlier that day, and I introduced myself as a university lecturer. It was only at the end of the interview, when the recorder had been turned off and we were both chatting about where I grew up and my “working class” and nursing background, that I felt some equilibrium in the “level” at which he perceived me.

Therefore, for subsequent interviews, I found it beneficial to give a brief synopsis of myself and my background at the start of the interview. Further ways in which interviewers can take steps to try and mitigate the power imbalance in the relationship have been suggested: these include first, seeing the interview as a sharing of experience; second, placing themselves in a subjective position within the interview; and third, giving interviewees some responsibility for the project.<sup>57</sup> However, Summerfield argues that the extent to which participants can participate in the research project is limited. The researcher nurtures, assists and validates the narrator’s interpretative role, but in the end, the work of the interpretation and analysis, and the skills and time required to undertake this, are the researcher’s own.<sup>58</sup>

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<sup>57</sup> Kristina Minister, ‘A Feminist Frame for the Oral History Interview’, in Sherna Gluck & Daphne Patai (eds) *Women’s Words* (New York, 1991), pp. 111-119.

<sup>58</sup> Summerfield, ‘*Reconstructing Women’s Wartime Lives*’, p. 26.

### Qualities of the researcher

Perks and Thompson argue that the core of oral histories is in the interview itself, and to interview successfully requires skill.<sup>59</sup> Further, essential qualities that the interviewer must possess include an interest and respect for people as individuals and an ability to respond flexibly to them. The interviewer must also have the capacity to show understanding and sympathy for the interviewees' point of view, 'and above all, a willingness to sit quietly and listen'.<sup>60</sup> Thompson argues that interviewers who cannot stop talking, or who 'contradict or push an informant with their own ideas, will take away information that is either useless or positively misleading'.<sup>61</sup> I believed that my skills as a mental health nurse were of benefit here, as we often have to explore clients' difficult and troublesome pasts.

Thompson discusses the debate over the most effective approach to the interview. He posits that there are two approaches to interviewing, the first being the "objective/comparative", usually based on a questionnaire, or at least a very highly structured interview in which the interviewer keeps control and asks a series of questions.<sup>62</sup> One benefit of this approach is that it can generate very useful material when the interviewer is sensitive and is prepared to abandon the script when necessary. However, if the interviewer is not able to do this, promising lines of inquiry are easily ignored. The other approach is the free-flowing dialogue between interviewer and respondent, with no set pattern, in which conversation is followed wherever it leads. This method can develop unexpected leads to completely new lines of enquiry. However, it can also easily degenerate into little more than anecdotal gossip.

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<sup>59</sup> Robert Perks & Alistair Thomson, *The Oral History Reader* 2<sup>nd</sup> (ed) (Oxon, 2000), p. 7.

<sup>60</sup> Kirby, 'The Resurgence of Oral History and the New Issues it Raises', p. 48

<sup>61</sup> Thompson, *The Voice of the Past: Oral History*, p. 154.

<sup>62</sup> Thompson, *The Voice of the Past: Oral History*, p. 225

That is not to say, however, that gossip is not useful to the historian. Giorno has argued for the importance of the currency of gossip, ‘Ordinarily it just seems like boring gossip,’ he says, ‘but it actually is the dynamic relationship between artists and poets.’<sup>63</sup> For him, gossiping is a form of social activity, which produces and maintains the affiliations of a community. This is an interesting expression, which signals Giorno’s appreciation of gossip’s central importance for understanding history. Therefore, to strike the balance between these two approaches, I utilised face-to-face semi-structured interviews, which lasted a maximum of two hours, as any longer tends to overtire the interviewee.<sup>64</sup> These were audio-taped and transcribed for historical interpretation.

Bertaux has argued that when interviewing similar groups, patterned responses occur, and that eventually the researcher reaches saturation point in terms of the available information and does not need to follow the interview schedule fully with further subjects.<sup>65</sup> The disadvantage with this method is that the researcher does not have the interviewee as an integrated whole, with the loss not only of the full experience of the subject but also of the social and political context. Therefore, as Summerfield points out, it is pertinent to show interest and respect for each individual interviewed, seeing them all as having something unique to offer the researcher.<sup>66</sup>

### **Data analysis and historical interpretation**

Prebble argues that in order to begin analysing oral history interviews one must engage in a process of immersion, questioning, contrasting and comparing, which requires openness and humility.<sup>67</sup> Oral history is not given from a theoretical perspective,

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<sup>63</sup> John Giorno, *You Got to Burn to Shine: New Selected Writings* (London, 1974), p. 159; see also, Gavin Butt, *Between You and Me: Queer Discourses in the New York Art World, 1948-1963* (Durham, 2005).

<sup>64</sup> Abbott & Sapsford, *Research methods for nursing and the caring professions*, pp. 267; see Appendix D for a copy of the semi-structured interview guides utilised.

<sup>65</sup> Daniel Bertaux. ‘From life-history approach transformation of sociological practice’, in Daniel Bertaux (ed.), *Biography and Society* (London, 1981), p. 111.

<sup>66</sup> Summerfield, ‘Culture and Composure’, p. 69.

<sup>67</sup> Prebble, *Ordinary Men and Uncommon Women*, p. 23.

meaning that it does not actively seek to convey a specific ideological value. The interpretation of such histories in respect of theories is left to the historians and so can provide material for the support or rebuttal of any number of philosophies. However, they will often challenge '[...] official documents and other works written from the perspective of white, male, dominant members of society', thus challenging history as it was traditionally determined.<sup>68</sup>

In addition to this, it should be noted that the nature of oral history itself is not limiting. For example, Gluck highlights that the form and content of oral history is versatile because it will allow variation depending on the information that is being recorded.<sup>69</sup> Topical interviews give a limited picture but autobiographical interviews can give a full view of an individual's life. That is not to say that one is better than the other: each can give a different view and provide a "marriage" which allows both to be of value, and enables modern historians to explore oral history in different ways.

It would be wrong, however, to state that the historian holds interpretative authority over the material. Indeed, the act of remembering can be very empowering and in some cases therapeutic, especially for gay people, who may have had to analyse their past fairly comprehensively.<sup>70</sup> Many of the therapeutic dimensions listed by Church and Johnson were apparent in the participants within the study – the sharing of feelings, the expression of satisfaction, or of anger at unresolved issues, changes in affect and a desire to contribute usefully.<sup>71</sup> Borland has posited that due to the participants having interpreted their past over a number of years, it is important that historians open up the

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<sup>68</sup> Earl R. Babbie & Lucia Benaquisto, *Fundamentals Of Social Research* (New York, 2009), p. 352.

<sup>69</sup> Gluck, 'What's So Special About Women?: Women's Oral History', p. 5.

<sup>70</sup> Cook, *A Gay History of Britain*, p. 213; Plummer, *Telling Sexual Stories*, p. 57.

<sup>71</sup> Oscar, M. Church & Michael, L. Johnson, 'Worth remembering: the process and products of oral history', *International History of Nursing Journal* 1 (1) (1995), p. 22.

exchange of ideas so that they do not simply gather data on others to fit their paradigms.<sup>72</sup>

Perks and Thomson also allude to the limited scope in terms of the selective nature of the oral history. Not only may the perspective be biased but there are also limitations posed by the choice of histories that have been collected, thus providing a major conflict in determining their usefulness:

On the level of the interview itself, for example, there have been telling criticisms of a relationship with information in which a middle-class professional determines who is to be interviewed and what is to be discussed.<sup>73</sup>

It may be that the interviewer has specifically chosen individuals for their perspectives, ease of interviewing or because they fit certain criteria. Borland, however, has argued that historians can go some way to work around issues of equality. Borland proposes that she is always concerned about the potential emotional effect that alternative readings and interpretations of personal testimonies may have on the living subject. The performance of a personal narrative is a fundamental means by which people comprehend their own lives and present a “self” to their audience. Historians’ representations of those performances, if not sensitively presented, may constitute an attack on our collaborators’ carefully constructed sense of self, which will serve to exacerbate the ideal of equality.<sup>74</sup> To work around this, Borland has suggested that it is important to work in alliance with the participant throughout not only the data

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<sup>72</sup> Katherine Borland, “‘That is not what I said’”. Interpretative conflict in oral narrative research’, in Robert Perks & Alistair Thomson (eds.), *The Oral History Reader* 2<sup>nd</sup> ed. (London, 1998), p. 319.

<sup>73</sup> Perks & Thomson. *The Oral History Reader*, pp. 26-27.

<sup>74</sup> Summerfield, ‘Culture and Composure’, p. 69.

collection phase, but also the interpretation phase. She goes on to state:

By extending the conversation we initiate while collecting oral narratives to the later interpretation, we might more sensitively negotiate issues of interpretive authority in our research. I am not suggesting that interpretations must be validated by our research collaborators. For when we do interpretations, we bring our own knowledge, experience, and concerns to our material, and the result, we hope, is a richer, more textured understanding of its meaning.<sup>75</sup>

In light of this, where possible, I re-contacted several participants by phone or e-mail for more information or to clarify their perceptions of certain matters or events. However, this was not always possible with some participants as they sadly passed away in the time frame between data collection and interpretation. Friedlander has also posited other reasons why this may not be possible: for example, the researcher may not have the financial resources to visit the participant a subsequent time.<sup>76</sup>

At times the interpretive process started before I had even met the participants face-to-face. I often made contact with potential interviewees over the phone to arrange a convenient time and place to conduct the interview (all chose to be interviewed in their own homes), and during this dialogue, we often became engaged in conversation about the topic in question. This gave me an opportunity to reflect on and analyse these conversations before we actually met, allowing me to follow up on any questions that had emerged from the initial telephone conversation during the actual interview. The interviews were audio-tape recorded and transcribed for ease of analysis. Ann Green argues that the way we tell stories, and the language we use, is not always as

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<sup>75</sup> Borland, "That is not what I said", p. 319.

<sup>76</sup> Peter Friedlander, 'Theory, method and oral history' in Robert Perks and Alistair Thomson *The oral history reader* (London, 1998), p. 314.

straightforward as it might first appear. It is ‘rarely a transparent or neutral medium’.<sup>77</sup> Therefore, I also found it useful to note the interviewees’ emotional responses, body language and their levels of engagement during the interview.

The interpretive process continued as I listened to the audiotapes in order to transcribe the interviews. I repeatedly visited and revisited the transcripts and, as new questions and themes emerged from my analysis, I often re-listened to the interviews. I also found supervision useful as a forum to test out ideas and themes that started to emerge.<sup>78</sup> As I became more absorbed in the details, reflections and experiences of both the nurses and former patients, I discovered that their testimonies offered unanticipated and important understandings of their shared culture and identity. In parallel to other oral history studies, the participants’ testimonies sent me back to the written primary sources to clarify dates, official views, or political and social contexts. Occasionally, I was directed back to the interviews to establish how events or practices appeared to the participants as I discovered new data in the archives.<sup>79</sup> While all participants’ testimonies are utilised in this thesis, it is important to acknowledge that I depend on some participants’ testimonies more than others. Although themes emerged from my analysis of the interviews because the participants were reflecting on the same things, some participants spoke at more length and were more articulate in their descriptions of events, so these testimonies have been used for clarity.

### **Anonymity and other ethical issues**

Some feminist oral historians recommend that interviewers should encourage openness in their respondents by guaranteeing their anonymity.<sup>80</sup> Maintaining the participants’ anonymity is done to protect respondents from public recognition; however, this

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<sup>77</sup> Anna Green, ‘“Unpacking” the Stories’, in Anna Green & Megan Hutching (eds.), *Remembering: Writing Oral History* (Auckland, 2004), p. 11.

<sup>78</sup> Carpenter, *Above All a Patient Should Never Be Terrified*, p. 57.

<sup>79</sup> Prebble, ‘*Ordinary Men and Uncommon Women*’, p. 24.

<sup>80</sup> Gluck, ‘What’s So Special About Women?’, p. 5.



contradicts one of the aims of homosexual history, which is to allow a platform for gay people to embrace and share their pasts that have often been hidden from history.<sup>81</sup> However, in the process of engaging, interpreting and analysing their testimony, I decided to offer all participants anonymity, due to my own role in writing about their past. My reason for this concurs with that of Baker and Stanley, who changed all participants' names in their study for their protection.<sup>82</sup>

Summerfield also gave all participants in her study pseudonyms, as she wanted to screen them from the public embarrassment, 'which my arbitration between their words and "the public" might cause'.<sup>83</sup> Summerfield goes on to argue that anonymity protects interviewees from the ultimate manifestation of the power inequity in the oral history relationship: 'the historian's interpretation and reconstruction in the public form of print of intimate aspects of their lives'.<sup>84</sup> I also consulted the participants regarding this issue, as some had agreed, on the consent form, (see Appendix H) to their actual names being used if I directly quoted their testimonies, and they all agreed that I could use a pseudonym in lieu of their real names. In light of these arguments, pseudonyms will be utilised throughout the thesis.

The study obtained ethical approval from the University of Manchester's ethics committee on 21<sup>st</sup> December 2009 (see Appendix E). I also worked under the auspices of the Ethical Guidelines for the Nurse Historian and Standards of Professional Conduct for Historical Inquiry in Nursing.<sup>85</sup> The main ethical issues of the study were confidentiality and anonymity of the participants and ensuring that the participants had given informed consent. As discussed above, I have given all participants anonymity.

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<sup>81</sup> Plummer, *Telling Sexual Stories Power*, p. 43

<sup>82</sup> Baker & Stanley, *Hello Sailor!*, p.16.

<sup>83</sup> Summerfield, *Reconstructing Women's Wartime Lives*, p. 26.

<sup>84</sup> Summerfield, *Reconstructing Women's Wartime Lives*, p. 32.

<sup>85</sup> June Brown, 'Editorial – Ethical Considerations in Historical Research', *American Association for the History of Nursing Bulletin* 38 (1993), p. 1-2.

Potential interviewees were sent a letter of invitation, Participant Information Sheet and a Consent Form (see Appendix F, G & H). In most cases, consent was returned by post, but in some cases interviewees chose to return it at the time of interview.

Parahoo argues that another pertinent aspect of all research is respect for non-maleficence.<sup>86</sup> Parahoo believes that it is often difficult to tease out the potential for psychological harm within research studies. This is particularly so when interviews are used for data collection, where the behaviour of the researcher in conducting the interview has as much (if not more) potential for causing psychological harm as the actual topic being researched. This was a pertinent area for this study, as the participants, particularly the former patients, were often recalling a very fraught chapter in their lives. Therefore, Patton suggests that it is helpful to know what arrangements are being made for unexpected eventualities during the research and what support will be available afterwards.<sup>87</sup> Kirby states that the interviewer must be supportive when needed and be ready to offer to switch off the tape recorder and let the interviewee recover his or her composure whenever necessary.<sup>88</sup> In light of this, one of the conditions of ethical approval was that I had to have the number of a counsellor available to give to the participants should they become distressed during the interview; however, all participants declined this when it was offered to them. A further condition of ethical approval was that all transcripts of the interviews with the participants had to be destroyed on completion of the study.

## **Conclusion**

The above discussion has outlined the methods used and explored the advantages, challenges and nuances of utilising oral history as the main source of primary data to

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<sup>86</sup> Kadar Parahoo, *Nursing Research: Principles, Process and Issues* (London, 1997), p. 67.

<sup>87</sup> Patton, *Qualitative Research and Evaluation Methods*, p. 158.

<sup>88</sup> Kirby, 'The Resurgence of Oral History and the New Issues it Raises', p. 47.

explore an area of nursing essentially hidden from history. Issues around intersubjectivity, composure and the equality between the researcher and the participant have been investigated. I argue, that the subjective in oral history is very important - both my own subjectivity as a gay nurse researcher, and the subjectivity of the stories the participants felt needed to be told in order to correct the bias of “heterosexist” history. Allowing this intersubjectivity is, therefore, a vital component in bringing out these stories, and allowing these narratives their place in history. As I searched for the existence of internal and external discrepancies and inconsistencies, I gained an understanding of the subjective experience and numerous constructed identities of the participants. Moreover, instead of seeing subjectivity as a limitation, I argue that it should be viewed as a positive, insofar as this allows the historian to see the authenticity of the data as complementary to “empirical” insights. Indeed, these rich, subjective stories, in feminist historians Gluck and Patai’s words, ‘turn up the muted channel’.<sup>89</sup> Therefore, I would also argue that this thesis makes a contribution to the field of histories of subjectivity.

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<sup>89</sup> Sherna Gluck & Daphne Patai *Womens Words* (New York, 1991), p. 11.

## CHAPTER II

# OPPRESSION AND SUPPRESSION OF THE “SEXUAL DEVIANT”, 1939 – 1967.

I would sometimes question the treatments we were giving, especially on ethical grounds. Then I would get home and turn on the television, open the newspaper, or read a book and all over it was either “homosexuals should be accepted”, or conversely “homosexuality is illegal, it is wrong, these people are irredeemable.” And thank goodness; “psychiatry is trying to do something about it” and erm “let’s try and give them extra resources to cure these deviants.” I just didn’t know who was right and what was wrong, it left me very perplexed.<sup>1</sup>

### **Introduction**

Nurses caring for patients receiving treatments for sexual deviations received mixed and muddled messages regarding the correct way to view these people. Between 1939 and 1967 there was a refocusing of public debate surrounding sexual deviations onto issues of aetiology rather than punishment.<sup>2</sup> Furthermore, it was under this highly charged debate that treatments for sexual deviations, in a bid to cure individuals suffering from these, really came to the fore. This chapter draws upon publications within the medical press, sociological understandings, news media, literary and film depictions of homosexuality to explore the complex social and cultural climate in which the homosexuals, transvestites and mental nurses were living from the 1930s to the 1960s.

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<sup>1</sup> Luke Vanston, interviewed 23<sup>rd</sup> June 2010.

<sup>2</sup> Some progress was made in the 1940s in modifying the legal attitude to homosexuality. Under the Criminal Justice Act of 1948, the conditions of probation were extended and improved. Under the Act the court could now order treatment under a qualified medical practitioner; see also The National Archives (NA), Kew, H0345/9, Proceedings of the Wolfenden Committee on Homosexual Offences and Prostitution (PWC), Summary Record of 21<sup>st</sup> Meeting, March 1956.

In doing so, it offers a context to explain why treatments for sexual deviations came to be developed and implemented.

## **World War II**

During World War II, there was a remarkable polarity between the allied and the National Socialist (Nazi) attitude towards homosexuality. An exploration of these contrasting mind-sets enables us to examine the socio-political context in which gay men lived during the war. Some interesting points have been made by historians, including the argument that the apparently tolerant attitude of the allies was thought to contribute to the later liberation of homosexuality.<sup>3</sup> Further, it has been suggested that due to the fact that service men were living in close proximity to each other, they were exposed to more liberal attitudes towards variations in sexual desires.<sup>4</sup> Nevertheless, pathological, psychological and psychoanalytical interpretations and analysis of homosexuality can be seen to be appearing during World War II. Therefore, it is important to explore this period.

During the first year of the war many male nurses were called up for military service and assigned to the Royal Army Medical Corps.<sup>5</sup> When the war ended many of these nurses returned to the mental hospitals and numerous ex-service personnel who had not previously worked in mental health were noted to join the profession due to limited employment opportunities.<sup>6</sup> Nolan argues that one of the main attractions of mental nursing to demobilized soldiers was the military-style atmosphere of the hospitals and

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<sup>3</sup> John Costello, *Love, Sex & War: Changing Values, 1939 – 45* (London, 1985), p. 162; Houlbrook, *Queer London*, p. 236.

<sup>4</sup> Peter Wildeblood, *Against the Law: The Classic Account of a Homosexual in 1950s Britain* (London, 1955).

<sup>5</sup> Within the first year of the war, 2, 000 male nurses left for military service and 600 women had left for war work: Chatterton “The weakest link in the chain of nursing?”, p. 67; see, also Peter Nolan, *A History of Mental Health Nursing*, p. 100; Peter Nolan, ‘Jack’s Story’, *Royal College of Nursing The History of Nursing Group 2* (2) (1987), pp. 22-28.

<sup>6</sup> Chatterton “The weakest link in the chain of nursing?”, p. 67.

the excellent sporting facilities.<sup>7</sup> In light of this, I will argue in Chapter IV that for some nurses who served in the war, mental nursing had much in common with service life: it 'provided a sheltered existence with most of their needs taken care of, where one had to do little thinking for oneself'.<sup>8</sup> For other nurses, working alongside homosexual men and women during the war appeared to have a liberating effect on their attitudes towards these people, and this was played out in their professional conduct when they later nursed such individuals; this will be explored in Chapter V.

There is evidence that nurses under Nazi rule played a role in assisting with the medical experiments undertaken within concentration camps in Nazi Germany and other occupied countries.<sup>9</sup> Moreover, the majority of these nurses excused their participation in such acts because they maintained that they were following orders from higher authority. However, there is also evidence to suggest that some nurses under Nazi rule engaged in subversive practices in order to protect the patients in their care.<sup>10</sup> While I emphasise the different context and that none of the nurses in this study knowingly murdered patients, as the nurses under Nazi rule did, I will go on to argue, in Chapters IV and V, that there may be something to be learnt from a comparison with the roles German nurses played while under Nazi rule and the roles of the nurses in this study. Some nurses in this study also reasoned that they were only following the orders of their superiors in regard to administering aversion therapy, while others engaged in subversive behaviours to avoid administering aversion therapy for sexual deviations.

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<sup>7</sup> Peter Nolan, 'The Development of Mental Health Nursing', in Jerome Carson, Leonard Fagin & Susan A. Ritter (eds.), *Stress and Coping in Mental Health Nursing* (London, 1995), p. 13.

<sup>8</sup> Nolan, 'Jack's Story', p. 25.

<sup>9</sup> See, e.g. Susan Benedict & Jane M. Georges, 'Nurses and the sterilization experiments of Auschwitz: A Postmodernist Perspective', *Nursing Inquiry* 13 (4) (2006), pp. 227-288; Bronwyn Rebekah McFarland-Icke, *Nurses in Nazi Germany: A Moral Choice in History* (Princeton, 1999), p. 130; Francis Biley, 'Psychiatric nursing: Living with the Legacy of the Holocaust', *Journal of Psychiatric and Mental Health Nursing* 9 (2002), p. 365; Hilde Steppe, 'Nursing in Nazi Germany', *Western Journal of Nursing Research* 14 (1991), p. 745.

<sup>10</sup> See, e.g. Susan Benedict, 'Maria Stromberg: A Nurse in the Resistance in Auschwitz', *Nursing History Review* 14 (2006), pp. 189-202.

*Liberal attitudes among the allies*

The start of World War II and mobilisation meant that men who had never been away from home suddenly found themselves on the move. They were mixing with other people of their own age and responsible only unto themselves – it is not surprising to find that the war created new sexual experiences for individuals. Julian Glover was called up for military service during the war, and after demobilisation went on to train as a mental nurse. He recalls working with a fellow soldier during the war who was homosexual:

I remember one young chap who I served with in the 1940 Campaign in France. He was overtly camp and didn't really hide it. He was a good source of entertainment for us; he could always be relied upon to lighten the mood. I had never met an overly gay person before, but if he "had my back" then I had his I suppose. It opened my mind and I was less prejudice against it. That is why I really struggled once I was expected to administer aversion therapies to the poor chaps later on.<sup>11</sup>

On the home front in World War II, the blackout in major cities provided cover for erotic encounters, with Quentin Crisp noting, 'When the blackout came, London became a vast double bed'.<sup>12</sup> Roy recalls Edinburgh being 'full of sailors who were quite easy; quite quite easy. The place was as if the world had gone mad because it was so easy'.<sup>13</sup> Many of the testimonies of gay men who lived during the war pertain to a sense of living for the moment – death may have been imminent for each of them, and this necessarily changed the way they and many others responded to sexual possibility: moral codes, old inhibitions, class divisions and customs were compromised in certain places and at certain times.<sup>14</sup>

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<sup>11</sup> Julian Glover, interviewed 4<sup>th</sup> January 2010.

<sup>12</sup> Quentin Crisp, *The Naked Civil Servant* (London, 1968), p. 155.

<sup>13</sup> "Roy" whose testimony appears in Porter & Weeks, *Between the Acts*, p. 78.

<sup>14</sup> Cook, *A Gay History of Britain*, p. 148

Gregory Gregson, who received aversion therapy in the 1960s, recalled his wartime experiences. He joined the Royal Air Force (RAF) in 1939 at the age of nineteen, but was captured by the Japanese during the fall of Singapore and spent the rest of the war in Prisoner of War (POW) camps; he recalls such transcending of class divisions and the tolerance of his colleagues:

We all just got on with it, we had a common goal, which was to beat Hitler and the Japanese, and that was it, really. I had had what you might call a fairly privileged background, but I was working alongside the “salt of the Earth” type people and it didn’t bother me or them - class didn’t come into war. In the POW camp I met a young chap from Liverpool. He had been a builder’s labourer before the war – very rough and ready looking [laughs] and we became lovers. The other lads in the camp knew and just turned a blind eye to it really. After a while, he was sent to another camp, though. I tracked him down after the war and we met up again; but it wasn’t the same. He had decided that he wanted to get married and have kids, and that it was the segregation from females that had developed his homosexual feelings. I was upset, but I understood. We still remained friends, though. In fact I’m godfather to his daughter.<sup>15</sup>

Meanwhile, as we have seen from the testimony of Julian Glover above, overtly camp<sup>16</sup> gay men could find themselves relatively accepted in the services. John Beardmore, an officer in the Navy, recalls Freddy, a former choirboy, who was on his ship. He had the job of relaying messages from the captain to the rest of the ship:

At moments of high drama he sometimes diffused the tension by camping it up, so when the captain issued orders to open fire, he simply repeated “open fire dear” which would crack up the troops. [...] He was immensely popular on the ship.<sup>17</sup>

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<sup>15</sup> Gregory Gregson, interviewed 2<sup>nd</sup> January 2010; see, also Wildeblood, *Against the Law*, p. 19 – 21 (regarding the acceptance and tolerance to his homosexuality while he was in prison).

<sup>16</sup> I have utilised here Richard Dyer’s definition of camp as ‘a characteristically gay way of handling the products of a culture through irony, exaggeration, trivialization, theatricalization and an ambivalent making fun out of the serious and respectable.’ Richard Dyer, *The Culture of Queers* (London, 2002), p. 250.

<sup>17</sup> Jivani, *It’s Not Unusual*, p. 64.



I would argue that Freddy was a kind of talisman, and even though John, who related this story, identified himself as homosexual, he clearly saw himself to be in a different category to Freddy; this could be due to the fact he was an officer and men in higher ranks had to be especially cautious.<sup>18</sup> Moreover, this highlights the hidden and complex impact of class within homosexual culture.<sup>19</sup> In light of this, I argue in Chapter III that there appear to be some parallels between this wartime pattern and the dynamic between the more effeminate homosexual lower ranking nurses and their senior administrators, who were also homosexual, in mental hospitals during the study period.

Patrick Higgins argues that such ‘campery’ could be tolerated and enjoyed in the forces.<sup>20</sup> Nevertheless, while sexual contact between people of the same sex appears to have been fairly common in the forces, and some had a more liberal attitude towards this, it still remained furtive and secret. Being caught would mean a certain court martial and subsequent disgrace, not only for having committed a ‘crime’ but, furthermore, because the ejection from the post meant that the individual was not ‘doing his bit’.<sup>21</sup> Indeed, courts martial for sex between men increased during the war years – rising from 48 in 1939 to 324 in 1944/45.<sup>22</sup>

There was hostility among some British citizens regarding United States of America (USA) Army personnel stationed in the UK during the war years, with the wartime comedian Tommy Tinder popularising the phrase ‘Over paid...oversexed and over here’.<sup>23</sup> Nevertheless, there have always been cultural and medical interchanges between

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<sup>18</sup> Jivani, *It's Not Unusual*, p. 70.

<sup>19</sup> For a more detailed exploration of class within homosexual urban culture: see, e.g. Houlbrook, *Queer London*, pp. 167-195.

<sup>20</sup> Higgins, *Heterosexual Dictatorship*, 56; Cook, *A Gay History of Britain*, p. 187.

<sup>21</sup> Davidson, *And Thus Will I Freely Sing*, p. 66; Jivani, *It's Not Unusual*, p. 67.

<sup>22</sup> Lesley Hall, *Sex Gender and Social Change Since 1880* (Basingstoke, 2000), p. 144.

<sup>23</sup> See, e.g. Davidson, *And Thus Will I Freely Sing*; Jivani, *It's Not Unusual*, p. 58.

the USA and the UK – not least during the war.<sup>24</sup> Therefore, it is important to explore the USA policies concerning homosexuals in their army during the war years.

The USA Army made a concerted effort to eradicate homosexuals from its ranks. This was mainly driven by the medical profession, who were of the opinion that homosexuality was a pathology.<sup>25</sup> Psychiatrists tried to detect gay men at induction stations either by their ‘effeminate looks or behaviour or by repeating certain “homonyms” (words from the homosexual vocabulary) and watching for signs of recognition’.<sup>26</sup> These homonyms were: “blow”, “fairy”, “French”, “fruit”, “queer”, “rear”, “suck”, “pansy”, and “Greek”.<sup>27</sup> No explanation or rationale for the selection of these words is offered. However, a problem arose when men who did not want to fight faked homosexuality in order to be discharged. Therefore, diagnostic tests were devised, including one by Nicolai Giosca, which was published after the war. Giosca came to the scientifically dubious notion that homosexual men did not display a gag reflex when a tongue depressor was put in their throat.<sup>28</sup> A C Cornsweet, a commander in the US Naval Reserve, and Dr. Hayes, an army physician, conducted a survey among two hundred gay men. They concluded that they had discovered a specific reaction common to all those ‘confirmed to the practice of sexual oralism’.<sup>29</sup> This constituted a localisation of pleasure which could only be described by a true homosexual.<sup>30</sup>

There were also studies describing the characteristics of homosexuals. George Henry studied thirty-three homosexual mental patients. He concluded that the homosexual male is characterised by a feminine carrying angle of the arm, long legs, narrow hips,

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<sup>24</sup> See, e.g. Peter Neushul, ‘Fighting Research: Army Participation in the Clinical Testing and Mass Production of Penicillin during the Second World War’, in Roger Cooter, Mark Harrison & Steve Sturdy (eds.), *War, Medicine & Modernity* (Stroud, 1998), pp. 203-224.

<sup>25</sup> Jivani, *It’s Not Unusual*, p. 58.

<sup>26</sup> Jivani, *It’s Not Unusual*, p. 58.

<sup>27</sup> Willaim T. Doidge & Wayne H. Holtzman, ‘Implications of Homosexuality Among Air Force Trainees’, *Journal of Consulting Psychology* 24 (1) (1940), p. 10.

<sup>28</sup> Nicolai Giosca, ‘The Gag Reflex and Fellatio’, *American Journal of Psychiatry* 107 (1950), p. 380.

<sup>29</sup> Jivani, *It’s Not Unusual*, p. 58.

<sup>30</sup> Jivani, *It’s Not Unusual*, p. 58.

large muscles, deficient hair on the face, chest and back, feminine distribution of pubic hair, a high-pitched voice and a small penis and testicles.<sup>31</sup> Jivani suggests that an indication of how futile these studies were came at the end of the war when *Newsweek* ran an article on the United States Army's own figures on homosexuality that had just been tabulated.<sup>32</sup> During the course of the Second World War, between 3,000 and 4,000 men were discharged for this 'abnormality' and an unspecified number were released as 'neuropsychiatric cases'.<sup>33</sup>

An indication of the British Army's policy on homosexuality is given by a War Office document made public in 1950, entitled "The Second World War: Army Discipline", which stated: 'confirmed homosexuals whose rehabilitation is unlikely should be removed from the Army by the appropriate means'.<sup>34</sup> The regulation only refers to "confirmed" homosexuals, which could suggest that repeated offences were necessary and even then expulsion from the army was only considered appropriate for those confirmed homosexuals who could not be rehabilitated.<sup>35</sup> Dudley Cave recalls being discharged from the army and being referred to an army psychiatrist who told him, 'Well, my advice to you is to find someone of like mind and settle down with him and stop bothering'.<sup>36</sup> However, when Quentin Crisp went for his physical examination for the Army, he was asked if he was homosexual. He replied, 'yes'. Nevertheless, he was still examined, which caused great consternation among the medics: 'All the doctors were in a terrible state when they saw me. They were terribly flustered, rushed about

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<sup>31</sup> George Henry, 'Psychogenic Factors in Overt Homosexuality', *American Journal of Psychiatry* xiii (1940), p. 57. The describing of homosexual characteristics can be traced back to Mangus Hirschfeld who in 1897 founded the Scientific Humanitarian Committee. The motto of the Committee, "Justice through Science", reflected Hirschfeld's belief that a better scientific understanding of homosexuality would eliminate hostility toward homosexuals.

<sup>32</sup> Jivani, *It's Not Unusual*, p. 70.

<sup>33</sup> *Newsweek*, 24<sup>th</sup> June, 47.

<sup>34</sup> Costello, *Love, Sex & Wars*. The original document is on p. 162.

<sup>35</sup> Jivani, *It's Not Unusual*, p. 70.

<sup>36</sup> Hall Carpenter Archives Gay Men's Oral History Group, *Walking After Midnight: Gay Men's Life Stories* (London, 1989), p. 33.

and talked to each other in whispers'.<sup>37</sup> Following his examination, he was given his exemption papers, which stated that he suffered from 'sexual perversion'.<sup>38</sup> This testimony attests the emphasis the medical profession placed on the body, and their perceived ability to diagnose homosexuality via medical examination.<sup>39</sup>

John Costello argues that the British military authorities took homosexuality seriously, and reports were commissioned on the behaviour of homosexual soldiers. A British Army study of sexual offenders by Charles Anderson concluded that homosexuals 'achieved gratification from those of their comrades who turned towards them as substitutes for women'; they were also known 'to dominate the group, obtain love, respect, and acknowledgement of prowess. He must lead, cannot be led, and finds it intolerable to be in a passive position of obeying'. Over a third of the cases examined 'had Fascist leanings and were facile exponents of power politics'. The report concluded that homosexuals 'form a foreign body in the social macrocosm' and vindicated the wartime policy of offenders being 'quietly invalided out of service, with appropriate advice about medical treatments, unless they had to be brought up before a court martial'.<sup>40</sup> A further report by a medical officer reported a threat to the navy and nation from the 'dry rot' of 'homosexualists' bent on 'racial suicide'.<sup>41</sup>

Joanna Bourke argues that psychiatrists never tired of implying that men who collapsed under the strain of war were 'feminine' or 'latent homosexuals'. She proposes that a respected psychiatrist, Philip S. Wagner, used reproachful comments such as, 'socially and emotionally immature soldiers' who 'shrunk from combat with almost feminine

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<sup>37</sup> Crisp, *The Naked Civil Servant*, p. 156.

<sup>38</sup> Crisp, *The Naked Civil Servant*, p. 156.

<sup>39</sup> See, e.g. Allen Coppen, 'Body-Build of Male Homosexuals' *British Medical Journal* 26 (1939), pp. 1443-1445.

<sup>40</sup> Charles Anderson, 'On Certain Conscious and Unconscious Homosexual Responses to Warfare', *British Journal of Medical Psychology* 2 (1945), pp. 157-162; Costello, *Love, Sex & Wars*, p. 162.

<sup>41</sup> Costello, *Love, Sex & War*, p. 167.

despair and indignation' to describe homosexual soldiers in the military.<sup>42</sup> Worried that such 'socially and emotionally stunted' individuals were being rewarded by being excused from combat, he recommended that they be immediately forced back to the battlefields and threatened with disciplinary actions should their symptoms reappear.<sup>43</sup> These reports highlight that the homosexual was considered a case for psychological interpretation. Cook posits that in some cases, such interpretations were used to underscore familiar stereotypes of homosexual treachery and to draw an implicit analogy between a passive position in the forces and homosexual sex.<sup>44</sup>

#### *Nazi treatment of homosexuality*

While there is some evidence of the pathologizing of homosexuality by the allies during the war, across Europe, it was on the Nazi side that homosexuals were to become subject to unprecedented persecution, torture and medicalisation in the 1930s and 1940s. While it could be argued that the majority of nurses practicing in the UK during the 1950s and 1960s would not have known about the treatment of homosexuals in Germany during Nazi rule, because the testimonies of homosexual men who lived through this period were not in the wider public domain until the late 1970s following the gay liberation movement,<sup>45</sup> an exploration of this period is pertinent because it has implications for the present study, and will be used for comparison purposes in Chapters IV and V.

The opening salvo in the Nazi campaign to rid Germany of its homosexuals took place in 1933, with the rise of the Nazi Party in Germany. The initial target was Hirschfeld's

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<sup>42</sup> Joanna Bourke, *Disciplining The Emotions: Fear, Psychiatry and the Second World War*, in Roger Cooter, Mark Harrison & Steve Sturdy (eds.), *War, Medicine & Modernity* (Stroud, 1998), p. 231.

<sup>43</sup> Philip S. Wagner, 'Psychiatric Activities During the Normandy Offensive', *Psychiatry* 9 (1946), pp. 348-356.

<sup>44</sup> Cook, *A Gay History of Britain*, p. 149.

<sup>45</sup> Once the concentration camps had been liberated, homosexual men were transferred to prison because homosexuality was still illegal. See, e.g. Heinz Heger, *The Men with the Pink Triangle* (Boston, 1980).

Institute of Sexual Research, condemned by the Nazis as ‘the international centre of the white-slave trade’ and ‘an unparalleled breeding ground of dirt and filth’.<sup>46</sup> A band of around one hundred young fanatics descended upon the institute, smashing everything they could lay their hands on. Then in 1935, Nazi lawyer Hans Frank warned that the ‘epidemic of homosexuality’ was threatening the new Reich.<sup>47</sup> This sparked the rewording of the original Paragraph 175 (1871), which was a provision of the German Criminal Code, which made homosexual acts between males a crime.

On June 28, 1935, Paragraph 175 was revised to extend the concept of ‘criminally indecent activities between men’.<sup>48</sup> It permitted the authorities to arrest any male on the most trivial charges, such as furtive glances at other men. The specialists in the Ministry of Justice were not content until anything that could remotely be perceived as sex between males was labelled a transgression.<sup>49</sup> As with British law, lesbians were not regarded as a threat to Nazi racial policies and were not generally targeted for persecution. This vicious campaign against Germany’s homosexuals was led by the head of the Schutzstaffel (SS, defence detachment), Reichsführer (leader) Heinrich Himmler.<sup>50</sup>

Himmler’s obsession with eugenics led him to name homosexuals ‘contragenics’.<sup>51</sup> He saw them as unlikely to produce children and increase the German birth rate and because of this, he believed they deserved to be systematically exterminated before they spread the ‘poison of racial suicide’.<sup>52</sup> He was particularly eager to ensure that such behaviour was not practiced in his military ranks. Himmler announced in 1940:

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<sup>46</sup> Richard Plant, *The Pink Triangle* (New York, 1986), p. 51.

<sup>47</sup> Hans Geissler, Homosexuellen-Gesetzgebung. In Plant, *The Pink Triangle*, p. 26.

<sup>48</sup> Gad Beck, *An Underground Life: Memoirs of a Gay Jew in Nazi Berlin* (Wisconsin, 1999), p. 21.

<sup>49</sup> Heger, *The Men with the Pink Triangle*, p. 56.

<sup>50</sup> Plant, *The Pink Triangle*, p. 72.

<sup>51</sup> Beck, *An Underground Life*, p. 89.

<sup>52</sup> Heger, *The Men with the Pink Triangle*, p. 57.

When a man in the Security Service, in the SS, or in the government has homosexual tendencies, then he abandons the normal order of things for the perverted world of the homosexual. Such a man drags ten others after him, otherwise he can't survive. We can't permit such a danger to the country: the homosexual must be entirely eliminated.<sup>53</sup>

After toying with the idea of drowning homosexuals in swamps, Himmler persuaded Hitler to issue a secret directive in 1941 warning that:

Any member of the SS or Gestapo who engages in indecent behaviour with another man or permits himself to be abused by him for indecent purposes will, regardless of age, be condemned to death and executed. In less grave cases, a term of not less than six years' penal servitude or imprisonment may be imposed.<sup>54</sup>

The period between 1937 and 1939 saw the peak of the Nazi persecution of homosexual men, and it is estimated that between 5,000 and 15,000 were interned in concentration camps.<sup>55</sup> These prisoners were marked with a pink triangle to signify their homosexuality. Moreover, according to many survivor accounts, homosexuals were among the most abused in the camps.<sup>56</sup> The Nazis believed that homosexuality was a sickness that could be cured. Therefore, they designed policies to 'cure' homosexuals of their 'disease' through humiliation and hard work.<sup>57</sup> Guards often derided and beat homosexual internees upon arrival, often separating them from other inmates; they were also subjected to medical experiments to cure them of their "disease".<sup>58</sup> Moreover, evidence suggests nurses played a role in assisting with the medical experiments

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<sup>53</sup> Costello, *Love, Sex & War*, p. 161.

<sup>54</sup> Costello, *Love, Sex & War*, p. 161.

<sup>55</sup> Plant, *The Pink Triangle*, p. 21.

<sup>56</sup> See, e.g. Pierre Seel, *I, Pierre Seel, Deported Homosexual* (New York, 1994); Heger, *The Men with the Pink Triangle*; Plant, *The Pink Triangle*.

<sup>57</sup> Plant, *The Pink Triangle*, p. 14.

<sup>58</sup> See, e.g. Seel, *Deported Homosexual*; Heger, *The Men with the Pink Triangle*; Plant, *The Pink Triangle*.

undertaken within concentration camps in Nazi Germany and other occupied countries.<sup>59</sup>

### *Reflections on World War II*

The influx of foreign troops and a “live for the moment” attitude expressed by many exposed the British to different and more liberal sexual attitudes during the war; and the majority of homosexual men were just as enthusiastic to fight as their compatriots. Gay men were, however, fighting for a country that didn’t recognise their right to be who they were without fear. Moreover, pathological, psychological and psychoanalytical interpretations and analysis of homosexuality can be seen to be appearing during World War II. This was mainly driven by Army psychiatrists. Nevertheless, Paul Jones argues that gay men in the UK had what could be called a ‘good’ war.<sup>60</sup> World War II had chipped away some of the old taboos. Servicemen living in close proximity to each other were made aware that men who chose a sexual relationship with other men were not suffering from a deadly disease, nor were they cowards or effeminate. Indeed, Costello argues that the very act of bringing so many homosexuals together, may have contributed to the evolution of the future Gay Liberation movement.<sup>61</sup> Set against the war years, in the backlash that followed, complained Crisp, ‘the horrors of peace were many’.<sup>62</sup>

### **Rebuilding the empire, 1945 - 1951**

After the Second World War, fears surrounding homosexuality acquired a particularly powerful resonance, and narratives of sexual danger as corruption predominated in

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<sup>59</sup> See, e.g. Benedict & Georges, ‘Nurses and the Sterilization Experiments of Auschwitz’, pp. 227-288; McFarland-Icke, *Nurses in Nazi Germany*, p. 130; Biley, ‘Psychiatric nursing: Living with the Legacy’, p. 365; Steppe, ‘Nursing in Nazi Germany’, p. 745.

<sup>60</sup> Jones, *Tales from Out in the City*, p. 57; Jivani, *It’s Not Unusual*, p. 55

<sup>61</sup> Costello, *Love, Sex & War*, p. 173.

<sup>62</sup> Crisp, *The Naked Civil Servant*, p. 160.



public discourse.<sup>63</sup> For many observers, the rapid social changes unleashed by the war seemed to have rendered Britain's stability problematic. In the immediate post-war years, Harry Hopkins argues that the country had the atmosphere of one 'huge transit camp'.<sup>64</sup> Public transport was dirty, overcrowded and tardy; there were no dining cars on trains, and the queues on the platforms were very long. The squatter movement – and the speed with which it spread across the country – took the newly elected Labour Government by surprise.<sup>65</sup> Divorce rates drastically increased – so much so that the administrative offices could not cope with the demand this created.<sup>66</sup> Furthermore, women had taken over what was traditionally regarded as men's work and as a result gender divisions had become blurred.<sup>67</sup> Matt Houlbrook suggests that these social changes destabilized the critical interpretative categories – masculinity and nationhood – within which narratives of sexual difference and danger were framed. Established notions of Britishness seemed threatened from every direction. Therefore, homosexual urban culture was viewed as ever more dangerous, assuming a central symbolic position as a key threat to the establishment in the post-war politics of sexuality.<sup>68</sup>

#### *Domesticity and retrenchment of gender roles*

The government took decisive action and there was a growing emphasis on propaganda regarding the importance of domesticity and family life in its traditional form.<sup>69</sup> The National Marriage Guidance Council (1948) and the Royal Commission on Marriage and Divorce (1951) were symptomatic responses to this perceived crisis. Meanwhile

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<sup>63</sup> Houlbrook, *Queer London*, p. 236.

<sup>64</sup> For a detailed discussion of the social changes following World War II: see, e.g. Harry Hopkins, *The New Look* (London, 1963).

<sup>65</sup> Hopkins, *The New Look*, p. 57.

<sup>66</sup> Weeks, *The World We Have Won*, p. 29; Jivani, *It's Not Unusual*, p. 89

<sup>67</sup> For a detailed discussion regarding women's wartime lives, see, e.g. Summerfield, *Reconstructing Women's Wartime Lives*; Juliette Pattinson, *Behind Enemy Lines: Gender, Passing and the Special Operations Executive in the Second World War* (Manchester, 2007).

<sup>68</sup> Houlbrook, *Queer London*, p. 236; Frank Mort, *Capital Affairs: London and the Making of the Permissive Society* (New Haven, 2010), p. 178.

<sup>69</sup> Hall, *Sex, Gender and Social Change*, pp.150-166.

conventional gender roles were retrenched and strengthened.<sup>70</sup> Houlbrook argues that this led London's homosexual scene to become less 'blatant' and the flamboyant 'queans' began to disappear from the streets.<sup>71</sup>

Sue March posits that film portrayals pressed the idea of the model family and the heterosexual couple.<sup>72</sup> Pre-war films such as *Design for Living*<sup>73</sup> in 1933, which tackles a sexually ambiguous love story between two men and a woman, and *Look up and Laugh*<sup>74</sup> starring Gracie Fields in 1935 were replaced with post-war films such as *Brief Encounter* in 1945. Within this film, Celia Johnson played a middle-class housewife who falls in love with another man she meets by chance at a railway station. Overcome by guilt over a few clandestine meetings involving what may have been considered heavy "petting"<sup>75</sup> at the time, she decides that the best course of action is to return to her stable but unexciting husband.

The language within this film also tacitly retrenched gender roles and pressed the idea of the model wife and husband. When the two lead characters' were proudly describing their spouses the male lead described his wife as 'rather delicate' while the female lead proudly described her husband as 'unemotional and not delicate at all', therefore reinforcing the notion that the ideal husband should be masculine and impassive, which I would argue made the concept of effeminacy and transvestism more broadly somewhat threatening. This may not have been a cultural shift effecting the entire

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<sup>70</sup> Hall, *Sex, Gender and Social Change*, pp.150-166.

<sup>71</sup> Houlbrook, *Queer London*, p. 236

<sup>72</sup> Sue March, *Gay Liberation* (New York, 1974); Jivani, *It's Not Unusual*, p. 91; Higgins, *Heterosexual Dictatorship*, p. 107.

<sup>73</sup> *Design for Living* was originally a play by Noel Coward and was first shown in 1932.

<sup>74</sup> Throughout *Look up and Laugh* there are clearly two gay male characters, played for laughs, but in a major musical sequence there is one unusual aspect. The number is 'Love is Everywhere' and Gracie is saying goodnight to diverse characters, each in love in a different way - the miser with his money, the young couple, a spinster lady dreaming of love. She then approaches the gay couple, who are seen in silhouette behind a blind, as she approaches the two men she pauses and gives a warm smile as if in acknowledgement of their relationship.

<sup>75</sup> Petting among unmarried individuals was strongly deplored in the later 1940s and 1950s and caused great concern for the Family Planning Association, as it was believed to be a slippery slope to illegitimate children or hasty marriages: Hall, *Sex, Gender and Social Change in Britain Since 1880*, pp.156-157.

population, but it indicates that there may have been a change in mainstream attitudes. Indeed, many simply yielded to this prevailing attitude. Albert Holliday recalls how the pressure of this propaganda largely influenced his decision to get married:

It seemed that every film I watched and book I read made marriage look like such an attractive option. Maybe I was brainwashed [...] I didn't want to be lonely and there were a lot of questions from my family regarding me getting married [...] I had met a girl at art school. She was hugely talented and I admired her creativity. I knew she loved me very much, so marriage seemed like the next step – it was the fashion, then.<sup>76</sup>

In 1945, the Archbishop of Canterbury gave a sermon in which he called upon Britons to reject 'wartime morality' and return to living 'Christian lives'.<sup>77</sup> In the House of Lords, Earl Winterton observed that 'few things lower the moral fibre and injure the physique of the nation more than tolerated and widespread homosexuality'.<sup>78</sup> The message was clear: homosexual men were seen to undermine post-war social reconstruction, not least by turning their backs on family life.<sup>79</sup>

### *The Kinsey Report*

The central symbolic position of homosexuality within politics was to be further exacerbated with the publication of Alfred Kinsey's study – *Sexual Behaviour in the Human Male* – in 1948.<sup>80</sup> His data upturned all conventional notions of how the sexual universe was configured by reporting that thirty-seven percent of American men had engaged in at least one homosexual experience to the point of orgasm since adolescence and that four percent of males were exclusively homosexual all their lives. While there has been

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<sup>76</sup> Albert Holliday, interviewed 27<sup>th</sup> January 2010.

<sup>77</sup> Jivani, *It's Not Unusual*, p. 89.

<sup>78</sup> Earl Winterton in Montgomery Hyde, *The Other Love: An Historical and Contemporary Survey of Homosexuality in Britain* (London, 1970), p. 226-227.

<sup>79</sup> Cook, *A Gay History of Britain*, p. 167.

<sup>80</sup> Alfred Kinsey, Warren Pomeroy & Clyde Martin, *Sexual Behaviour in the Human Male* (Philadelphia, 1948).

criticism of the reliability of the report,<sup>81</sup> Kinsey's data were difficult to refute. The study was based upon data obtained from 5,300 Americans carefully selected and balanced to attempt to give a representative picture of American male sexual behaviour. Parts of the data were based on as many as 12,000 cases. Indeed, Kinsey wrote:

In brief, homosexuality is not the rare phenomenon which it is ordinarily considered to be, but a type of behaviour which ultimately may involve as much as half the male population.<sup>82</sup>

It was this aspect of the report that was considered most alarming. Until then it was the generally accepted notion that homosexual men were a tiny minority. The idea that gay men were everywhere was extremely disturbing. Even more disturbing was Kinsey's development of the spectrum theory of sexuality, which ranged people in seven categories from zero to six according to where they stood on the continuum from exclusive heterosexuality to exclusive homosexuality. In reality, he argued, individuals not only occupied each of the seven categories but every gradation in between. In essence, this raised an even more perturbing idea: homosexuals were not a distinct group – everyone was a little homosexual.

While the research was conducted in the US, it did impact on the UK. In Doncaster, the local magistrates were so incensed by the publication of Kinsey's work that they decided to ban it on grounds of obscenity. However, the Doncaster bench were later persuaded by higher authorities not to go ahead with their decision when it became clear that it would be impossible to justify.<sup>83</sup>

In 1948, the Mass Observation Survey entitled "Little Kinsey" reported 'the isolationist manner in which homosexual groups appear to function'. A draft appendix described a

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<sup>81</sup> See, e.g. Aggleton, *Deviance*; Walter Alvarez, *Homosexuality* (New York, 1974).

<sup>82</sup> Kinsey, Pomeroy & Martin, *Sexual Behaviour in the Human Male*, p. 23.

<sup>83</sup> Jones, *Out in the City*, p. 68; Jivani, *It's Not Unusual*, p. 96.

‘homosexual group’ on a trip to Brighton. The men had a ‘distinctive outlook’ and ‘were not at all keen on the company of non-homosexuals except neuters, borderline cases and possible coverts’.<sup>84</sup> It was also found that sixty percent of those sampled were antipathetic to homosexuality (it was ‘absolutely detestable’, said one respondent; ‘I shouldn’t think they’re human’, said another). Bob Cant argues that the distain of the public was more or less absolute; for the remainder, the burgeoning debate, analysis and press coverage of the 1950s would soon educate them about this type of person.<sup>85</sup>

### **Reaction, 1952 – 1955**

There was a brief explosive period of reaction to Kinsey’s data during the early 1950s which was expressed in three ways: via regulation by the police; by the publication of legal and sociological perspectives regarding sexual deviations; and through news media discourses.

#### *Regulation*

There was a sense that something had to be done about the “problem” of homosexuality and on 25<sup>th</sup> October 1952, the new head of the metropolitan police was appointed (Sir John Nott-Bower). The Home Secretary (Sir David Maxwell Fyfe) was noted to remark ‘homosexuals make a nuisance of themselves’<sup>86</sup> and later went on to tell the House of Commons:

Homosexuals...are exhibitionists and proselytizers and a danger to others...so long as I hold the office of Home Secretary, I shall give no countenance to the view that they should not be prevented from being such a danger.<sup>87</sup>

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<sup>84</sup> Liz Stanley, *Sex Surveyed 1949-1994: From Mass Observations: “Little Kinsey” to the National Surveys and Hite Report* (London, 1995), pp. 199-203.

<sup>85</sup> Cant, *Footsteps and Witnesses*, p. 167.

<sup>86</sup> Jivani, *It’s Not Unusual*, p. 99.

<sup>87</sup> NA, CAB/195/11, minutes of a meeting with Home Secretary and Prime Minister discussing issues around prostitution and homosexuality.

Nott-Bower was left in no doubt as to what his duties were and he made it clear that he was going to fulfil them with a ‘ferocious zeal’.<sup>88</sup> On October 25, 1953, *The Sydney Morning Telegraph* published a cable from its London correspondent, Mr Donald Horne, about a “Scotland Yard plan to smash homosexuality in London”.<sup>89</sup> Higgins argues, however, that there was never any dedicated ‘witch-hunt’ against homosexuals.<sup>90</sup> Nevertheless, Jivani has posited that the authorities during this time were more fervent in their persecution of gay men; arrests for homosexual offences did go up.<sup>91</sup> Indeed, Court cases involving sodomy, gross indecency and indecent assault had risen – from 719 in 1938 in England and Wales to 2,504 in 1955.<sup>92</sup>

As with William Newman, discussed in the introduction, the police made arrests by means of developing an intimate and dynamic relationship with their suspects becoming *agents provocateurs*. In urinals and on the streets, such tactics were ubiquitous, leaving many gay men and transvestites feeling extremely fearful and cautious in the first half of the 1950s.<sup>93</sup> Houlbrook argues that many men transgressed bourgeois conceptions of public and private through their dependence on public places, thus placing the homosexual within derogatory categories of sexual immorality. He goes on to suggest:

Such representations centred around the apparent correlation between homosexual sex and the urinal – the most dismal and marginal of all public spaces, associated with intolerable bodily functions. The discursive production of person and place was a mutually constitutive process, in which notions of the homosexuals’ character were derived from the nature of that site at which he was most often arrested.<sup>94</sup>

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<sup>88</sup> Jivani, *It’s Not Unusual*, p. 99.

<sup>89</sup> “Scotland Yard to Smash Homosexuality”, *The Sydney Morning Telegraph*, 25<sup>th</sup> June, 1953.

<sup>90</sup> Higgins, *Heterosexual Dictatorship*, p. 67; see, also Houlbrook, *Queer London*, p. 37

<sup>91</sup> Jivani, *It’s Not Unusual*, p. 100.

<sup>92</sup> Statistics for Sodomy also include bestiality cases: Jeffery Weeks, *Coming Out*, p. 158.

<sup>93</sup> Weeks, *The World We Have Won*, p. 55; Jivani, *It’s Not Unusual*, pp. 98-99.

<sup>94</sup> Houlbrook, *Queer London*, p. 63.

Embedding the homosexual in the dirt and marginality of the urinal, the magistrate Harold Sturge defined homosexual sex as ‘morally wrong, physically dirty and progressively degrading’.<sup>95</sup> Butcher took this to the extreme:

Urinals have a certain odour...a staleness [which]...excites [homosexual men]...When a urinal has been cleaned out with Dettol and scrubbed clean and smells clean they will not go anywhere near it...once the smell of cleanliness has worn off you can see these people...working themselves up to a frenzy...they are on heat...it is like the bitch, once they have the scent there is no holding them, they are oblivious to anything else.<sup>96</sup>

Houlbrook argues that Butcher neatly linked the dismal urinal to the supposed anonymity of the encounters that took place there, defining the homosexual as incapable of love and driven by inexorable, menacing lust.<sup>97</sup> Moreover, it could be proposed that the indecent assault and importuning charges generated by *agents provocateurs* only served to reinforce this construction. In Anomaly’s terms, the homosexual was ‘an abnormally lustful person of more or less insatiable and uncontrollable impulses...[a] moral leper, corrupt, obscene and monstrous’.<sup>98</sup>

Greta Gold who received aversion therapy in the 1960s for transvestism, recalls the climate at the time as ‘very scary’.<sup>99</sup> Oscar Mangle remembers being ‘[...] convinced I was going to be arrested’ and ‘[...] burning all my letters to Louis [his lover] - I didn’t want anything that could incriminate me’.<sup>100</sup> Moreover, this demonstrates how the subjective experience is paramount. Whether there was an orchestrated campaign to target these individuals or not, it “felt” like a witch-hunt to these individuals. Many of the participants reflected on the negative impact that unsupportive attitudes from the

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<sup>95</sup> NA, HO 345 7: CHP II: memorandum submitted by Harold Sturge, metropolitan magistrate, Old Street.

<sup>96</sup> NA, HO 345 12: CHP TRANS 8, Q633, 3.

<sup>97</sup> Houlbrook, *Queer London*, p. 63.

<sup>98</sup> Mark Anomaly, *The Invert and His Social Adjustment* (London, 1948), p. 7-8.

<sup>99</sup> Greta Gold, interviewed 24<sup>th</sup> March 2010.

<sup>100</sup> Oscar Mangle, interviewed 21<sup>st</sup> June 2010.

police had on them, and for Molly Millbury this provided the catalyst for her receiving treatment:

I started dressing [wearing women's clothes] at 16. What I used to do was go for a walk in the early hours of the morning, dressed in a skirt and coat. Probably not a good idea for a young person to be out at that time in the morning, which was why the police stopped me. My instant reaction was to run away and to try to hide and avoid the police. The police caught me and took me to the police station. It was a blues and twos event. Lots of people came in and saw me – it was like I was in a “freak show”. I got quite a rough ride off the police. They seemed to think I was connected with rapes and sexual assaults, and all sorts, and I was quizzed and questioned about that for about three or four hours. [...] My family came to collect me and marched me to my GP the next day and I was referred to a psychiatrist.<sup>101</sup>

Anxieties were further exacerbated by the antipathy towards homosexuality by the then Director of Public Prosecutions (Sir Theobald Mathew).<sup>102</sup> In murder assault cases, defence councils frequently highlighted the provocation and insult of a homosexual approach. A twenty-two-year-old Norwich sailor was acquitted after the Judge told the jury they should be in no doubt that the forty-four-year-old murdered man was a ‘pervert’.<sup>103</sup> Cook argues that roles were recast in courtrooms: the victim had got his just deserts, highlighting the dangers that could go with gay sex. Gay men were vulnerable to blackmail, theft and violence and, yet were unlikely to get much sympathy.<sup>104</sup>

### *News media*

Newspapers became less taciturn and euphemistic in the 1950s. This may have been in response to competition from television. Waters argues that the decade after the war

<sup>101</sup> Molly Millbury, interviewed 31<sup>st</sup> December 2010.

<sup>102</sup> Chris Waters, *Disorders of the Mind, Disorders of the Body Social: Peter Wildeblood and the Making of the Modern Homosexual*. In Becky Conekin, Frank Mort & Chris Waters (eds.) *Moments of Modernity Reconstructing Britain 1945-1964* (London, 1999), p. 135.

<sup>103</sup> “Sailor Cleared of Manslaughter.” *News of the World*, 26<sup>th</sup> October, 1947.

<sup>104</sup> Cook, *A Gay History of Britain*, p. 169.



witnessed the emergence of what might best be termed a tabloid discourse of homosexuality.<sup>105</sup> During this period, the general public were exposed to more sensational depictions of the predatory homosexual, his sinister networks of vice, and also the idea of an intrepid police force and judiciary doing their best to combat the threat. Through such reports, medical aetiologies of sexual difference that distinguished between men on the basis of whom they had sex with permeated everyday life.<sup>106</sup> Homosexuals were highlighted by the *Sunday Pictorial* in 1951 when it exposed “The Squalid Truth” that British spies Guy Burgess and Donald Maclean defected to the Union of Soviet Socialist Republics (USSR) having betrayed American secrets, were ‘sex perverts’ and asserted that ‘homosexuals – men who indulge in unnatural love for another – are known to be bad security risks. They are easily won over as traitors’.<sup>107</sup>

Cook argues that the *Sunday Pictorial* tellingly defined the homosexual for a readership it assumed might be uncertain of the term, and returned to the enduring notion of homosexual treachery.<sup>108</sup> In 1952, the same paper warned parents of the dangers of “Evil [homosexual] Men” who ‘infest London and the social centres about many provincial cities’.<sup>109</sup> Moreover, many of the participants in this study reflected on the negative impact the media had on their lives and in some cases it provided the catalyst for them to seek medical treatment. Delroy Heath received aversion therapy in the 1960s, and his testimony below suggests that the media not only portrayed homosexuals as individuals the public should be fearful of; but also that homosexuality was an illness that could be cured:

[...] all I had to do was open the daily paper and it was rubbed in my face how evil and perverse I was. It made me feel like ending

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<sup>105</sup> Waters, ‘Disorders of the Mind, Disorders of the Body Social’, p. 135.

<sup>106</sup> Houlbrook, *Queer London*, p. 192.

<sup>107</sup> “The Squalid Truth”, *The Sunday Pictorial*, 25<sup>th</sup> September, 1955.

<sup>108</sup> Cook, *A Gay History of Britain*, p. 168.

<sup>109</sup> “Evil Men”, *The Sunday Pictorial*, 25<sup>th</sup> May, 1952.

it all. I knew I had to do something; it was either kill myself or cure myself.<sup>110</sup>

In addition during this period there was the very public arrest, trial and conviction of three influential individuals in 1954 - Lord Montagu, a peer of the realm, Peter Wildeblood, the diplomatic correspondent of the *Daily Mail*, and Michael Pitt-Rivers, a wealthy landowner and cousin of Montagu's. The trio were convicted of conspiring to incite two RAF men – Edward McNally and John Reynolds – to 'commit unnatural offences'. The press reports made much of the case and of the precedent that had been set – this was the first time that a peer of the realm had been convicted in a criminal court since the right of peers to be tried by their fellow peers, in the House of Lords, was abolished in 1948. The case made legal history, but it was also a milestone in the history of Britain's attitude towards gay men.

The public curiosity towards the trial had been fed by the popular press who, argues Jivani, were 'agog'.<sup>111</sup> However, not all the general public had an unsympathetic interest towards the case: indeed, on the 24<sup>th</sup> March 1954, the *Daily Sketch* mentioned in its report that, as the sentences were delivered to the suspects, an elderly woman in the public gallery gasped 'poor boys!'<sup>112</sup> Indeed, Wildeblood recalls the derision of some but also the support of others during his trial especially as he left the court after sentencing:

It was some moments before I realised that they [the crowd outside the court] were not shouting insults, but words of encouragement. They tried to pat us on the back and told us to "keep smiling", and when the doors were shut they went on talking through the windows and gave the thumbs-up sign and clapped their hands.<sup>113</sup>

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<sup>110</sup> Delroy Heath, interviewed 28<sup>th</sup> April 2010.

<sup>111</sup> Jivani, *It's Not Unusual*, p. 110.

<sup>112</sup> "Final Day of the Montagu Trial", *Daily Sketch*, 24<sup>th</sup> March, 1954.

<sup>113</sup> Wildeblood, *Against the Law*, pp. 94-95.

Jeffrey Weeks argues that not only did this trial mark the nadir of the persecution of gay men in the country: in retrospect it was hugely influential in persuading the liberal intelligentsia that something must be done regarding the “problem” of homosexuality.<sup>114</sup>

#### *Legal and sociological perspectives*

A number of sociological studies were published during the 1950s which provided convincing accounts of the homosexual. However, these perspectives were in somewhat of a conflict regarding the debate on how best to deal with the “problem” of homosexuality. Tudor Rees and Harley Usill’s *They Stand Apart: A Critical Survey of the Problem of Homosexuality* (1955) drew upon “expert” opinion from legal and medical perspectives ‘to examine the problem and to focus public attention to its gravity’.<sup>115</sup> Tudor Rees was a Judge and came from a legal perspective. He argued that the problem should be dealt with by the law and the current law regarding homosexuality should remain. He went on to suggest that:

Such a change in the law begs the whole moral issue, one which must be thought out carefully or there would be danger that it may have the effect of giving a legal *carte blanche* to all types of offenders.<sup>116</sup>

Conversely Lindsay Neustatter, a consultant psychiatrist, wrote a more empathic chapter within the study entitled: “Homosexuality: The Medical Perspective”.

Those who lay down the law in regard to sex seem to take it for granted that we know, in fact, what is normal and healthy, whereas we only know what is customary. [...] We plead, therefore, for more research, and for the recognition of the fact

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<sup>114</sup> Weeks, *Coming Out*, p. 164; Jivani, *It's Not Unusual*, p. 111.

<sup>115</sup> Tudor Rees and Harley Usill, *They Stand Apart: A Critical Survey of the Problem of Homosexuality* (London, 1955).

<sup>116</sup> Rees and Usill, *They Stand Apart*, p. viii.

that the invert is not a villain to be punished, but a patient to be studied – to our own ultimate advantage.<sup>117</sup>

Michael Schofield produced a fairly sympathetic work – *Society and the Homosexual* (1952) (published under the pseudonym Gordon Westwood). Schofield's main aim was to bring the subject of homosexuality out into the open for public discourse. 'The secrecy and shame that surrounds the subject at present gives it the aura of forbidden fruit which is unwise and unhealthy'.<sup>118</sup> Underpinning this argument was his belief that treatment should replace punishment:

The fate of the homosexual offender now depends upon the wisdom and discretion of the magistrate. Some of them have an intelligent understanding of the nature of the disease; others are not swayed by medical opinion even when it is available and their own interpretation of the law is their only guide.<sup>119</sup>

Despite their differing viewpoints regarding homosexuality, what both these works did was bring some of the debates regarding the subject out into the wider public's consciousness. Elizabeth Granger, a nurse who undertook a degree-level nurse education, recalls reading both the books as a nursing student and the somewhat mixed message she was left with after reading them:

I remember reading two books about homosexuality when I was at university. As I recall they were background reading to some sociology lectures. One was called "Society and the Homosexual" by, erm...Gordon Westwood, I think. The other was "They Stand Apart" – I can't remember the author of that, though. What I do remember, however, was that the Westwood book was a lot more supportive of homosexuals. It talked about treatments and these people being mentally ill. It had particular resonance for me as I wanted to be a psychiatric nurse, and I thought one day I may nurse a homosexual patient. However,

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<sup>117</sup> Lindsay Neustatter, 'Homosexuality: The Medical Perspective', in Tudor Rees and Harley Usill (eds.), *They Stand Apart: A Critical Survey of the Problem of Homosexuality* (London, 1955).

<sup>118</sup> Gordon Westwood, *Society and the Homosexual* (New York, 1952), p. 178.

<sup>119</sup> Westwood, *Society and the Homosexual*, p. 168.

the other book I felt had more of an antipathetic view of homosexuals, as I remember the author was arguing that prison was the best place for these people. I was left slightly confused about my position on the issue.<sup>120</sup>

Interestingly the Church of England was broadly sympathetic during this period, and focused on the misery and anxiety experienced by many gay people in their investigation into “the problem of homosexuality”. The resulting report in 1954 advocated the legalisation of sex between consenting men and an equal age of consent, arguing that as it stood the law led to blackmail and suicide.<sup>121</sup> This notion was also pressed in new literary works, such as Rodney Garland’s *The Heart in Exile* (1952) and Mary Renault’s *The Charioteer* (1953). Both of these novels attempted to portray a respectable and discreet homosexual who should be tolerated and granted legal recognition. Moreover, each focussed on the way in which the law regarding homosexuality had led to misery, isolation and even suicide. Unna Drinkwater was a staff nurse during this period and recalled reading *The Heart in Exile*: ‘Not only was it a well written book, but it gave me an understanding of the challenges homosexual men faced. I had never realised how difficult it must have been for them’.<sup>122</sup> The empathy Unna gained towards homosexuals after reading this book could have influenced her clinical practice when she nursed a patient receiving treatment for homosexuality. Unna’s testimony will be explored in Chapter V when we are introduced to the “subversive nurses” in this study. Moreover, Houlbrook and Waters argue that *The Heart in Exile* should be ‘read as an explicitly political intervention on behalf of the middle-class homosexual’.<sup>123</sup> More broadly, along with the film *Victim* (1961), a tragic tale of blackmail and suicide, all the above tacitly pressed the case for reform.

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<sup>120</sup> Elizabeth Granger, interviewed 3<sup>rd</sup> May 2010.

<sup>121</sup> “The Problem of Homosexuality: report by clergy and doctors”. *The Times*, 26<sup>th</sup> February, 1954.

<sup>122</sup> Unna Drinkwater, interviewed 29<sup>th</sup> December 2009.

<sup>123</sup> Matt Houlbrook & Chris Waters, ‘The Heart in Exile: detachment and desire in 1950s London’, *History Workshop Journal* 62 (2006), p. 145.

There had never been so much public discussion, coverage and analysis – both critical and supportive. Roger Davidson argues that public opinion was not slavishly following the line about “evil men” pedalled by the *Sunday Pictorial* and other papers.<sup>124</sup> Indeed, many of the participants recalled receiving mixed messages during this period. Pat Mullins was a State Enrolled Nurse (SEN) and recalls the perplexity she felt regarding her position on homosexuality and transvestism: ‘I was terribly confused about the whole issue. The papers were saying this, the doctors and “experts” were saying that. I didn’t know who to believe!’<sup>125</sup> It was in this context that the *Sunday Times* called for an enquiry:

The law [...] is not in accord with a large mass of public opinion [...] The case for a reform of the law as to acts committed in private between two adults is very strong [...] the case for an authoritative inquiry into it is overwhelming.<sup>126</sup>

### **The Wolfenden Committee, 1954**

A proposal for a Royal Commission enquiry into homosexuality and prostitution had already been made to the Cabinet by Home Secretary Sir David Maxwell Fyfe.

However, Prime Minister Winston Churchill was noted to remark:

The Tory Party won’t want to accept responsibility for making the law on homosexuality more lenient – or for *maisons tolerees*.

But without enquiry -

i) could we not limit publicity for homosexuality, as was done for divorce?

ii) persons convicted should have opportunity to apply for medical treatment.

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<sup>124</sup> Davidson, *And Thus Will I Freely Sing*, p. 111; Cook, *A Gay History of Britain*, p. 173; Higgins, *Heterosexual Dictatorship*, p. 87; Cook, *A Gay History of Britain*, p. 173.

<sup>125</sup> Pat Mullins, interviewed 14<sup>th</sup> July 2010.

<sup>126</sup> *Sunday Times*, 28<sup>th</sup> March, 1954.

Otherwise, I wouldn't touch the subject. Let it get worse – in a hope of a more united public pressure for some amendment.<sup>127</sup>

An interpretation of Churchill's opposition to the Commission has been suggested to be that any legal reform arising from this may have lost Tory votes.<sup>128</sup> As a compromise, Fyffe agreed to downgrade the level of investigation from Royal Commission to Departmental Committee.<sup>129</sup> Therefore, in response to the escalating anxieties about vice and public immorality in London, the Departmental Committee on Homosexual Offences and Prostitution, chaired by John Wolfenden, was set up on 4<sup>th</sup> August 1954 to appraise the law affecting homosexuality from the point of view of making it less draconian.<sup>130</sup>

Davidson argues that some of the fullest and most compelling evidence to the Wolfenden Committee in favour of homosexual law reform came from medical witnesses.<sup>131</sup> Drs Inch and Boyd from the Scottish Prisons and Borstal Services aired grave doubts as to the value of imprisonment in reforming sexual offenders and favoured the decriminalisation of homosexual behaviour for consenting adults over 21. They advocated that courts should have routine psychiatric reports on all homosexual offenders prior to sentencing, supplied by a properly-staffed University or Regional Hospital Board Clinic, and for the homosexual recidivist or 'homosexual psychopath' there should be a separate psychopathic institute. Finally, treatment regimes had to be

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<sup>127</sup> NA, CAB/195/11, minutes of meeting with Home Secretary and Prime Minister discussing issues around prostitution and homosexuality.

<sup>128</sup> "An Uneasy History", *Attitude Magazine*, March, 2010.

<sup>129</sup> Mort, *Capital Affairs*, p. 140.

<sup>130</sup> Mort, *Capital Affairs*, p. 139.

<sup>131</sup> Roger Davidson, 'Law, Medicine and the Treatment of Homosexual Offenders in Scotland, 1950-1980', in Ingrid Goold & Charles Kelly (eds), *Lawyers' Medicine: The Legislature, the Courts & Medical Practice, 1760 – 2000* (Oxford, 2009), p. 129.

more effectively monitored and sustained by means of improved staff resources for after-care and social work.<sup>132</sup>

Evidence submitted by Drs Winifred Rushford and W.P Kreamer also favoured the decriminalisation of homosexual behaviour between consenting adults as integral to changing social attitudes and to refocusing public discourses onto issues of aetiology rather than punishment. Underlying their evidence was a belief that a less punitive policy would in fact produce a more liberal and sympathetic attitude to homosexuality in British society.<sup>133</sup> John Glaister contributed to the British Medical Association's evidence to the Wolfenden Committee. He combined a pathological view of homosexuality with support for its limited decriminalisation. He was a vigorous supporter of coercive measures, including segregation in colonies, for 'the inveterate and degenerate sodomist, the debauchers of youth, and those who resort[ed] to violence to meet their desires'. However, he did not feel that the incidence of homosexuality threatened the nation with 'racial decadence' and considered that consenting acts of adults in private (not including sodomy) were a matter 'of private ethics' and should be dealt with outside of the law. In his opinion, even though society's disapproval was 'inevitable and desirable' and while homosexuality was definitely not something to be encouraged, imprisonment was not the answer. Glaister viewed prison as 'the last place for homosexual treatment'.<sup>134</sup>

There were, however, attacks on the argument regarding the "medicalization" of homosexuality. The most noteworthy refutation of this notion came from James Adair, a member of the Wolfenden Committee, and former Procurator-fiscal. He was scathing of the tendency of psychiatrists to sentimentalise the problem of homosexuality and to

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<sup>132</sup> NA, HO345/15, CHP/TRANS/41, PWC, evidence of W Boyd, 1<sup>st</sup> November 1955; see, also Davidson, 'Law, Medicine and the Treatment of Homosexual Offenders', pp. 129-130.

<sup>133</sup> Davidson, 'Law, Medicine and the Treatment of Homosexual Offenders', p. 130.

<sup>134</sup> British Medical Association Archives, B/107/1/2, memo. By Professor John Glaister, 30<sup>th</sup> June 1955.



downplay its paedophilic aspects and damage to physical health.<sup>135</sup> In his opinion, much of the evidence presented by ‘mental specialists’ was ‘quite inexplicable and in not a few cases manifestly indefensible’. He believed that homosexuality had become the latest disease ‘fashion’ or ‘craze’ of ‘medical men’, and highlighted the uncertainties of medical and mental science ‘and the limited knowledge and powers of the medical profession under existing circumstances to deal with homosexual patients’. Adair argued that a significant proportion of homosexuals seeking treatment were only doing so in order to evade the due process of law and were merely using medical therapy as a concealment for their prevision. Many, he posited, were already too old at 18 for treatment, with their sexuality and behaviour ‘for all practical purposes immutable’.<sup>136</sup>

The committee only heard evidence from three professed homosexuals – all educated and middle class. Waters argues that these men did little to represent the diverse homosexual community, as access to the committee was highly exclusive, embedded in the materiality of power, class and privilege.<sup>137</sup> The three men were: Carl Winter the director of the Fitzwilliam Museum in Cambridge; Patrick Trevor-Roper, a Harley Street consultant; and Peter Wildeblood, the diplomatic correspondent for the *Daily Mail*.<sup>138</sup> All deliberately approached Wolfenden to counter what Winter termed the ‘disproportionate emphasis on [homosexuality’s] more morbid aspects’ and the negative implications of the law’s salience in shaping public knowledge of sexual difference.<sup>139</sup> While many other homosexual men’s rights to speak were rejected, as they were perceived as ‘disreputable cranks’,<sup>140</sup> Winter, Trevor-Roper and Wildeblood were able to draw upon the privileges of social connection and status, thus enabling their voice to be

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<sup>135</sup> Davidson, ‘Law, Medicine and the Treatment of Homosexual Offenders’, pp. 133-134.

<sup>136</sup> NA, HO345/12 and /16, PWC, 15<sup>th</sup> October 1954, 10<sup>th</sup> April 1956; HO345/2, J Adair to WC Roberts, 4<sup>th</sup> October 1956; HO345/10, note on WC discussion meetings, 11<sup>th</sup> and 12<sup>th</sup> September 1956.

<sup>137</sup> Waters, *Disorders of the Mind, Disorders of the Body Social*, p. 149.

<sup>138</sup> Weeks, *Coming Out*, p. 166; Cook, *A Gay History of Britain*, p. 172; Houlbrook, *Queer London*, p. 255.

<sup>139</sup> NA, HO 345 14, CHP TRANS 32: two witnesses called by chairman (28<sup>th</sup> July 1955).

<sup>140</sup> Houlbrook, *Queer London*, p. 255.

heard.<sup>141</sup> Nevertheless, the committee believed that these men were adequately representative of Britain's diverse homosexual population.

The three men mapped the lifestyle of the homosexual in a way that the committee members could identify with. They positioned the homosexual within a middle-class home with a network of appropriate friendships. This ran parallel with the wider behavioural and emotional codes associated with respectability, particularly the emphasis upon self-control, restraint and discretion.<sup>142</sup> This in turn condemned the effeminate homosexual, and other public homosexual practices, particularly the use of streets and parks for sex, as dangerous and immoral. Indeed, Trevor-Roper distanced himself from the effeminate homosexual, noting how 'most homosexuals dislike male effeminacy.'<sup>143</sup> Meanwhile, Wildeblood remarked such men were 'deplored' by homosexuals.<sup>144</sup>

Houlbrook argues that by surrounding the homosexual within this 'exclusive social and subjective geography and condemning those people and practices who dared to contravene the public domain'; Wildeblood, Winter and Trevor-Roper contrived a political narrative for a particular audience.<sup>145</sup> While the Wolfenden Committee provided a space for homosexual politics, it privileged certain voices but silenced others. The legal reforms that the three men argued for were limited: they asked only that the words 'in private' be removed from the Labouchere Amendment of 1885, thereby decriminalising encounters that took place in the home. At no point did they advocate for the legislation of public practices, a reconfigured relationship between the state and homosexual commercial venues, or the right to be visibly different.<sup>146</sup> All agreed that the laws regulating *public* sexual behaviour should be retained 'targeted at the

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<sup>141</sup> Waters, *Disorders of the Mind, Disorders of the Body Social*, p. 149.

<sup>142</sup> Houlbrook, *Queer London*, p. 259.

<sup>143</sup> NA, HO 345 8, CHP 53.

<sup>144</sup> Wildeblood, *Against the Law*, p. 57; Waters, 'Disorders of the Mind', p. 145.

<sup>145</sup> Houlbrook, *Queer London*, p. 259.

<sup>146</sup> Cant, *Footsteps and Witnesses*, p. 101; Cook, *A Gay History of Britain*. p. 172.

disreputable “queer” who continued to transgress the public-private boundary.”<sup>147</sup> The conservative imperative of the law reform that followed angered some homosexual men. This will be discussed further in Chapter VI.

Nevertheless, on the 4<sup>th</sup> September 1957, the Committee published its report, in which it recommended that homosexual sex in private between consenting adults over 21 should be decriminalized; that buggery should be reclassified from a felony to a misdemeanour (reducing the potential length of sentences); and that sentences which were more than twelve months old should not be prosecuted, except in the case of indecent assault. The report also advocated further research into causes and treatment of homosexuality and suggested that oestrogen treatment be made available to all prisoners who wanted to access it.<sup>148</sup>

The press response to the Wolfenden report was mixed. Whilst the *Mail* feared legislation would ‘certainly encourage an increase in perversion’ and the *Express* wanted ‘family life’ to continue to be protected from ‘these evils’, the *Times*, *Mirror*, *Guardian* and *Telegraph* were broadly sympathetic.<sup>149</sup> The press were also keen to report on the recommendation within the report relating to treatment of homosexuality, with the *Mirror* headline reading “Planned to Help a Million”; the *Express* “One Million Need This New Clinic”; and the *Sunday Pictorial* “Sex Pills for Scots in Jail”,<sup>150</sup> thus highlighting the message that homosexuality was an illness that could nevertheless be cured.

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<sup>147</sup> Houlbrook, *Queer London*, p. 261.

<sup>148</sup> Despite this recommendation, it would take until 1967 for the government to decriminalise homosexuality in England and Wales with the passing of the Sexual Offences Act 1967. The reasons for this ten-year gap will be explored in Chapter VI, as will the implications of the conservative imperative the new Act.

<sup>149</sup> “What the Papers Say about the Report.” *Evening News*, 5<sup>th</sup> September, 1957.

<sup>150</sup> “Planned to Help a Million.” *The Mail*, 6<sup>th</sup> September, 1957; “One Million Need This New Clinic.” *The Express*, 23<sup>rd</sup> August, 1957; “Sex Pills for Scots in Jail.” *The Sunday Pictorial*, 16<sup>th</sup> February, 1958.

### The therapeutic state

Psychiatrists were also keen to promote Wolfenden's recommendations regarding medically treating homosexuals, and during the 1950s and 1960s Jones argues that the medical profession had a kind of authority enjoyed neither before nor since.<sup>151</sup> Waters has suggested that during these two decades Britain witnessed the 'therapeutic state', based on the belief that experts, with their 'modern knowledge', could assist in the eradication of any number of social maladies.<sup>152</sup> The medical profession were seen to be advocating for these stigmatised individuals. Indeed, in 1961, the *Glasgow Herald* ran an article entitled "Treatment of Homosexuals: Public Opinion Hostile". The paper reported excerpts from Dr. Chesser's article earlier that week in the British Medical Association magazine *Family Doctor*. The newspaper reported that treatment of homosexuality was being 'gravely hindered by the hostility of public opinion...All the good work of the therapist is all in vain if society remains intolerant and uncooperative'.<sup>153</sup> I would argue that the psychiatrists were keen to take on the treatment of sexual deviants for a number of reasons, which I will explore in Chapter III.

### Freudian discourses

After World War II, Freudian arguments, which began in the 1920s, came to play a pertinent role in much of the public discussion of homosexuality in Britain. Waters has attributed this status to the work of a generation of interwar criminologists who had used Freud to further their own goals of reclaiming the delinquent.<sup>154</sup> Waters posits that Freudian dialogue could be found in *Against the Law* (1955), Wildeblood's book regarding his experiences and reflections of his trial and time in prison. He pondered

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<sup>151</sup> Jones, *Out in the City*, p. 127; Jivani, *It's Not Unusual*, p. 123.

<sup>152</sup> Waters, 'Disorders of the Mind', p. 151.

<sup>153</sup> "Treatment of Homosexuals: Public Opinion Hostile." *Glasgow Herald*, 28<sup>th</sup> September, 1961.

<sup>154</sup> Waters, 'Havelock Ellis, Sigmund Freud and the State', pp. 173-174.

whether his parents might have contributed to his ‘condition’; he referred to friendships between boys that had an ‘unconsciously homosexual basis’; he discussed adolescents who experienced a homosexual ‘stage’ before making ‘the natural transition into normality’; and he claimed that homosexuality resulted from ‘arrested development’.<sup>155</sup>

Westwood’s *Society and the Homosexual* (1952) discussed above and D.J. West’s *Homosexuality* (1955), were both indebted to a model of psychosexual development that originated with Freud. West’s study was prefaced by Dr. Hermann Mannheim, a psychoanalytically orientated criminologist, and also included contributions by Dr. Edward Glover, who had established the Institute for the Scientific Treatment of Delinquency in 1932, which was a Freudian-inspired treatment centre.<sup>156</sup> However, Waters argues that many homosexual men were suspicious of Freud and preferred to conceive of themselves through the experience and language of others, as documented and made available in print like Ellis, discussed in the Introduction.<sup>157</sup>

Nevertheless, by the 1950s, popular reportage was suspicious of the claims of Freudian psychoanalysis. The outcomes of treatment for sexual deviations by various psychoanalytical techniques were rather poor, despite the optimism expressed by some, especially Allen.<sup>158</sup> Indeed, David Curran and Daniel Parr found the rate of improvement to be no greater in twenty-five of their cases treated by psychoanalysis than in twenty-five others who received little or no treatment.<sup>159</sup> In 1958, Mary Woodward reported a series of homosexual patients referred by the courts and treated with psychoanalysis at the London Institute for the Study and Treatment of

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<sup>155</sup> Wildeblood, *Against the Law*, pp. 19-21; Waters, ‘Havelock Ellis, Sigmund Freud and the State’, pp. 173-174.

<sup>156</sup> Westwood, *Homosexuality* (London, 1955).

<sup>157</sup> Waters, ‘Havelock Ellis, Sigmund Freud and the State’, p. 174.

<sup>158</sup> Callen Allan, ‘The treatment of homosexuality’, *Medical Press* 235 (1956), p. 141; Alan Ellis, ‘The Effectiveness of Psychotherapy with Individuals who have Severe Homosexual Problems’, *Journal of Consulting Psychology* 20 (1956), pp. 58-60.

<sup>159</sup> David Curran & Daniel Parr, ‘Homosexuality: An analysis of 100 male cases seen in private’, *British Medical Journal* 1 (1957), pp. 797-801.

Delinquency. Out of 113 referred for treatment, data are reported for only sixty-four who either completed treatment or left for some good reason. Only seven patients had no homosexual impulse and an increased heterosexual interest at the conclusion of their psychoanalysis. Attempts made to obtain follow-up data were somewhat vague and inconclusive.<sup>160</sup>

Furthermore, Charlie Rubinstein was cautious of the claims of psychoanalysis, stating: 'Psychoanalysis can help to a certain extent and for a fair number. Some improve well beyond the original expectation'.<sup>161</sup> This recalls Freud's statement in 1938: 'In a certain number of cases we succeed...in the majority of cases it is no longer possible...the result of our treatment cannot be predicted'.<sup>162</sup> A large-scale psychoanalytic study was reported by Bieber.<sup>163</sup> Out of one hundred patients treated by full-scale psychoanalysis, 27% were apparently solely heterosexual at the close of treatment. However, those patients who were reported as responding to the treatment had all had heterosexual experience up to intercourse at some stage prior to treatment. The authors report their results only at the close of treatment, however, and give no follow-up data.

*Modification of sexually deviant behaviour: from Pavlov's dogs to the National Health Service.*

The disillusionment with a psychoanalytical approach to the treatment of sexual deviations was accompanied by an increasing interest in behaviour therapy approaches; Joseph Wolpe was one of the key drivers of the therapy. His book *Psychotherapy by Reciprocal Inhibition* (1958) mainly focussed on the treatment of disorders such as obsessions and phobias.<sup>164</sup> However, John Bancroft argued that this also had an

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<sup>160</sup> Mary Woodward, 'The Diagnosis and Treatment of Homosexual Offenders', *British Journal of Delinquency* 9 (1958), pp. 44-59.

<sup>161</sup> Charlie, R. Rubenstein, 'Psychotherapeutic Aspects of Male Homosexuality', *British Journal of Medical Psychology* 31 (1958), pp. 14-18.

<sup>162</sup> Ernest Jones, *The Life and Work of Sigmund Freud* (London, 1964), p. 43.

<sup>163</sup> Basil Bieber, *Homosexuality* (New York, 1965), p. 78.

<sup>164</sup> Joseph Wolpe, *Psychotherapy by Reciprocal Inhibition* (Stanford, 1958), p. 54.

influential effect in the field of sexual deviations and provided somewhat of a catalyst for utilising this approach to treat sexual deviations.<sup>165</sup>

There were several arguments in favour of applying learning-theory techniques to the treatment of sexual deviations. Firstly, there were the poor outcome results from psychoanalysis, as discussed above. Further, although the Wolfenden report had advocated for oestrogen treatment to be made available to all prisoners, and some studies had reported successful outcomes,<sup>166</sup> overall little success had been seen with this intervention. Oestrogen treatment had, however, been used in Scottish prisons for consenting sexual offenders for some time (especially in Perth) before its recommendation within the Wolfenden report.<sup>167</sup> Nevertheless, according to Inch, oestrogen treatment had never been pushed ‘to its limits’ – ‘to the extent of producing atrophy of the testicles or even gynaecomastis – but only to the point of eliminating or at least reducing libido’.<sup>168</sup> However, the tragic story of Alan Turing would refute Inch’s argument. Turing opted for oestrogen rather than a prison sentence after his relationship with another man in Manchester was exposed and prosecuted. The injections lowered Turing’s libido but also led to the growth of breasts and to depression. He was found dead in 1953, and although the coroner recorded an open verdict, it has been suggested it was almost certainly suicide.<sup>169</sup>

Furthermore, an argument concerned the intrinsic interest of applying learning theory principles, derived in the laboratory, to a field in which the problem was one of real-life behaviour. It was believed that sexual behaviour could be described as consisting of

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<sup>165</sup> Bancroft, ‘Aversion Therapy of Homosexuality: A pilot study of 10 cases’, p. 1418

<sup>166</sup> See, e.g. Francis Golla & Robert Sessions-Hodge, ‘Hormone Treatment of the Sexual Offender’, *The Lancet* 11 (1949), pp. 1006 – 1007; Joshua Bierer, ‘Stilboestrol in Out-Patient Treatment of Sexual Offenders: A Case Report’, *British Medical Journal* (1950), pp. 935-936; Bancroft, *Deviant Sexual Behaviour*, p. 29.

<sup>167</sup> Davidson, ‘Law, Medicine and the Treatment of Homosexual Offenders’, p. 129

<sup>168</sup> NA, HO345/15, CHP/TRANS/42, PWC, evidence of TD Inch, ‘Sexual Offenders: Treatment in Prisons’.

<sup>169</sup> Cook, *A Gay History of Britain*, p. 166; Jivani, *It’s Not Unusual*, p. 123; Weeks, *The World We Have Won*, p. 57.

two components: an intrinsic meditational component and an extrinsic behavioural component. The possibility of directly manipulating the latter and hence of influencing the former was theoretically, at any rate, quite evident.<sup>170</sup> Clearly, most of the operant responses involved in homosexual behaviour could not be reproduced in a laboratory setting, and were therefore not available for manipulation. Homosexual behaviour could, however, be considered as being frequently initiated by the visual response of looking at an attractive sexual object, whilst transvestism could be considered as being initiated by the visual and tactile response of wearing the opposite sex's clothes. Therefore, at least one sexual response was available for laboratory manipulation. In addition, it was shown that there had been some success using aversion therapy to treat alcoholism.<sup>171</sup>

Therefore, it was deemed that aversion therapy was the way forward in the bid to cure individuals suffering from homosexuality and transvestism. These treatments were largely based on "behaviourism", which itself became less popular in the last decades of the twentieth century. Behaviourism has its origins in the psychological laboratories where the techniques developed were used as a basis for clinical work. The most influential drivers of this approach were Pavlov, Thorndike, Watson and Skinner.<sup>172</sup> Thorndike is recognised for devising laws of learning, whereas Watson was one of the initial proponents of the theory that emotions could be learnt.<sup>173</sup> Operant theory, the theory that deals with modification of voluntary behaviour, was initially posited by Skinner: this included the laws of reinforcement and punishment.<sup>174</sup> Most noteworthy

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<sup>170</sup> David H. Barlow, 'Increasing Heterosexual Responsiveness in the Treatment of Sexual Deviation: A Review of the Clinical and Experimental Evidence', *Behaviour Therapy* 4 (1973), p. 655.

<sup>171</sup> See, e.g. Nvzia V. Kantrovich, 'An Attempt at Associate Reflex Therapy in Alcoholism', *Psychology Abstracts* 4282 (1930), p. 26.

<sup>172</sup> John Sugden, Andrew Bessant, Mike Eastland and Ray Field, *A Handbook for Psychiatric Nurses* (London, 1986), pp. 219-220.

<sup>173</sup> John Watson & Rosaline Rayner, 'Conditioned Emotional Reactions', *Journal of Experimental Psychology* 3 (1920), pp. 1-14.

<sup>174</sup> Brian F. Skinner, *Science and the Human Behaviour* (New York, 1953), pp. 34-37.



in relation to the treatments developed for sexual deviation, however, was the work of Pavlov, who developed the theory of “classical conditioning”. Aversion therapy was the logical extension of Pavlov’s classical conditioning.

Pavlov (1849-1936) was a Russian psychologist investigating digestive enzymes in saliva. He believed that if an animal could learn to associate an innocuous irrelevant event (the sound of bells ringing) with something critical and important (eating), then it is possible that habits could be created or destroyed by applying pleasure or discomfort respectively. Basic instinctual responses to certain stimuli were labelled the ‘unconditioned response’.<sup>175</sup> This includes salivating in the presence of a delicious meal, especially if one has not eaten for a while, becoming aroused at the sight of an attractive person, and running from a dangerous situation. Most other environmental stimuli are neutral, neither positive nor negative enough to affect the conditioning of an organism in and of itself. Nevertheless, when a neutral stimulus is paired with a powerful conditioned stimulus that evokes the unconditioned response, eventually the subject would react to the neutral stimulus (conditioned response) as strongly as the unconditioned one.<sup>176</sup> For example, at first Pavlov’s dogs all salivated at the appearance of a plate of meat, but failed to respond to the sound of the bell ringing.<sup>177</sup> Pavlov would ring the bell and produce the meat at the same time. After conditioning the dogs in that fashion, eventually, all the researcher would have to do was ring the bell in order to produce the salivation response in the dogs, as the sound of the bell ringing and the appearance of food had become linked in the dogs’ minds. Thus the response to the neutral stimulus was known as the ‘conditioned response’. So it is interesting that

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<sup>175</sup> Diane Coon & Jane O. Mitterer, *Introduction to Psychology: Gateways to Mind and Behaviour* (New York, 2009), p. 36.

<sup>176</sup> Sugden, Bessant, Eastland and Field, *A Handbook for Psychiatric Nurses*, pp. 219-220

<sup>177</sup> Lyn Y. Abramson, ‘Relevance of Animal Learning Models to Behavioural Psychotherapy’, *British Association for Behavioural and Cognitive Psychotherapies* 4 (1976), p. 2.

psychiatrists were able to make the links between previous experiments on dogs and the idea that human beings could be treated by similar interventions.

### *Techniques of modification*

In the treatment of sexual deviants, two powerful conditioned stimuli were used: chemical and electrical. Electrical aversive techniques consisted of giving electric shocks via electrodes fixed to the patient's wrists, calves or feet. Patients would be asked to fantasise as well as watch pictures of men in various states of dress. In some cases, electric shocks were paired with erections above a certain size, measured by a plethysmograph (a pressure transducer encircling the penis).<sup>178</sup> Chemical aversion techniques utilised apomorphine, an emetic, which produced nausea and vomiting in the patient. When the medication had become effective, the patients were usually shown pictures of undressed men.<sup>179</sup>

As discussed in the introduction to this thesis, the first official report of aversion therapy being utilised to treat a homosexual was published in 1935 by Louis Max. He required a homosexual patient to fantasize about an attractive sexual stimulus in conjunction with electric shock, hence employing a classical conditioning approach.<sup>180</sup> He found it necessary to use an electric shock higher than that used in other laboratory studies on human subjects to cause a 'diminution of emotional value of the sexual stimulus'. Each treatment lasted several days, and over three months, the effect was cumulative. Max reported that four months after the end of the treatment, the patient said, 'The terrible neurosis has lost the battle, not completely but by 95 per cent of the way.'<sup>181</sup> No further details are given of the long-term effect of this revolutionary

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<sup>178</sup> Bancroft, 'Aversion Therapy for Homosexuality', p. 1420.

<sup>179</sup> Stanley Rachman, 'Aversion Therapy: Chemical or Electrical?', *Behaviour Research and Therapy* 2 (1965), p. 289.

<sup>180</sup> Max, 'Breaking up a Homosexual Fixation', p. 734.

<sup>181</sup> Max, 'Breaking up a Homosexual Fixation', p. 734.

therapeutic intervention. This report was extremely brief, but the implication was that the author had been applying a method based on laboratory learning experiments. The fact that Max had used an electrical shock higher than that which was usual in laboratory studies displays the lack of regulation and the experimental nature of such treatments. The report, being an abstract of a paper read at a meeting, passed apparently unnoticed in the literature until the 1950s.<sup>182</sup>

The next published case of aversion therapy being used to treat sexual deviation, following Max, was reported by Raymond in 1956, and used a form of aversion therapy to treat a case of fetishism.<sup>183</sup> Freund followed in 1960 with a pioneering paper.<sup>184</sup> He administered to his patients a mixture of caffeine and apormorphine in a number of treatment sessions, never exceeding twenty-four. When the emetic mixture became effective, slides of dressed and undressed men were shown to the patient, and then the patient was shown films of nude or semi-nude women seven hours after the administration of testosterone propionate. Sixty-seven patients are reported on in this paper; treatment was refused to none. Out of twenty court referrals, only three achieved any kind of heterosexual adaptation, and in no case did this last for more than a few weeks. The first follow-up was undertaken after three years. Out of the forty-seven patients who presented other than due to a court referral, twelve had shown some long-term heterosexual adaptation. A second follow-up two years later traced the histories of these twelve. At that time none of them could claim complete absence of homosexual desires, and only six could claim complete absence of homosexual behaviour. Three of the group were in fact engaging in homosexual behaviour fairly frequently. Ten of them had heterosexual intercourse at least every two weeks, but only

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<sup>182</sup> Barlow, 'Increasing Heterosexual Responsiveness in the Treatment of Sexual Deviation', p. 655.

<sup>183</sup> Max, 'Breaking up a Homosexual Fixation', p. 734; Michael Raymond, 'Case of Fetishism Treated by Aversion Therapy', *British Medical Journal* 2 (1956), pp. 854-846.

<sup>184</sup> Kevin Freund, 'Some Problems in the Treatment of Homosexuality', in Henry J. Eysenck (ed.), *Experiments in Behaviour Therapy* (London, 1960), p. 79.

three found females other than their wives sexually attractive. Clearly these results did not encourage an attitude of optimism, and Freund's series is the only one that included a satisfactory follow-up. Treatments, however, continued despite the lack of solid evidence-based outcomes.

In 1962, Basil James reported a case where he used apomorphine in the treatment of a 40-year-old homosexual.<sup>185</sup> The treatment was rather more invasive than that reported by Freund, and was carried out at two-hour intervals. It involved the patient being given an emetic dose of apomorphine and 57ml of brandy. As soon as nausea occurred, a strong light was shone onto a large piece of cardboard on which were pasted several photographs of nude or semi-nude men. The patient was asked to select an attractive image, and recreate the experiences he had had with his current homosexual partner. This fantasy was verbally reinforced by the consultant on the first three occasions; thereafter, a tape recorder was played twice every two hours during the period of nausea. This consisted of an explanation of his homosexual behaviour, together with the effects of this behaviour on him, with words such as 'sickening' and 'nauseating' being attached to social consequences.

The following night the patient was awakened every two hours and was played a tape recording which optimistically explained the future consequences if he were no longer homosexual. During the three days following aversion therapy, photographs of 'sexually attractive young females' were placed in his room, and each morning he received an injection of testosterone propionate and was told to retire to his room whenever he felt any sexual excitement. The treatment was carried out for a period of thirty hours, and twenty-four hours later was repeated for a further thirty-two hours. The treatment was carried out in a darkened side room (see Figure 3). Further, the

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<sup>185</sup> Basil James, 'Case of Homosexuality Treated by Aversion Therapy', *British Medical Journal* 17 (1962), p. 768.

treatments continued without a break, and it was only after thirty hours that treatment was terminated because the patient developed acetonuria.<sup>186</sup> Five months after the treatment, the paper reported a highly satisfactory outcome, in that there was a complete change from homosexual to heterosexual behaviour. This paper displays a mixture of techniques involved in this treatment, without any discussion of the research base underpinning them.



**Figure 3. Side-room at Glenside Hospital, Bristol, where the treatment discussed by James (1962) was administered.**

**Source: Reprinted with permission from the Glenside Hospital Museum, Bristol.**

The paper sparked some controversy, and in particular, opposition from a fellow doctor. In a letter to the editor published by the *British Medical Journal* on 31<sup>st</sup> March 1962, Sidney Crown wrote:

Sir – I was surprised to find in the paper by Dr. Basil James on aversion therapy in homosexuality that a method of treatment

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<sup>186</sup> Acetonuria: the excretion in the urine of excessive amounts of acetone, an indication of incomplete oxidation of large amounts of fat; common in diabetic acidosis and starvation: Barbara J. Irwin & Judith A. Burckhardt, *NCLEX-RN Strategies for the Registered Nursing Licensing Exam* (New York, 2008), p. 43.

carried out on a single case followed up for such a short period was afforded the status of an article in one of the most widely read medical journals. Treatment in psychiatry is hindered by premature publication. As in other branches of medicine, a new therapy should be critically evaluated from the results of a controlled series of cases, with appropriate statistical analysis and adequate follow-up, before it is published. Scientific caution is, perhaps, particularly important in an emotionally toned subject such as homosexuality. Already the medical correspondent of an influential Sunday newspaper has, equally uncritically, featured the article in his column.<sup>187</sup>

Aversion therapy to treat homosexuality was not supported as a treatment option by the medical professional as a whole. The same can be said for the nursing profession and some nurses in this study engaged in subversive behaviours to avoid participating in these therapies. The testimonies of these nurses will be explored in Chapter VI. In a possible response to Crown, Basil James and his colleague Donal Early wrote a letter to the editor of the *British Medical Journal*, stating that they felt that ‘a follow-up report would be of general interest’.<sup>188</sup> The follow-up report was given eighteen months post treatment, and despite the report stating that the patient’s feelings for his current girlfriend did not have ‘the same emotional component as his homosexual experiences’; the authors concluded that in their opinion, the ‘patient remains a sexually normal person’.<sup>189</sup> Moreover, in the original paper by Basil James discussed above, James expressed his ‘appreciation of the way in which the nursing staff co-operated so fully in the treatment’.<sup>190</sup> However, it is debatable whether this was co-operation, coercion or obedience. This debate will be taken further in Chapter V when we are introduced to the “subordinate nurses” in this study.

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<sup>187</sup> Sidney Crown, ‘Aversion Therapy for Homosexuality’, *British Medical Journal* 31 (1962), p. 943.

<sup>188</sup> Basil James & Donal F. Early, ‘Aversion therapy for homosexuality’, *British Medical Journal* 23 (1963), p. 538.

<sup>189</sup> James & Early, ‘Aversion Therapy for Homosexuality’, p. 538.

<sup>190</sup> James, ‘Case of Homosexuality Treated by Aversion Therapy’, p. 770

The majority (four) of the participants in this study received chemical aversion therapy. Conversely, in Smith and his colleagues' study, more of their participants received electrical aversion therapy.<sup>191</sup> This could attest the capricious nature of these treatments, as they varied throughout the country and had no general protocols or ethical guidelines.<sup>192</sup> Nevertheless, participants in both the studies recalled their experience of receiving this treatment in macabre detail:

I can still taste the vile taste of stale sick in my mouth. All I wanted was to wash my mouth out with fresh water, but I wasn't even allowed that. I remember trying to sneak out of my "prison cell" one night to get some water, but the nurses caught me and literally threw me back in. I was not allowed out for three days. I went to the toilet in the bed; I had no basin, no toilet facilities – nothing. I had to lie in my own faeces, urine and vomit. I thought I must be dreaming at one point, it was like a torture scene by the Gestapo in Nazi Germany trying to extract information from me – I thought I was going to die.<sup>193</sup>

Meanwhile Oscar Mangle recalls, 'What was going through my mind was not that I was scared of being gay. I was petrified I would not come out of this mental hospital alive. I was a very frightened young man'.<sup>194</sup> The Sunday newspaper to which Crown was referring above was *The Observer* with an article entitled "How Doctor Cured a Homosexual" (see Figure 4).<sup>195</sup> *The Sunday Pictorial* also ran a similar article the previous year entitled "'Twilight' Men Can Be Cured" (see Figure 5),<sup>196</sup> thus reinforcing the notion that homosexuality was an "illness" that could nevertheless be "cured".

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<sup>191</sup> Smith, King & Bartlett, 'Treatments of Homosexuality in Britain since the 1950's', p. 1

<sup>192</sup> Smith, King & Bartlett, 'Treatments of Homosexuality in Britain since the 1950's', p. 3.

<sup>193</sup> William Newman, interviewed 29<sup>th</sup> April 2010.

<sup>194</sup> Oscar Mangle, interviewed 21<sup>st</sup> June 2010.

<sup>195</sup> "How Doctor Cured a Homosexual". *The Observer*, 18<sup>th</sup> March, 1962.

<sup>196</sup> "'Twilight' Men Can Be Cured". *The Sunday Pictorial*, 5<sup>th</sup> February, 1961.

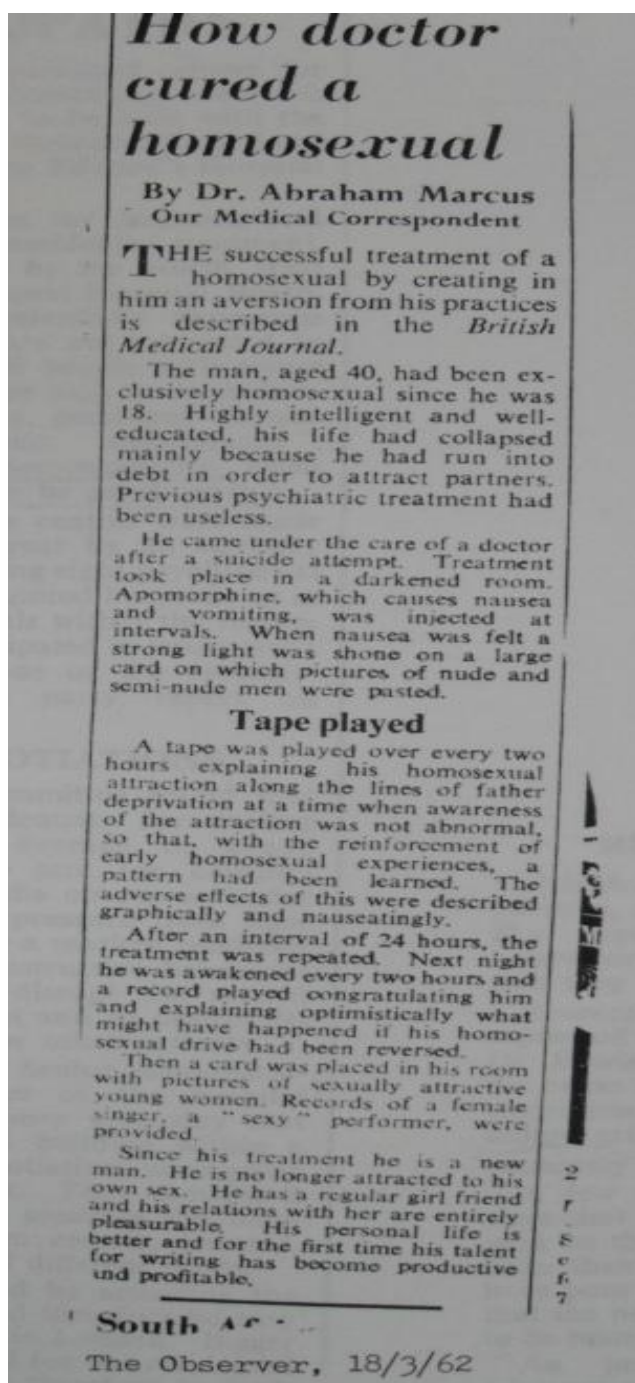


Figure 4. *The Observer* report on "How Doctor Cured a Homosexual", 18<sup>th</sup> March, 1962. Source: Reprinted with permission from the Gay and Lesbian News Media Archives, London.





Figure 5. *The Sunday Pictorial* report "'Twilight' Men Can Be Cured", 5<sup>th</sup> February, 1961. Source: Reprinted with permission from the Gay and Lesbian News Media Archives, London.

Jackie Fletcher remembers the press reportage of the patient she had nursed and it serving as an affirmation of the work she was doing:

I remember the press discussing “how a doctor had cured a homosexual” and although it didn’t name names or places, I knew the report was referring to the man I had nursed. It was my “fifteen minutes of fame” as they say [laughs]. I suppose the fact it was printed for all to see was confirmation of the good work we were doing.<sup>197</sup>

*Choice of the Noxious Stimulus: chemical or electrical?*

As we have seen above, there were two types of noxious stimulus utilised for the treatments for sexual deviation – chemical and electrical. However, the literature appears to suggest that there was some contention regarding the most therapeutic choice of aversive stimulus. Simon Rachman and John Barker both pointed out that chemical aversion was highly unpleasant, not only for the patient, but also for the therapist and nursing staff.<sup>198</sup>

A number of other papers followed on from James and included studies by Isaac Oswald<sup>199</sup> and Angus Cooper.<sup>200</sup> Both also used noxious (i.e. emetic) stimuli and treatment that continued without a break, and in some cases the patient was kept awake by means of amphetamines.<sup>201</sup> Health care staff also played tape recordings of contemptuous comments about the patient to them, and allowed them no food or drinks other than the prescribed alcohol. Raymond remarked that ‘modification of attitudes and psychological conversation are more easily obtained in states of exhaustion

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<sup>197</sup> Jackie Fletcher, interviewed 12<sup>th</sup> February 2010.

<sup>198</sup> Simon Rachman, ‘Aversion therapy: Chemical or Electrical’, *Behavioural Research Therapy* 2 (1965), pp. 289-299; John C. Barker, ‘Behavioural Therapy for Transvestism: A Comparison of Pharmacological and Electrical Aversion Techniques’, *British Journal of Psychiatry* 111 (1965), pp. 268-276.

<sup>199</sup> Isaac Oswald, ‘Induction of Illusory and Hallucinatory Voices with Consideration of Behaviour Therapy’, *Journal of Mental Science* 108 (1962), pp. 196-212.

<sup>200</sup> Angus J. Cooper, ‘A Case of Fetishism and Impotence Treated by Behaviour Therapy’, *British Journal of Psychiatry* 109 (1963), pp. 649-653.

<sup>201</sup> Barker, ‘Behaviour Therapy for Transvestism’, p. 269.

and hunger'.<sup>202</sup> Cooper suggested that the desired changes were 'more easily obtained in fatigued and debilitated subjects'.<sup>203</sup> Meanwhile, Oswald attempted to produce a 'maximal emotional crisis in order to facilitate conversion' in the case of a patient being treated for transvestism.<sup>204</sup>

In this case the patient was actually required to carry out the fetishistic acts. With the onset of nausea and vomiting, the patient was returned to bed and 'received intensive moral suggestion'. During the whole day he was not allowed to discard his female clothes, but was instructed to look at his reflection in the mirror and re-enact in his mind every detail of his 'disgusting perversion'. The patient was kept awake at night by means of amphetamine, and a tape recording played pejorative comments about him for twenty minutes every two hours. The patient finally broke down after seven days of this regime, having neither eaten nor slept for six days. Three days after treatment, a right ventricular stress was noted and this was considered to be due to a toxic myocarditis<sup>205</sup> produced by the emetine.<sup>206</sup> Despite this being a potentially fatal condition, the treatment continued. This could give an indication of the medical attitude towards this patient group at the time. A similar technique was used by Daniel Clarke, again with female clothes. Moreover, as we saw with Oswald, the emphasis on antipathy by the health care professional is shown by the flowing phrase from Clarke, 'At one session, by a particularly happy chance, one of his [the patients] favourite pictures fell into the vomit in the basin so that the patient had to see it every time he puked.'<sup>207</sup>

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<sup>202</sup> Raymond, 'Case of Fetishism Treated by Aversion Therapy', p. 855.

<sup>203</sup> Cooper, 'A Case of Fetishism and Impotence Treated by Behaviour Therapy', p. 650.

<sup>204</sup> Oswald, 'Induction of Illusory', p. 210.

<sup>205</sup> Toxic myocarditis: inflammation of the heart muscle which if not treated can be fatal: Irwin & Burckhardt, *NCLEX-RN Strategies*, p. 39.

<sup>206</sup> Emetine is a drug used to induce vomiting: Irwin & Burckhardt, *NCLEX-RN Strategies*, p. 65.

<sup>207</sup> Daniel F. Clarke, 'Fetishism Treated by Negative Conditioning', *British Journal of Psychiatry* 109 (1963), pp. 404-408.

In 1963 Thorpe, Schmidt and Castle reported the use of electric shock as the noxious stimulus.<sup>208</sup> Here the treatment was carried out in a room with a floor area of nine square feet, and the floor was completely covered by an electric grid. 'Strong' electric shocks were delivered through the electric grid to the patient's bare feet. The patient was requested to bring one of his own photos of a nude male; this was fixed to the wall, and illuminated by a bright light operated by a psychologist. The electric shocks were administered in response to increases in penile erection, measured by a plethysmograph. Within each treatment session, the picture was illuminated forty times. On nine of these occasions, the patient was randomly shocked. Follow-up contact appears to have been through letter. The patient reported utilising heterosexual fantasy, and stated that he had made one attempt at heterosexual intercourse. Occasional homosexual patterns of behaviour had occurred, but the patient was not unduly worried about these, which he regarded as 'a safety valve'. The authors admitted that many would consider this patient to have technically relapsed. However, they predicted a satisfactory heterosexual adjustment for him, and they therefore considered his treatment to have been successful.

In 1964 Robert McGuire and Michael Vallance described what they state to be a classical conditioning technique.<sup>209</sup> The patient was required to signal to the therapist when the mental image of his usual fantasy was clear. When he did so, a shock was administered. The procedure was repeated throughout a thirty-minute session, which was held up to six times per day. The authors also designed a small and completely portable electrical apparatus to be used in the treatment, and this was usually handed

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<sup>208</sup> John G. Thorpe, Edward Schmidt & David Castell, 'Comparison of Positive and Negative (Aversive) Conditioning in the Treatment of Homosexuality', *Behaviour Research and Therapy* 1 (1963), pp. 357-362.

<sup>209</sup> Robert J. McGuire & Michael Vallance, 'Aversion Therapy by Electric Shock: A Simple Technique', *British Medical Journal* 1 (1964), pp. 151-153.

over to the patient so that he could treat himself in his own home. He was told to use the apparatus whenever he was tempted to indulge in the fantasy concerned.

Moreover, as with the testimony of William Newman, who received chemical aversion therapy, the participants in this study who received electrical aversion therapy found this equally unpleasant:

I remember sitting in the room on a wooden chair “dressed” [wearing women’s clothes], but I had to be barefoot as my feet had to touch the metal electric grid. My penis was also wired up to something to measure if I got an erection – I felt totally violated. [...] I remember the excruciating pain of the initial shock; nothing could have prepared me for it. Tears began running down my face and the nurse said: “What are you crying for? We have only just started!”...[Chokes]...I was speechless.<sup>210</sup>

Meanwhile some nurses also found the therapy similarly distressing to witness:

I remember the first time I witnessed it [electrical aversion therapy]. I thought it was barbaric, I mean I remember thinking: “Where was the treatment?” The young lad nearly jumped out of his skin with the jolt of the first shock. Then you could see it was almost mental torture waiting for the next one!<sup>211</sup>

The medical press were keen to publish their studies and claim successful outcomes. However, King and Bartlett argue that there was no confirmation of successful outcomes beyond penile volume measurements in response to erotic stimuli, or the patient reporting that they now believed they were heterosexual or that they were repulsed at the thought of wearing the opposite sex’s clothes.<sup>212</sup> In treatments that did not use a plethysmograph to measure penile volume measurements, the success of the treatment and, therefore, the patients discharge was based mainly on self-report from

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<sup>210</sup> Greta Gold, interviewed 24<sup>th</sup> March 2010.

<sup>211</sup> Luke Vanson, interviewed 23<sup>rd</sup> June 2010.

<sup>212</sup> King & Bartlett, ‘British Psychiatry and Homosexuality’, p. 47.

the patient.<sup>213</sup> Indeed, some patients in this study were able to use this to their advantage and engaged in subversive behaviours in order to be discharged from the hospital; their testimonies will be explored in Chapter V. Moreover, on analysis of the above treatments for sexual deviations, it appears that there was a level of arbitrariness to their selection and a variety of methods were adopted. Furthermore, with no ethical guidelines, the treatment of choice appeared to rest largely on the unilateral decision of the consultant psychiatrist. It is becoming clear that these treatments lacked regularity and a sound evidence base.

### *Referral pathways*

It appears that many men were referred for these treatments by their general practitioner (GP). However, Delroy Heath's testimony above, and other participants in this study, also reflected on the negative impact the media had on their lives – in some cases it provided the catalyst for them to seek treatment via their GP. This was often exacerbated by unsupportive attitudes from their friends, family and the police.<sup>214</sup> Indeed, six of the men interviewed approached their GPs about their problems and were referred to National Health Service (NHS) professionals who specialised in this area. However, all reported that their GPs appeared perplexed by their disclosure and appeared to show little empathy for their situation. Albert Holliday sought treatment due to the turmoil in which he found himself when he realised he was attracted to members of the same sex:

This was terrifying really because I was thrown into confusion and it made me very poorly because I had three children, little ones, and a wife, and we all loved each other, we had been happy building our lives, you know. I was very fond of my wife as well and everything was going okay and then all this began to happen

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<sup>213</sup> Smith, King & Bartlett, 'Treatments of Homosexuality in Britain since the 1950s', p. 4.

<sup>214</sup> Dickinson, Tommy, Cook, Matt, Playle, John & Hallett, Christine, "Queer" Treatments: Giving a voice to former patients who received treatments for their "sexual deviations". *Journal of Clinical Nursing*, 21 (9) (2012), p. 1349. A copy of this paper has been included in Appendix I.

and threw me into awful confusion and made me very, very poorly and so I thought I had to go to the doctor. So I did.<sup>215</sup>

William Newman was given an option of imprisonment or he could be remanded provided he was willing to undergo psychological treatment when he was entrapped and arrested by an undercover police officer in a public place for importuning:

Well when I was given the option, prison or hospital, well I just thought if I go to prison...if the other inmates found out what I was in there for, well, I just thought they would kill me! I mean, I was fairly accepting of my sexuality, but in society and particularly within a prison, it was viewed in the same light as a paedophile. No, I'm not going to prison, that is all I could think. So I just said, "Yeah, I'll go to hospital for the aversion therapy." I knew it was not going to make me straight, I didn't want it to, but it seemed a better option than prison.<sup>216</sup>

I would argue that William Newman was tacitly coerced into receiving treatment, and although the other men in this study self-referred via their GPs, it could be debated that all the patients were implicitly coerced into receiving aversion therapy by the media and the paternalistic attitudes of their GPs. The reasons why medical – and nursing – staff might have had such paternalistic attitudes will be discussed in Chapter III. Moreover, these influences could all have led to the health care professionals not upholding the patients' autonomy in relation to their decision to consent to the treatment; the notion of patients consent to treatment for aversion therapy will be explored in Chapter IV.

### **Reaction: press, public and nurses**

The late 1950s to the mid-1960s witnessed a marked refocusing of public debate surrounding sexual deviations onto issues of aetiology rather than punishment, and the press were keen to report this. Indeed, when an anonymous donor gave Crumpsall

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<sup>215</sup> Albert Holliday, interviewed 27<sup>th</sup> January 2010.

<sup>216</sup> William Newman, interviewed 29<sup>th</sup> April 2010.

Hospital, Manchester a donation of between £6,000 and £7,000 to set up a research and treatment unit for homosexuality, the *Birmingham Post*, the *Manchester Daily Telegraph*, the *Guardian*, the *Times* and the *Scotsman* all reported the case with a level of optimism.<sup>217</sup>

Furthermore, the *New Statesman* published a letter from a former patient who had received treatment in the Portland Clinic at No. 8 Bourdon Street, London, following a 'homosexual offence'. The treatment in his case was so 'amazingly helpful' that he wanted to promote the clinic to others in his position.<sup>218</sup>

Many of the former patients who participated in this study recalled their initial exuberance at this shift in ideology. For many, discovering that there was a "cure" for their disorder gave them a sense of hope and legitimacy. Oscar Mangle recalls reading a newspaper article discussing how gay men could be cured by psychiatrists: 'No longer was I an evil pervert. Now I believed I could be viewed as a patient with all the vulnerabilities and sympathy a patient demands'.<sup>219</sup> Moreover, the press reportage of the patient Jackie Fletcher nursed served to reinforce her belief in the 'good work' she was doing.<sup>220</sup>

However, in spite of the popular reportage of these cases, some papers were still unsympathetic, with *The Scotsman* running headlines, "Growing Problem of the Homosexual" and "Control Must Come Before Cure".<sup>221</sup> Meanwhile the *Guardian* peddled the headline "Homosexuals Cured More Easily in Prison".<sup>222</sup> Reports such as this left Luke Vanston, whose testimony we heard at the beginning of the chapter, and

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<sup>217</sup> "Homosexuality Research Unit." *Birmingham Post*, 25<sup>th</sup> November, 1964; "Gift to Start Homosexuality Research Unit." *Manchester Daily Telegraph*, 25<sup>th</sup> November, 1964; "£6,000 Gift for Research into Homosexuality." *The Guardian*, 25<sup>th</sup> November, 1964; *The Times*, 25<sup>th</sup> November, 1964; "Offer for Study of Homosexuality." *The Scotsman*, 26<sup>th</sup> November, 1964.

<sup>218</sup> *New Statesman*, 31<sup>st</sup> January, 1959.

<sup>219</sup> Oscar Mangle, interviewed 21<sup>st</sup> June 2010.

<sup>220</sup> Jackie Fletcher, interviewed 12<sup>th</sup> February 2010.

<sup>221</sup> "Growing Problem of the Homosexual." *The Scotsman*, 5<sup>th</sup> June, 1959; "Control Must Come Before Cure." *The Scotsman*, 6<sup>th</sup> June, 1959

<sup>222</sup> "Homosexuals Cured More Easily in Prison." *The Guardian*, 10<sup>th</sup> October, 1965.



Charles Dance, who was a nursing student when he nursed patients who were receiving treatment for various sexual deviations, very confused:

I felt like I was being given very mixed messages about the homosexuals I was nursing. I didn't know whether to believe the newspapers, the sociologists or the doctors I was working with. It really troubled me that there was such a lack of parity between these views.<sup>223</sup>

### **Conclusion**

The period explored in this chapter witnessed many debates regarding the ideal way to manage the perceived problem of sexual deviation in men. Despite the liberal attitude expressed by many during World War II, this is also the period when the idea that homosexuality as a pathology was more popularised. There appeared to be a cultural shift after the war marking a drive for the nation to return to pre-war values with a growing emphasis on domesticity, family life, and social order, with which it was believed that homosexual men were at odds. Although there was never any dedicated witch-hunt of homosexual men during the 1950s, the incidence of arrests and convictions did increase. This included some influential people. Homosexual men living through this period expressed hypervigilance towards the police and felt fearful and cautious. Homosexuality was being brought out into public rhetoric by the media, literary, medical, sociological and legal discussions. These played a role in shaping public knowledge about who the sexual deviant was and what he represented. However, these were all portraying mixed messages regarding homosexual men, leaving the recipients very confused.

Following Wolfenden, there was a distinct altering of notions regarding homosexuality from a criminal perspective to understandings of the subject as pathology. There was a

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<sup>223</sup> Charles Dance, interviewed 5<sup>th</sup> December 2010.

shifting of control and power from the courts to the medical profession, many of whom were optimistically promoting their worth in being able to cure these individuals by reporting successful outcomes. Furthermore, we see ideas regarding what was perceived to be the most efficacious therapy to cure these individuals changing through the period from psychoanalysis to oestrogen therapy and finally onto aversion therapy. These therapies were reported somewhat sanguinely by the media and the medical profession, and by the late 1950s, the desire to have sex with another man was being more universally seen to be the result of an ingrained condition, which could nevertheless now be cured.

However, there were still opponents to this view, with some still believing that the sexual deviant should be dealt with under the auspices of the law. I would argue, therefore, that despite this post-war propagation of writings regarding sexual deviations, no one explanatory system emerged victorious in these years. Through these intersecting narratives of sexual danger and medical discourses, the sexual deviant was constructed beyond the boundaries of national citizenship and, therefore, was a fitting subject for social exclusion, legal repression or medical treatment. When nurses came on duty to care for patients receiving treatment for their sexual deviations during the 1950s and 1960s, they did so in a world in which tabloid, psychoanalytic, behavioural, legal, medical and other sexological discourses of sexual deviations competed with each other for attention, causing considerable confusion.

# CHAPTER III

## WORK AND PRACTICE OF MENTAL NURSES, 1930 – 1959.

It seemed like the order of the day was to do things to patients, whether that was shock them into next week, pump them full of insulin or carve away at their brains. Although we can all look back on this in horror - at the time, it was exciting; we believed we could actually cure patients, whereas before such treatments, there was little hope of it. It was just what we did; we didn't really think to question it.<sup>1</sup>

### **Introduction**

In parallel to the messages nurses were receiving regarding homosexuality and transvestitism during the 1930s to the 1960s, within their clinical practice they were also introduced to two new legislative frameworks brought in by the Mental Treatment Act, 1930, which was geared towards a model of treatment, where patients would have greater autonomy, and the Mental Health Act 1959, which put a new emphasis on community care. During this period, nurses also witnessed what has been described as 'therapeutic optimism', as new therapeutic options, particularly somatic (physical) therapies, for treating psychiatric patients were introduced.<sup>2</sup> The introduction of these new approaches raised expectations of curative treatment, in keeping with the nomenclature of the new 1930 Act. Within this chapter I aim to explore these innovative treatments in a bid to gain an insight into the culture and practices within which the mental hospitals' nurses were working during the 1930s to the 1950s. I will also argue that given the emphasis placed on somatic therapies, by the time aversion

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<sup>1</sup> Edward Lyons, interviewed 10<sup>th</sup> February 2010.

<sup>2</sup> Nolan, 'Mental Health Nursing – origins and developments', p. 254.

therapies for sexual deviations came to the fore in the early 1960s, nurses were accustomed to administering treatments which caused distress to patients. This offers a context to explain some nurses' acceptance of aversion therapy.

However, I argue that despite this new-found therapeutic optimism, the culture of many mental hospitals – and their nurses – was still custodial, impersonal and ritualized. The work of nurses was also largely constrained by the asylum-type conditions in which they worked, and the character and quality of patient care was marred by factors such as overcrowding and severe understaffing. I will also explore the hitherto hidden history of gay life amongst male homosexual nurses within mental hospitals and, deconstruct the contentious dichotomy of these nurses administering treatments for patients “suffering” from the same “condition” as themselves.

Finally, given the emphasis placed on community care in the latter part of the 1950s, with the introduction of the Mental Health Act 1959, psychiatrists and nurses felt insecure in their jobs. Moreover, I will argue that both these professions responded to the government's uncertainty regarding the most effective way of dealing with sexual deviants by developing and implementing treatments to “cure” these individuals as a tacit way of bringing new patients into hospital, and proving their worth to the government, who at the time were determined to reduce patient numbers and spending on mental hospitals.

### **The Mental Treatment Act, 1930: from therapeutic pessimism to therapeutic optimism**

The Mental Treatment Act, 1930 was the first major revision of mental health policy since the Lunacy Act, 1890, and with the introduction of this new Act, asylums became

hospitals.<sup>3</sup> The 1930 Act was introduced following, amongst other things, a book by Montagu Lomax, *The Experiences of an Asylum Doctor* (1921).<sup>4</sup> The book led to stories in the national press, questions in the House of Commons and an internal investigation. The investigation scrutinized evidence from thirty-eight witnesses, including five inmates, which led to a report of this inquiry. John Hopton argues that this report was generally hostile to Lomax; however, it recommended ‘improvement of diet, the introduction of formal training for nursing staff and improvement in care’.<sup>5</sup>

The internal inquiry which followed the publication of Lomax’s book led to a Royal Commission on Lunacy and Mental Disorder (The Macmillan Commission, 1924-1926). The published report by the committee dismissed many of Lomax’s allegations and claims but agreed with his overall recommendation that psychiatry was in need of reform.<sup>6</sup> The specific recommendations of the report were that the population of each mental hospital should not exceed one thousand patients; only formally qualified specialists in psychiatry should become Superintendents of psychiatric hospitals; seclusion should only be utilized in clearly defined situations and its use monitored closely; the quality of food and type of employment for patients should be reviewed; and aftercare facilities for the rehabilitation of patients should be developed.<sup>7</sup>

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<sup>3</sup> Kathleen Jones, *A History of Mental Health Services* (London, 1972).

<sup>4</sup> Montagu Lomax, *The Experiences of an Asylum Doctor* (London, 1921). Lomax wrote his book after working at Prestwich Asylum in Manchester as a *locum tenens* during the First World War. ‘He stated his rationale for writing the book was that under the legislation then in force, the psychiatric system for the pauper insane was defective and open to abuse, while the book itself was an indictment of the regime at Prestwich Asylum in particular and psychiatric care in general. He described the asylum as gloomy, dilapidated, barrack-like and dirty; considered the patients’ clothing and diet to be of poor quality; described the regime as dull and monotonous; and criticised the lack of a system for assessing and categorising patients according to their needs. He also considered that many attendants were lazy, vain, unjust, mean and tyrannical but attributed this to long hours, low pay, lack of prospects and generally being treated with contempt by hospital management’: Hopton, ‘Prestwich Hospital in the Twentieth Century’, p. 351; Jones, *A History of Mental Health Services*, p. 232-234; Tom Butler, *Mental Health, Social Policy and the Law* (Basingstoke, 1985), p. 83.

<sup>5</sup> Hopton, ‘Prestwich Hospital in the Twentieth Century’, p. 351; Kathleen Jones, *Mental Health & Social Policy, 1845-1959* (London, 1960), p. 94.

<sup>6</sup> Nolan, *A History of Mental Health Nursing*, p. 82-83.

<sup>7</sup> Hopton, ‘Prestwich Hospital in the Twentieth Century’, p. 352.

The Royal Commission on Lunacy and Mental Disorder led to the 1930 Mental Treatment Act. Kathleen Jones suggests that the new 1930 Act did four things: it reorganized the Board of Control; it made provisions for voluntary treatment; it gave official blessing to the establishment of psychiatric out-patient clinics and observations wards; and, in line with the Local Government Act of 1929, it abolished outmoded terminology, and brought the official expressions used in conjunction with mental illness into line with the modern approach to the subject.<sup>8</sup>

Harrington argues, however, that these changes were not unprecedented. The Maudsley Hospital, funded mainly by Dr. Henry Maudsley, had opened in 1915 with the express intention of providing care to early and acute cases; much of its work was on an outpatient basis.<sup>9</sup> A number of voluntary hospitals had also started to offer outpatient facilities, initially in response to the number of soldiers returning from the First World War suffering from “shell-shock”.<sup>10</sup> These facilities were usually under the supervision of asylum Superintendents, but located on general hospital premises. However, these innovations were limited: before the 1930 Act the vast majority of people in receipt of publicly funded psychiatric care were the legally committed inmates of asylums.<sup>11</sup> With the passing of the Act, by the late 1930s, just over a third of all asylum admissions were of voluntary status and a total of 177 outpatient clinics were in existence.<sup>12</sup>

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<sup>8</sup> Jones, *Mental Health & Social Policy*, p. 94.

<sup>9</sup> Valerie Harrington, *Death of the Asylum: The Run-Down and Closure of Prestwich Mental Hospital*. Unpublished MSc thesis, University of Manchester. (Manchester, 2004), p. 18. See also Joan Busfield, ‘Restructuring Mental Health Services’, in Marijke Gijswijt-Hofstra & Roy Porter (eds), *Cultures of Psychiatric and Mental Health Care in Post-War Britain and the Netherlands* (Amsterdam, 1998), p. 16.

<sup>10</sup> The phenomenon of shell-shock had a profound influence on conceptions of mental illness and on psychiatric practice. Doctors and nurses within psychiatry were expected to treat men suffering from shell-shock and return them, cured and ready for military service, as quickly as possible. Shell-shock was an ill-defined but demonstrably ‘real’ condition which psychiatrists were able to address. Respectable people – men of ‘good character’ – appeared to go mad. Society was forced to take madness more seriously and to redraw the line between that condition and sanity: Harrington, *Death of the Asylum*, p. 18; Nolan, ‘Mental Health Nursing – Origins and Developments’, pp. 253-254; See also Tracey Longhran, ‘Hysteria and Neurasthenia in pre-1914 British Medical Discourse and in Histories of Shell-Shock’, *History of Psychiatry* 19 (2008), pp. 25-46.

<sup>11</sup> Harrington, *Death of the Asylum*, p. 19.

<sup>12</sup> Joan Busfield, *Managing Madness: Changing Ideas and Practice* (London, 1986) pp. 295-300.

### **Change of terminology, voluntary and temporary patients**

The Local Government Act of 1929, which reformed the Poor Law system and created Public Assistance Boards, which had the statutory duty to provide extra-mural services for the mentally ill, had already swept away such terms as “pauper” and “Poor Law”.<sup>13</sup> Nevertheless, the 1930 Act abolished the outdated words that were still being used officially in connection with mental illness. “Asylum” was replaced by “mental hospital” or simply “hospital”; and “lunatic” – except “criminal lunatic” (where the individual had been in contact with the criminal justice system), – ‘was replaced by a variety of phrases such as “patient” or “person of unsound mind” as the context might require’.<sup>14</sup>

The Macmillan Report had considered only two categories of patients – “Voluntary” and “Involuntary”. The 1930 Act established three: “Voluntary”, “Temporary” and “Certified”. The procedure for certified patients was already established under the Lunacy Act of 1890.<sup>15</sup> The broadening of the categories of patients reflected the philosophy of the new Act, which was geared towards a model of treatment, where patients would have greater autonomy.

### **New therapeutic options**

#### *Somatic treatments*

Francis James argues that by the 1930s, psychiatrists were left caring for patients for whom in many cases there was no effective treatment;<sup>16</sup> the treatment offered amounted to little beyond custodial care, particularly for patients with an ill-defined diagnosis such

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<sup>13</sup> Busfield, *Managing Madness*, pp. 319-320; Nolan, *Psychiatric Nursing Past and Present*, p. 137.

<sup>14</sup> Pamela Dale & Joseph Melling, *Mental Illness and Learning Disability Since 1850: Finding a Place From Mental Disorder in the United Kingdom* (London, 2006), p. 112; Jones, *Mental Health & Social Policy*, p. 121.

<sup>15</sup> Jones, *Mental Health & Social Policy*, p. 120.

<sup>16</sup> Francis E. James, ‘Insulin Treatment in Psychiatry’, *History of Psychiatry* iii (1992), p. 221; Before the 1930s, unpleasant and ineffective treatments included: ‘the bath of surprise’ a reservoir of water into which the patient was suddenly precipitated while standing on its moveable and treacherous cover, cold showers and ‘the swivel chair’, which involved spinning the patient around continually in a swivel chair: Roy Porter, *Madness: A Brief History* (Oxford, 2002), p. 102.

as dementia praecox.<sup>17</sup> Psychiatrists wanted effective therapies and an improved understanding of mental patients.<sup>18</sup> In keeping with the ethos of the new Act, they were seeking to treat and cure patients, enabling them to return to their homes and into employment.<sup>19</sup> Not only were there changes in the legislative framework, the therapeutic options for treating psychiatric patients were being transformed during the 1930s. There was a spirit of optimism within psychiatry, as new somatic treatments were introduced, which provided hope to psychiatrists – and nurses – who had previously had few effective treatments to draw on. However, ironically these new and distinctly unpleasant somatic treatments were being introduced at a time when patients were being given greater legal rights to accept or reject treatment. The four most significant were: insulin treatment, Cardiazol treatment, electroconvulsive therapy (E.C.T.) and leucotomy.<sup>20</sup> Thus, from having no therapeutic interventions beyond sedation for the mentally ill, four treatments were now available and a ‘wave of enthusiasm resulted in the adoption of these therapies before proper evaluation’.<sup>21</sup>

Patients undergoing such treatments required varying degrees of nursing care in its more medical sense. This led to some nurses taking on new roles, thus bringing the medical and nursing professions closer together.<sup>22</sup> Prebble argues that the introduction of somatic treatments did two things: it not only shifted the nurses’ roles towards a more medical focus, but also impacted on their work in other ways. Some treatments provided opportunities for staff to engage in one-to-one care of patients, and due to

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<sup>17</sup> Dementia praecox (a ‘premature dementia’ or ‘precocious madness’) referred to a chronic, deteriorating psychotic disorder. It was characterized by rapid cognitive breakdown, which usually began in the late teens or early adulthood. It was eventually reframed into a substantially different disease concept and relabelled as schizophrenia: Sugden, Bessant, Eastland and Field, *A Handbook for Psychiatric Nurses*, p. 178.

<sup>18</sup> Andrew Scull, ‘Desperate Remedies: A Gothic Tale of Madness and Modern Medicine’, *Psychological Medicine* 17 (1987), p. 562; David Crossley, ‘The Introduction of Leucotomy: A British Case History’, *History of Psychiatry* iv (1993), p. 557.

<sup>19</sup> Jack D. Pressman, *Last Resort: Psychosurgery and the Limits of Medicine* (Cambridge, 1998), p. 41.

<sup>20</sup> Edward Shorter, *History of Psychiatry: From the Era of Asylum to the Age of Prozac* (New York, 1997), pp. 522-530; Arton, *The Professionalization of Mental Nursing in Great Britain*, p. 62; Carpenter, *Above All a Patient Should Never Be Terrified*, p. 57; Busfield, *Managing Madness*, p. 67.

<sup>21</sup> James, ‘Insulin Treatment in Psychiatry’, p. 222.

<sup>22</sup> Nolan, ‘The Development of Mental Health Nursing’, p. 12.



their effectiveness, some treatments gave nurses hope that their patients could be cured or at least achieve early discharge from hospital. A more negative impact of the treatments, however, was the coercive role expected of nurses.<sup>23</sup> It is important to highlight that I will be drawing on Kate Prebble's work regarding mental nurses' experiences providing somatic treatments in New Zealand (NZ) within this section, due to the paucity of literature discussing this subject with UK nurses. Therefore, the different geographical area means that her data cannot be automatically transferred to the UK. Nevertheless, while Prebble's study was based on mental nurses in NZ, she argues that the system for training and registration of mental nurses in NZ followed the system of the RMPA in the UK, and all nurses were issued a copy of the Handbook for Mental Nurses, known colloquially as "The Red Book".<sup>24</sup> This could suggest, therefore, that there were some parallels between the NZ and UK nurses. Moreover, her work provides some valuable insights into the roles nurses played in relation to administering these treatments, which is important for this study.

#### *Insulin treatment*

Insulin was first prepared and utilised in Toronto by Banting and Beat in 1922 for the treatment of diabetes mellitus; this was life changing for patients suffering from the condition as it virtually freed them from a death sentence. James argues that the clinical observations that led to the use of insulin in psychiatry were the return of patients' weight to within normal limits and the induction of sleepiness and coma from insulin overdose.<sup>25</sup> Manfred Shakel first noted the effects of insulin coma on schizophrenia symptoms in 1933, but it had gained popularity since a Swiss researcher, Max Muller,

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<sup>23</sup> Prebble, 'Ordinary Men and Uncommon Women', p. 119.

<sup>24</sup> Prebble, 'Ordinary Men and Uncommon Women', pp. 137-138.

<sup>25</sup> James, 'Insulin Treatment in Psychiatry', p. 222.

had arranged a conference on new therapies in 1937.<sup>26</sup> The first cases of insulin treatment in the UK were by Dr. Pullar-Streckerin, who worked under the supervision of Professor Henderson in Edinburgh.<sup>27</sup>

Insulin treatment was first used in England in Moorcroft House, a private psychiatric hospital where the help of Dr. Freudenberg from Vienna was enlisted.<sup>28</sup> James argues this was partly due to the fact that ‘private licensed mental hospitals were less subject to control by central and local government than asylums or other institutions administered by local authorities’.<sup>29</sup> For two years Dr. William Sargent<sup>30</sup> was endeavouring to persuade Professor Mapother<sup>31</sup> to try the treatment at the Maudsley Hospital. However, Edward Mapother considered the treatment too risky, particularly given that ‘the local coroner was fierce and ready to pounce on the psychiatrists at the slightest provocation’.<sup>32</sup> Nevertheless, in 1938, Dr. Sargent treated the first patients at the Maudsley Hospital suffering from schizophrenia using insulin treatment. Once introduced, insulin treatment was rapidly adopted and utilised at most mental hospitals. However, the conditions in many hospitals were far from ideal.<sup>33</sup>

The treatment involved daily injections of insulin, which were gradually increased until the patient’s blood sugar was so low that he/she fell into a deep coma. The patient would be kept in an unconscious state for approximately four hours. The patient would

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<sup>26</sup> Wilfred L. Jones, *Ministering to Minds Diseased: A History of Psychiatric Treatment* (London, 1983), p. 21; James, ‘Insulin Treatment in Psychiatry’, p. 221.

<sup>27</sup> James, ‘Insulin Treatment in Psychiatry’, p. 222.

<sup>28</sup> Shorter, *History of Psychiatry*, p. 522.

<sup>29</sup> James, ‘Insulin Treatment in Psychiatry’, p. 222.

<sup>30</sup> ‘William Sargent (1907-1988) was a pioneer during the war years in the introduction of physical treatment in psychiatry. Following the war he served his association with the Maudsley Hospital and became physician in charge of psychological medicine at St. Thomas’ Hospital until his retirement in 1971’: James, ‘Insulin Treatment in Psychiatry’, p. 235.

<sup>31</sup> ‘Edward Mapother (1881-1940) first came to psychiatry when he joined the staff of Longrove Hospital, Epsom. Later, he became the first Superintendent of the Maudsley Hospital and in 1937 the first professor in clinical psychiatry in the University of London’: James, ‘Insulin Treatment in Psychiatry’, p. 235.

<sup>32</sup> James, ‘Insulin Treatment in Psychiatry’, p. 223.

<sup>33</sup> Joel Braslow, *Mental Ills and Bodily Cures* (London, 1997), 34.

then be brought back to consciousness by tube feeding with a glucose solution or, in an emergency, by being given intravenous glucose. Patients were treated daily over a period of five to six weeks.<sup>34</sup> Unna Drinkwater recalls that insulin was administered every day except Sundays, when patients were allowed to, ‘rest and stock up on food mainly carbohydrates’.<sup>35</sup> There were serious risks involved in this procedure and these included respiratory difficulties, projectile vomiting, seizures, irreversible coma, collapse and delayed coma. Insulin therapy was considered to be ‘intricate and exacting and unremitting medical and nursing attention [was] required for its success’.<sup>36</sup>

In the treatment of anxiety, hysteria, and anorexia, a less intensive form of insulin treatment – “sub-coma shock treatment” – was sometimes utilised. This intervention involved administration of insulin at high enough doses to produce symptoms such as hunger, drowsiness, weakness and sweating. However, because the patient did not go into a coma, it was not considered as risky.<sup>37</sup>

Insulin treatment was usually administered on a specialised unit to a small group of patients by experienced medical and nursing staff. This ensured the maintenance of enthusiasm and high standards of care.<sup>38</sup> Insulin treatment had to be supplemented by other forms of therapeutic interventions. Not only were nurses required to provide physical care, monitor symptoms and regulate the patients’ diets; they also had to consider psychological factors. Nurses had to manage agitated behaviour and listen sympathetically when patients emerged from unconsciousness – such intensive psychological support was usually not possible in their work on the wards. Insulin treatment appeared to create enthusiasm among nurses, as the challenging environment

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<sup>34</sup> Adams, *Challenge and Change in a Cinderella Service*, p. 128; Prebble, ‘*Ordinary Men and Uncommon Women*’, p. 119.

<sup>35</sup> Unna Drinkwater, interviewed 29<sup>th</sup> December 2009.

<sup>36</sup> Prebble, ‘*Ordinary Men and Uncommon Women*’, p. 119; see also Jones, *Ministering to Minds Diseased*, p. 22.

<sup>37</sup> Adams, *Challenge and Change in a Cinderella Service*, p. 128; Prebble, ‘*Ordinary Men and Uncommon Women*’, p. 119.

<sup>38</sup> Adams, *Challenge and Change in a Cinderella Service*, p. 128.

of these specialist units was a welcome change for them compared to the dull routines of ward work. However, monitoring and care for patients receiving insulin was usually reserved for the senior nurses.<sup>39</sup> Nevertheless, nurses taking on these advanced practices did not appear to have a deep knowledge of the theoretical underpinning for their interventions. Emily Whitbread recalls witnessing insulin treatment as a student nurse:

I was only a student and the senior staff nurse would give the heavy dose of insulin but before she did that she would pass a tube down into her [the patient's] stomach, and then after she was out, put out with insulin for so long, they would pour some liquid glucose, and that would bring her round. And when she was fully round, you used to have to take her down into the shower, give her a hot shower for a while and suddenly switch it round to the cold, now whatever that was for I don't know. I couldn't see sense of that. When I asked the staff nurse she said: "It's just what Sister says we have to do".<sup>40</sup>

During the 1939-45 War, insulin treatment suffered because of the reductions in medical and nursing staff and the lessened availability of insulin and glucose. After 1945, it was noted to pick up again. However, it was severely criticised in a 1953 paper in the *Lancet* entitled 'The Insulin Myth' in which good results were ascribed to the strong suggestive effect of the technique together with enthusiasm of a dedicated staff, the inculcation of a group morale in a special unit and the 'total push' adjuvant treatment.<sup>41</sup> The treatment appeared to decline after the publication of this article. Further reasons for its decline were ascribed to poor selection of patients, neglect of technique and limited rehabilitation of patients.<sup>42</sup>

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<sup>39</sup> Prebble, *Ordinary Men and Uncommon Women*, p. 119; Adams, *Challenge and Change in a Cinderella Service*, pp. 129-130.

<sup>40</sup> Emily Whitbread, interviewed 7<sup>th</sup> January 2010.

<sup>41</sup> Harold Bourne, 'The Insulin Myth', *Lancet* ii (1953), p. 964.

<sup>42</sup> Jones, *Ministering to Minds Diseased*, p. 23.

### *Cardiazol treatment*

In 1938 Ladislav von Meduna started treating patients suffering from psychosis with Cardiazol to chemically induce convulsions; this was on the mistaken basis that those with epilepsy did not develop schizophrenia.<sup>43</sup> Cardiazol was usually utilized as a cardiac or respiratory stimulant. In psychiatry, Cardiazol was given in large doses to induce an epileptic convulsion. Cardiazol was used mainly with people suffering from schizophrenia, and was given in a series of 12-20 intravenous injections. The treatment was usually commenced between 7 and 10 a.m. The patient would be placed on their back in bed with arms and legs stretched out. A pillow was placed under the patient's head and a folded pillow put under the shoulders to prevent injuries due to the violent seizures that the treatment induced. Roughly ten seconds after the Cardiazol had been administered, the doctor in charge of the treatment would take hold of the patient's wrists and in the same movement press the patient's shoulders down. In the following 50 seconds, in which the convulsions normally lasted, the patient had tonic seizures<sup>44</sup> with stiffening of the body and subsequently clonic seizures.<sup>45</sup> The patient would generally turn blue, and their arms and legs would rapidly and rhythmically jerk until they eventually passed out.<sup>46</sup>

In the majority of cases, treatment was administered twice, and sometimes three times, weekly.<sup>47</sup> It was considered less problematic than insulin treatment and required less time each day. However, it still had its risks and many patients feared the powerful

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<sup>43</sup> Meduna of Hungary had made the 'discovery' that the brains of people with schizophrenia and those with epilepsy were different. He first experimented with producing seizures by administering camphor, but when this was found to be unreliable, he changed to using Cardiazol: German E. Berrios, 'The scientific origins of electroconvulsive therapy: a conceptual history', *History of Psychiatry* viii (1997), p. 106.

<sup>44</sup> This type of seizure causes a person's body to stiffen, because all the body's muscles contract. The person may sound like they are crying out as air is pushed out of their lungs and they may lose control of their bladder or bowels.

<sup>45</sup> A seizure characterized by rhythmic or semi-rhythmic contractions of a group of muscles. The arms, neck and facial muscles are most commonly involved.

<sup>46</sup> Jesper Vaczy Kragh, 'Shock Therapy in Danish Psychiatry', *Medical History* 54 (2010), p. 348.

<sup>47</sup> Adams, *Challenge and Change in a Cinderella Service*, p. 129.

effect of Cardiazol. Indeed, one former patient who received the treatment was noted to remark:

About 10 seconds after having received the injection, it is as if you are pulled out of yourself and into another world, but you can still see the persons around you as if in a limpid fog. It is utterly unbearable and quite impossible to get out of. Sometimes the effect is stronger, sometimes weaker; when it is strong you have hallucinations...The room you are lying in begins to look like Hell, and it is as if you are burned by an invisible fire. It is scary. But luckily it is over now.<sup>48</sup>

Another patient was noted to remark ‘they shock me with terror’.<sup>49</sup> Despite this, Edward Lyons commented, ‘[...] even if they were kicking and screaming they still got the jab’.<sup>50</sup>



**Figure 6. A patient in an unrestrained Cardiazol convulsion circa 1941.**

**Source: Reprinted with permission from the *American Journal of Psychiatry*, (Copyright ©1941). American Psychiatric Association.**

<sup>48</sup> Testimony of a former patient who received Cardiazol cited in Kragh, ‘Shock Therapy in Danish Psychiatry’, p. 351.

<sup>49</sup> Testimony of Martha Sherman, a former patient cited in Braslow, *Mental Ills and Bodily Cures*, p. 110.

<sup>50</sup> Edward Lyons, interviewed 10<sup>th</sup> February 2010.

*Electroconvulsive therapy*

In 1937 Cerletti and Bini introduced electroconvulsive shocks, which were perceived to be safer and less unpleasant than Cardiazol treatment.<sup>51</sup> Shortly after the Second World War commenced, Flemming, Golla and Walter published the first British trial of ECT in the *Lancet*.<sup>52</sup> The authors concluded that ‘no untoward results have been observed; the claims of Cerletti and Bini are confirmed; the method is technically effective, simple and safe and arouses no fear or hostility in the patients’.<sup>53</sup> German Berrios argues that the *Lancet* paper is significant, ‘because its views on the safety and feasibility of ECT reassured the British psychiatric brotherhood that a more controllable method of inducing seizures had been found’.<sup>54</sup>

The electroshock machine occasioned great enthusiasm among psychiatrists, and the machine was introduced widely into most psychiatric hospitals during the 1940s. It was favoured by psychiatrists because it produced instant unconsciousness, induced less fear from the patients, elicited no physical upset after the convulsion and was deemed safer than Cardiazol.<sup>55</sup> Indeed, Elliot Whitman was noted to remark ‘ECT was like the Prozac of today – everyone had it!’.<sup>56</sup> However, there were risks, mostly fractures of limbs and vertebrae, particularly in the elderly. These dangers began to be mitigated when a new procedure called ‘modified ECT’ was introduced. This procedure used succinylcholine, a muscle relaxant, to cause paralysis a few moments before seizure, and a short-acting anaesthetic, methohexital (‘Brevital’).<sup>57</sup>

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<sup>51</sup> James, ‘Insulin Treatment in Psychiatry’, p. 223; Braslow, *Mental Ills and Bodily Cures*, 57.

<sup>52</sup> Gerald W. T. H. Flemming, Fredrick L. Golla & William Walter, ‘Electric-Convulsion Therapy of Schizophrenia’, *Lancet* II (1939), pp. 1353-5. Flemming et al. ‘administered 75 electrical shocks of the brain, as a result of which there have been 50 major convulsions and 25 minor seizures. The major convulsions are similar to spontaneous ones and are followed by complete amnesia for the shock’.

<sup>53</sup> Flemming, Golla & Walter, ‘Electric-Convulsion Therapy of Schizophrenia’, p. 1355.

<sup>54</sup> Berrios, ‘The Scientific Origins of Electroconvulsive Therapy: A Conceptual History’, p. 107.

<sup>55</sup> Shorter, *History of Psychiatry*, p. 221; Braslow, *Mental Ills and Bodily Cures*, p. 97.

<sup>56</sup> Elliot Whitman, interviewed 20<sup>th</sup> March 2010.

<sup>57</sup> Adams, *Challenge and Change in a Cinderella Service*, p. 126.

Nurses were involved in the administration of shock treatment, as with the other treatments. They were responsible for preparing the patients, guaranteeing they had nil by mouth prior to the treatment and attempting to alleviate any fears the patient may have had regarding the treatment. To reduce the possibility of fractures, the treatment was given on a firm mattress placed on top of a fracture board and four to six nurses held the patient down firmly during the convulsion. A gag was placed in the patient's mouth to prevent biting of the tongue. Usually a nurse applied the paddles to the patient's temples while the doctor switched on the current. Post treatment, they observed and reported any side-effects.<sup>58</sup> Jackie Fletcher recalls her unease with the restraining of patients receiving ECT:

We literally had to throw ourselves over the patient to stop them thrashing about. It would usually take five of us: one nurse would hold the patients head and try to compress the jaw; one would hold the feet, while two would be on either side of the patient holding the patients shoulders with one hand and the patient's hand with another, meanwhile another would press down on the pelvis. I remember thinking it was awful. I could see the benefit for really depressed people, but for schizophrenia, I really couldn't see its worth.<sup>59</sup>

Meanwhile, Charles Dance recalls the education he received regarding ECT:

I can almost visualise the lecture on ECT by this psychiatrist: he said you won't understand this, so it was a good place to start with students, and he drew this diagram of a skull, and this skull was full of arrows and they were all pointing the same way, and he said now this is me and you. Now people with schizophrenia, and he drew all these arrows all over the place – that's schizophrenia, give them ECT and all the arrows go the same way as you and me...you kind of think, that's a very good theory, but it didn't hold water, it was "crap". It was one of those happy accident discoveries really. So it was extensively used, really quite extensively, particularly in acute care.<sup>60</sup>

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<sup>58</sup> Prebble, *Ordinary Men and Uncommon Women*, p. 121.

<sup>59</sup> Jackie Fletcher, interviewed 12<sup>th</sup> February 2010.

<sup>60</sup> Charles Dance, interviewed 5<sup>th</sup> December 2010.



Electroconvulsive therapy features fairly frequently in the testimonies of former nurses and patients who tell of their experiences of mental hospitals during the 1940s to the 1950s.<sup>61</sup> Many nurses recall its inception as a major breakthrough for mania and clinical depression. Furthermore, it appeared to make a positive impact on the nurses' working environment; as increased rate of discharge, success with severely depressed patients and shortening of manic episodes all forged a pathway for nursing staff to begin working in a rehabilitative manner with some patients.<sup>62</sup>

Conversely, as we have seen in the testimony of Jackie Fletcher above, nurses were also perturbed about aspects of ECT administration. Most nurses recall feeling tense or horror-struck when they first witnessed ECT, especially before the introduction of modified ECT. Furthermore, despite psychiatrists perceiving that it was less feared than Cardiazol, many patients were petrified of ECT, they suffered unwanted side-effects such as memory loss, and some took great lengths to avoid it; some went as far as attempting suicide.<sup>63</sup> Indeed from a patient's point of view, Janet Frame described the ward atmosphere on ECT days as resembling that in a prison on execution day.<sup>64</sup>

There was tangible evidence of the efficacy of ECT for severe affective disorders. However, electroconvulsive therapy was also utilized to control behaviour, and to treat disorders for which it had questionable efficacy, particularly schizophrenia.<sup>65</sup> Adam Carter recalled such incidences of ECT being used to control behavior: 'If they were as you might describe "unmanageable", these people were unmanageable, then they might

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<sup>61</sup> See, e.g. Michael King, *Wrestling with the Angel: A Life of Janet Frame* (Auckland, 2000); Gittins, *Madness in its Place*; Prebble, 'Ordinary Men and Uncommon Women', pp. 122-123; Adams, *Challenge and Change in a Cinderella Service*, pp. 124-127.

<sup>62</sup> Prebble, 'Ordinary Men and Uncommon Women', pp. 122.

<sup>63</sup> Adams, *Challenge and Change in a Cinderella Service*, p. 127; Prebble, 'Ordinary Men and Uncommon Women', p. 123.

<sup>64</sup> King, *Wrestling with the Angel*, p. 97.

<sup>65</sup> Braslow, *Mental Ills and Bodily Cures*, p. 97; Adams, *Challenge and Change in a Cinderella Service*, p. 126.

go for half a dozen ECT's'.<sup>66</sup> Moreover, it was the nurses' responsibility to ensure that patients came for their treatments, and all the nurses in the study recalled this aspect of their role in relation to ECT. However, their views seemed embedded in vagueness about their ability to question this. Peter Mellor commented, 'It was fairly common to have to drag the patient, kicking, screaming and biting for ECT. Looking back, that is awful, at the time, it was what we did – doctors' orders'.<sup>67</sup> However, reflecting back, one nurse in Prebble's study summed up his attitudes to the use of un-modified ECT: '[...] when you didn't have anything else, what did you use?'<sup>68</sup> Although pharmacological advances in psychiatry have lessened the need for ECT, it still has a place in the psychiatric armamentarium.

### *Frontal leucotomy*

Arguably the most invasive of all the somatic treatments was the prefrontal leucotomy (known as lobotomy in the United States), which for upwards of twenty years was utilised in the UK, and by 1954 had been performed on upwards of twelve thousand people, although the final figure may never be known.<sup>69</sup> The treatment involved brain surgery to cut the nerve fibres leading back from the prefrontal lobes. The objective was to interfere with negative, ingrained emotional and psychological patterns.<sup>70</sup> The procedure was usually performed using local anaesthetic. This reduced the overall risk of a general anaesthetic and enabled the surgeon to monitor the immediate effects of leucotomy by engaging the patient in what must have been an overwrought dialogue.<sup>71</sup>

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<sup>66</sup> Adam Carter, interviewed 25<sup>th</sup> March 2010.

<sup>67</sup> Peter Mellor, interviewed 8<sup>th</sup> August 2010.

<sup>68</sup> Prebble, *Ordinary Men and Uncommon Women*, pp. 124.

<sup>69</sup> Crossley, 'The Introduction of Leucotomy', p. 554.

<sup>70</sup> Pressman, *Last Resort*, p. 36.

<sup>71</sup> Crossley, 'The introduction of leucotomy', p 555.

Some of these conversations were recorded, and were rather macabre:

Surgeon: 'What is going through your mind now?'

Patient: 'A knife'.<sup>72</sup>

The prefrontal leucotomy was introduced by Egas Moniz in 1936 for aggressive or seriously disturbed patients.<sup>73</sup> However, this was popularized by an American neurologist Walter Freeman (pictured in Figure 7) in collaboration with neurosurgeon, James Watts.<sup>74</sup> They published a book *Psychosurgery* in 1942 detailing pre-operative care, operative technique and post-operative care.<sup>75</sup> There had been a paucity of academic discussion regarding psychosurgery in Britain prior to 1942, when eight patients were operated on, the first of whom had a leucotomy preformed in Bristol in December 1940.<sup>76</sup> The *Lancet* published the results of these procedures in July 1941 and noted that they were 'encouraging' and went on to claim that 'improvement could be hoped for in every type of case'.<sup>77</sup> Given adequate conceptual ground, leucotomy developed rapidly in the UK. Furthermore, the original aims of the leucotomy programme at one Mental Hospital, as stated in its 1943 Annual Report, were that it would 'hasten recovery' and help the 'hospital stay to be curtailed'.<sup>78</sup> Early reports in the British medical press posited that leucotomy could offer relief from anxiety, apprehension, obsession symptoms and 'tension states' and also control distressing behaviour. A central

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<sup>72</sup> Walter Freeman & James Watts, *Psychosurgery: Intelligence, Emotion and Social Behaviour Following Prefrontal Lobotomy for Mental Disorders* (Illinois, 1942), p. 109

<sup>73</sup> Along with neurosurgeon Almeida Lima, Moniz resected part of the prefrontal lobes of twenty patients transferred from the Bombarda asylum to the neurology service of the Santa Marta Hospital in Lisbon. Seven had been "cured", seven ameliorated, and in six there was no change: Shorter, *History of Psychiatry*, p. 226.

<sup>74</sup> Crossley, 'The Introduction of Leucotomy', p. 553.

<sup>75</sup> By 1942 Freeman and Watts had operated on eighty cases: Crossley, 'The Introduction of Leucotomy', p. 554.

<sup>76</sup> Crossley, 'The Introduction of Leucotomy', p. 554.

<sup>77</sup> Emanon L. Hutton, & Gerald W. T. H Fox, 'Early Results of Prefrontal Leucotomy', *The Lancet* cxxli (1941), pp. 3-7.

<sup>78</sup> Medical Superintendent's Annual Report to the Committee of Visitors of the North Wales Countries Mental Hospital for 1943, p. 25 cited in Crossley, 'The Introduction of Leucotomy', p. 561.

assertion by the medical profession was that it could resocialize a subcategory of individuals otherwise predestined to institutional care. A common view was that the operation was indicated more by symptoms and behaviour than by diagnosis *per se*.<sup>79</sup>

I would argue that nurses had an implicit but fairly influential role in the selection of patients for leucotomy. It appears that the selection of patients at the North Wales Psychiatric Hospital, Denbigh, was influenced by the degree of behavioural disturbance and, therefore, the extent of nursing supervision required. In at least half of the original twenty-four patients operated on there, nursing challenges were explicitly stated. Indeed, the supervising psychiatrist made the following plan for one patient: ‘leucotomy [has been] carried out largely with an eye on easing nursing care [in a patient who is] a low grade imbecile, destructive, unclean and cannot apply himself to anything’.<sup>80</sup> This selection criterion was publicly accredited in the psychiatric literature of the time. Leucotomy may be prescribed for patients ‘who require a great deal of nursing supervision, who [are] a constant source of trouble’.<sup>81</sup>

The testimonies of some of the participants in the study corroborate this notion. Edward Lyons recalled this implicit power nurses appeared to have had in relation to leucotomy: ‘If a patient was hard work we could express this to the doctor, and this could have a big impact on whether they went under the knife or not’.<sup>82</sup> Meanwhile, Susan Traherne recalled an incident where a patient was given a leucotomy as a result of their behaviour:

I remember \*\*\*\* \* [name of her nursing colleague]. Well a patient bit him. He took a working party out from \*\*\* [name of the ward]. It was at a time when \*\*\* [name of the ward] was full of rough ones. Well one of the patients hacked \*\*\*\* \* [name of her nursing

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<sup>79</sup> Crossley, ‘The Introduction of Leucotomy’, p. 555.

<sup>80</sup> Crossley, ‘The Introduction of Leucotomy’, p. 556.

<sup>81</sup> Roger Strom-Olsen, ‘Results of Prefrontal leucotomy’, *Journal of Mental Science* lxxxix (1943), p. 491.

<sup>82</sup> Edward Lyons, interviewed 10<sup>th</sup> February 2010.

colleague] head – took a massive chunk out of it! So they did a leucotomy on this patient. And he was like a vegetable, after the leucotomy.<sup>83</sup>

There is no documentary evidence to suggest, however, that leucotomy was ever carried out for disciplinary reasons or solely to control behaviour.<sup>84</sup> Indeed, Unna Drinkwater commented, ‘It was always seen as a last resort and never considered as an inconsequential intervention, as there were definite risks involved’.<sup>85</sup> Nevertheless, some psychiatrists were advocating for leucotomy to be deliberated for any patient who had been in hospital for more than a year.<sup>86</sup>

Prebble suggests that nurses were involved in all aspects of the procedure: pre-operatively, they had to ensure the patient had nil by mouth, shave the patients’ head, and also escort them, sometimes in restraints, for the procedure. They were required to restrain the patient during the procedure too if required and hand instruments to the doctor (see demonstration below). Prebble goes on to argue that post-operatively the patients required intensive nursing care, since they were usually confused and disorientated, uncooperative and incontinent; they had to be toileted frequently to help them regain bladder control. The patients usually suffered from fatigue, apathy and inattention in the early stages post-surgery and required intensive retraining in basic living skills, such as table manners and self-care. In most cases, patients were found to require, ‘long-term aftercare by nursing staff experienced in details of rehabilitation and habit training’, and improvement was slow.<sup>87</sup> Julian Glover recalls patients’ presentation post-surgery, ‘[...] they were completely disorientated. There was no feeling or

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<sup>83</sup> Susan Traherne, interviewed 30<sup>th</sup> December 2009.

<sup>84</sup> Crossley, ‘The Introduction of Leucotomy’, p. 553.

<sup>85</sup> Unna Drinkwater, interviewed 29<sup>th</sup> December 2009.

<sup>86</sup> Percy T. Rees, ‘Symposium on Prefrontal Leucotomy’, *Journal of Mental Science* xc (1943), p. 161.

<sup>87</sup> Prebble, ‘*Ordinary Men and Uncommon Women*’, pp. 124.

expression in the face and they would often be sat drooling in a corner on the floor for weeks'.<sup>88</sup>



**Figure 7. Here Walter Freeman is performing a leucotomy at Western State Hospital, Steilacoom, USA, on July 7, 1949. He is inserting a leucotomy instrument under the patient's eyelid in order to destroy tissue in the brain's frontal lobe. Note also the nurses restraining the patient.**

**Source: Reprinted with permission from the Seattle Post-Intelligencer Collection, Museum of History & Industry, Seattle, Washington, USA**

It is interesting to note that in Figure 7 there are eighteen people observing the doctor conducting the procedure. This could demonstrate their idealisation, trust and confidence vested in him. While the picture is taken in a hospital in the USA, I argued in Chapter II that there have always been medical interchanges between the UK and USA. Furthermore, the testimonies of the participants in this study demonstrate that

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<sup>88</sup> Julian Glover, interviewed 4<sup>th</sup> January 2010.

such idealisation and faith in doctors was also evident in UK hospitals. This could offer a context to explain why some nurses participated in this clinical practice and did not think to question it: nurses appeared to assume that the doctors' knowledge, morals and values were superior to their own.

Chlorpromazine arrived in Britain in the early part of 1954 and its introduction had a huge influence in reducing the use of leucotomies and other somatic treatments.<sup>89</sup> Crossley argues that the relief of suffering having had a leucotomy was brought at a price of 'accepting a level of existence qualitatively different from and usually below that which the patient had enjoyed before onset of their illness'.<sup>90</sup> Following leucotomy, 25% of patients received no benefit at all, for 3% their condition was exacerbated and a further 3% - 4% were killed by it.<sup>91</sup> Psychosurgery is still performed in contemporary medical practice; however, it is under much tighter social and legislative controls. Unna Drinkwater sums up this aspect of her nursing career:

Looking back it was a barbaric procedure fuelled by desperation. However, at the time there was so much enthusiasm for it. A lot of nurses, especially some of the more ambitious "career nurses" you might call them, were desperate to get involved with it. I can just imagine what their CVs would have said: "I have assisted with Brain Surgery"!...[Rolls eyes]...I on the other hand, a nurse who happily stayed at the patients' bedside my entire career, found the procedure brutal to say the least. It was so disturbing; at least before the procedure the patient had life, and the majority of patients were a mess after it. It really was heartrending. Pathetic.<sup>92</sup>

During the 1950s psychiatrists and nurses continued to use a variety of somatic treatments, depending heavily on a combination of insulin treatment, ECT, and to a

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<sup>89</sup> Adams, *Challenge and Change in a Cinderella Service*, pp. 138-143; Busfield, 'Restructuring Mental Health Services', p. 17.

<sup>90</sup> Crossley, 'The Introduction of Leucotomy', p. 562.

<sup>91</sup> George C. Tooth & Michael P. Newton, *Leucotomy in England and Wales, 1942-1954*, Great Britain Ministry of Health Reports on Public Health and Medical Subjects No. 104 (London, 1961), p. 21.

<sup>92</sup> Unna Drinkwater, interviewed 29<sup>th</sup> December 2009.

lesser degree, leucotomy, all of which became standard treatments for suitable cases. If one treatment was ineffective, another was tried.<sup>93</sup> Great emphasis was placed on these innovative treatments and all became orthodox, despite them being very experimental in nature and lacking regulation. There was a spirit of optimism, particularly during the 1930s, regarding somatic treatments, and nurses were taking on new and more advanced roles. Optimism was, however, premature. By the end of the decade, another war had erupted, causing intolerable strain on a system that was already seriously stressed. Furthermore, the Second World War delayed the widespread use of both ECT and psychosurgery in Britain and it was not until the end of the 1940s and the early 1950s that their use became common.<sup>94</sup> Nevertheless, I would argue that during the 1930s to the 1950s, nurses' exposure to somatic treatments normalised them to administering treatments which were both unpleasant and distressing for the patients receiving them, thus providing a possible interpretation for some nurses' acceptance of aversion therapy in later years.

## **The World War II years**

### *The impact of World War II*

Chapter II highlighted that in the early 1940s, many nurses were called up, including some who were still in training, and assigned to the Royal Army Medical Corps. Nationwide, psychiatric hospitals were cleared of patients in order to accommodate the large numbers of soldiers with war-induced mental health problems. Some mental hospitals were completely emptied and their patients were transferred to other hospitals, which soon became severely overcrowded.<sup>95</sup> The population of psychiatric hospitals rose so sharply during the Second World War that it became imperative to relieve the

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<sup>93</sup> Adams, *Challenge and Change in a Cinderella Service*, pp. 154-155; Prebble, *Ordinary Men and Uncommon Women*, p. 124.

<sup>94</sup> Busfield, 'Restructuring Mental Health Services', p. 17.

<sup>95</sup> Nolan, *A History of Mental Health Nursing*, p. 98.



pressure on them. The subsequent overcrowding coupled with low staffing levels increased the barely contained discontent amongst mental nurses.<sup>96</sup>

In some hospitals, up to a quarter of the nursing staff had gone. In response to this staffing crisis, the Mental Health Association lobbied for all male nurses with either GNC registration or the RMPA certificate to be made exempt from military service, and in August 1941, the Ministry of Health acted. They produced the Mental Nurses (Employment and Offences) Order, which was known colloquially as the “Standstill”. Claire Chatterton argues that this prohibited any member of the nursing staff from leaving who had worked in their hospital for more than a year, without the permission of the Visiting Committee. If they did so, they could be imprisoned or fined.<sup>97</sup>

Nolan argues that the War had a positive impact on mental nursing. During their time in military service, nurses learned to handle medical emergencies and acquired psychotherapeutic skills, which they would not have covered in training. Mental nurses on the home front were also developing new skills as the Maudsley Hospital was overwhelmed with soldiers suffering from neurasthenia and conversion hysteria, so these nurses were also involved in dynamic and innovative new approaches to the care of very disturbed patients.<sup>98</sup> Many nurses transferred these skills to their practice when they returned to their hospitals after the War.<sup>99</sup> Additionally, I argue in Chapter V that some nurses’ war-time experiences also had a positive impact and influence on the care they delivered to sexually deviant patients in later years. Conversely, in Chapter IV, I consider how the militarisation of nursing during and following the War may have had a negative effect on some nurses, by reinforcing the notion of obedience to higher authority.

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<sup>96</sup> Nolan, ‘The Development of Mental Health Nursing’, p. 12.

<sup>97</sup> Chatterton “*The weakest link in the chain of nursing?*”, p. 67.

<sup>98</sup> Nolan, ‘The Development of Mental Health Nursing’, p. 12.

<sup>99</sup> Nolan, *Psychiatric Nursing Past and Present*, p. 203.

*The Rushcliffe Committee*

In 1943 the Rushcliffe Report, more properly entitled ‘The Report of the Nurses’ Salaries Committee’, appeared, and provided a bedrock for discussions on nurses’ pay and conditions. This led to the setting up of the Nurses’ and Midwives’ Whitley Council in 1948. The aim of this was to improve the status of nursing and the quality of nurse training. The report also recommended that the working fortnight be reduced to ninety-six hours and that continuous night duty should not exceed three months for student nurses and six months for trained staff. It also suggested that all nurses should have twenty-eight days’ holiday a year and one off-duty day per week, with sick pay graded according to the length of service.<sup>100</sup>

*The Nurses Act, 1943*

Penny Starns argues that there was a lack of distinction between registered and assistant nurses during the late 1930s and early 1940s which polarised status issues in nursing.<sup>101</sup> This was further compounded during the war years with the introduction of the controversial ‘Nurses Act’ passed in 1943, which was an attempt to alleviate the chronic nursing shortage, particularly for tuberculosis, mental and chronic hospitals.<sup>102</sup> The Act created a new level of nurse who was Enrolled rather than Registered, and allowed ‘bona fide’ assistant nurses to apply to the GNC for enrolment.

A roll was established and advertisements encouraging nursing orderlies and assistants to apply to the GNC for enrolment on the basis of experience were placed around hospitals. This was noted to cause some anger amongst registered nurses as nursing assistants were being given a nursing qualification based purely on experience and

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<sup>100</sup> Stella Bingham, *Ministering Angels* (Over Wallop, 1979), p. 194.

<sup>101</sup> Penny Starns, ‘Fighting Militarism? British Nursing During The Second World War’, in Roger Cooter, Mark Harrison & Steve Sturdy (eds.), *War, Medicine & Modernity* (Stroud, 1998), p. 192.

<sup>102</sup> Bingham, *Ministering Angels*, p. 196

having sat no exam or assessment, as the criteria needed to apply were, ‘two years whole time training or experience of nursing the sick under trained nursing staff in hospital’.<sup>103</sup> Those whose names were entered on this roll, which was overseen by the GNC, were entitled to call themselves State Enrolled Assistant Nurses (SEANs). These nurses remained known as SEANs until the Nurses Amendment Act in 1961 shortened the title to State Enrolled Nurse (SEN).<sup>104</sup>

Despite publicity campaigns launched by the government, only the maternity field saw an improvement in the number of applicants.<sup>105</sup> Nolan argues that the introduction of the enrolled nurse had the effect of substantially increasing the number of trained nurses at no extra cost.<sup>106</sup> However, enrolled nurses were not introduced into mental nursing until 1964.<sup>107</sup> These new SENs were also known as ‘subordinate’ nurses.<sup>108</sup> Four former SENs have been interviewed as part of this study, three of whom are also, interestingly homosexual; their testimony is explored later in the chapter. Moreover, Chapter IV will explore the notion of these nurses being seen as subordinate, and explore how this may have impacted on their professional behaviour when nursing patients receiving treatments for sexual deviations.

### **Mental health and the National Health Service**

Nolan argues that the country was spiritually and economically drained by the two World Wars, and the creation of a National Health Service (NHS) in July 1948, free at the point of entry to every citizen, represented the ultimate act of national altruism.<sup>109</sup> However, the inclusion of mental health services into the NHS was by no means a

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<sup>103</sup> Chatterton “*The weakest link in the chain of nursing?*”, p. 131.

<sup>104</sup> Chatterton “*The weakest link in the chain of nursing?*”, p. 131

<sup>105</sup> Bingham, *Ministering Angels*, p. 196

<sup>106</sup> Nolan, *A History of Mental Health Nursing*, p. 102.

<sup>107</sup> Chatterton “*The weakest link in the chain of nursing?*”, p. 143

<sup>108</sup> Eileen Baggott, ‘The SEN in Psychiatric Hospitals’, *Nursing Times* 29 (1965), p. 1478; Chatterton “*The weakest link in the chain of nursing?*”, p. 129

<sup>109</sup> Nolan, ‘Mental Health Nursing – origins and developments’, p. 254

foregone conclusion. Mental health services were not included in early plans for the NHS, first featuring in the 1944 Plan.<sup>110</sup> Aneurin Bevan, the Minister of Health in the new Labour Government, supported their inclusion, echoing the 1926 Royal Commission Report in his statement ‘The separation of mental from physical treatment is a survival from the primitive conceptions and is a source of endless cruelty and neglect’.<sup>111</sup>

The major restructuring in 1948, following the creation of the NHS, brought the former county asylums under the control of the new Regional Hospital Boards (RHBs), while local authorities were charged with providing after-care facilities for patients. They in turn delegated local management functions to new Hospital Management Committees.<sup>112</sup> The new arrangements did not diminish the role of the mental hospitals’ Board of Control, which remained an important influence on management, and the hierarchy within the institutions went largely unchanged.<sup>113</sup> However, despite the advent of a nationwide health-service structure, the self-containment and remoteness of the mental health hospitals, located as they often were in the countryside, meant that they were difficult to incorporate into the NHS and were able to continue with many of their traditional practices.<sup>114</sup>

### **Hospital culture: daily life in psychiatric hospitals**

Despite the absorption of mental health services into the NHS and the medical rhetoric of curative treatment within psychiatry, the mental hospitals from the 1930s to the mid-1970s, where the patients would have received treatments for their sexual deviations,

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<sup>110</sup> Busfield, ‘Restructuring Mental Health Services’, p. 16.

<sup>111</sup> Quoted in Michael Foot, *Aneurin Bevan, 1945-1960* (St. Albans, 1975), p. 137

<sup>112</sup> Under the 1948 regulations the RHBs were responsible for ‘guiding and controlling the planning, conduct and development of services in their Regions; Hospital Management Committees, as the Board’s agents, for administering these services’: Harrington, *Death of the Asylum*, p. 21.

<sup>113</sup> See also Monica E. Baly, ‘The National Health Service’, in Monica E. Baly (ed), *Nursing & Social Change* (New York, 1995), pp. 180-196; Nolan, ‘Mental Health Nursing – origins and developments’, p. 254.

<sup>114</sup> Peter Nolan, ‘Swing and roundabouts: Mental Health Nursing and the Birth of the NHS’, *Mental Health Care* 1 (1998), pp. 371-374; Nolan, ‘Mental Health Nursing – origins and developments’, p. 254.

more closely resembled nineteenth-century asylums than they did twentieth century general hospitals.<sup>115</sup> Although the mental deficiency and mental illness hospitals accounted for nearly half the beds within the new health service, they were still seen very much as the ‘poor relation’.<sup>116</sup> Further, according to Nolan, job satisfaction among nurses during this period was poor due to overcrowding in hospitals, the hierarchical structure of mental hospitals, and nurses being utilised as domestics.<sup>117</sup> There appeared to be a mismatch between the idealism of mental hospital administrators and the reality of conditions. Administrators’ aims to provide comfortable, home-like conditions were often unable to be realised because they were battling against their Victorian legacy of resource constraint, overcrowding and understaffing. The pace of integration of mental health services into the NHS was disrupted by the relative isolation of the Hospital Management Committees (HMCs). Unlike the general hospitals that were grouped together, the mental hospital HMCs operated separately, which resulted in their peculiar methods and culture remaining little changed for some years to come.<sup>118</sup>

### *Overcrowding*

In 1946, there were 147,000 mental patients in institutional care. The government had recommended the maximum number of patients in any mental hospital should be 1000. However, by 1947, 67 of the nation’s 140 mental hospitals housed more and some had as many as 3,000 patients.<sup>119</sup> By 1952, nearly all regions reported overcrowding. In some cases, no new beds had been created since 1948 despite a rapid increase in voluntary admissions and older people. Furthermore, the mental hospitals were old, poorly maintained, under resourced with amenities, geographically isolated and ‘mostly

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<sup>115</sup> Hopton, ‘Prestwich Hospital in the Twentieth Century’, pp. 349-369.

<sup>116</sup> Harrington, *Death of the Asylum*, p. 21.

<sup>117</sup> Nolan, *Psychiatric Nursing Past and Present*, p. 193.

<sup>118</sup> Harrington, *Death of the Asylum*, p. 22.

<sup>119</sup> Charles Webster, ‘Nursing and the Early Crisis of the National Health Service’, *The History of Nursing group at the RCN, Bulletin 7* (1985), p. 12-24.

too large to provide an appropriate caring environment for highly vulnerable people'.<sup>120</sup> The growth of mental hospital populations was not accompanied by an equivalent increase in accommodation. Shortages of labour and building materials during and after the war inhibited building projects. Many hospitals, especially in London, had been bombed during the Second World War, but had never recuperated to the point where they were providing the equivalent level of service as before.<sup>121</sup>

An article in the *Nursing Mirror* in 1945 described 'Overcrowding as the worst problem'. They depict a vivid image of conditions with hospitals akin to 'stables' where, 'Beds are sometimes so close together that patients have to climb over each other's beds to reach their own and privacy is impossible'.<sup>122</sup> In addition, in 1953, the *Nursing Times* published an exposé of the conditions at Menston Hospital, near Leeds, where they reported a ward for 103 patients had only five toilets and mattresses were laid on the floor between beds to accommodate extra patients.<sup>123</sup> Overcrowding had an intense effect on nursing care. Day rooms often had to be converted to dormitories, so there was little indoor space for recreational or social activities, and patients had minimal privacy.<sup>124</sup> This can be demonstrated in Figure 8. The beds are very close together and there are no curtains around the beds for privacy.

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<sup>120</sup> Peter Nolan and Barone Hopper, 'Mental Health Nursing in the 1950s and 1960s Revisited', *Journal of Psychiatric and Mental Health Nursing* 4 (1997), p. 334.

<sup>121</sup> Nolan and Hopper, 'Mental Health Nursing in the 1950s and 1960s Revisited', p. 334

<sup>122</sup> Olive Griffiths, Norman Reid and Margaret Scott, 'Reconstruction Scheme for Mental Nursing', *Nursing Mirror* October 27, pp. 46 – 47.

<sup>123</sup> *Nursing Times*, 'Friends of Menston Hospital', *Nursing Times* November 28, pp. 1215-1216.

<sup>124</sup> Adams, *Challenge and Change in a Cinderella Service*, p. 87.

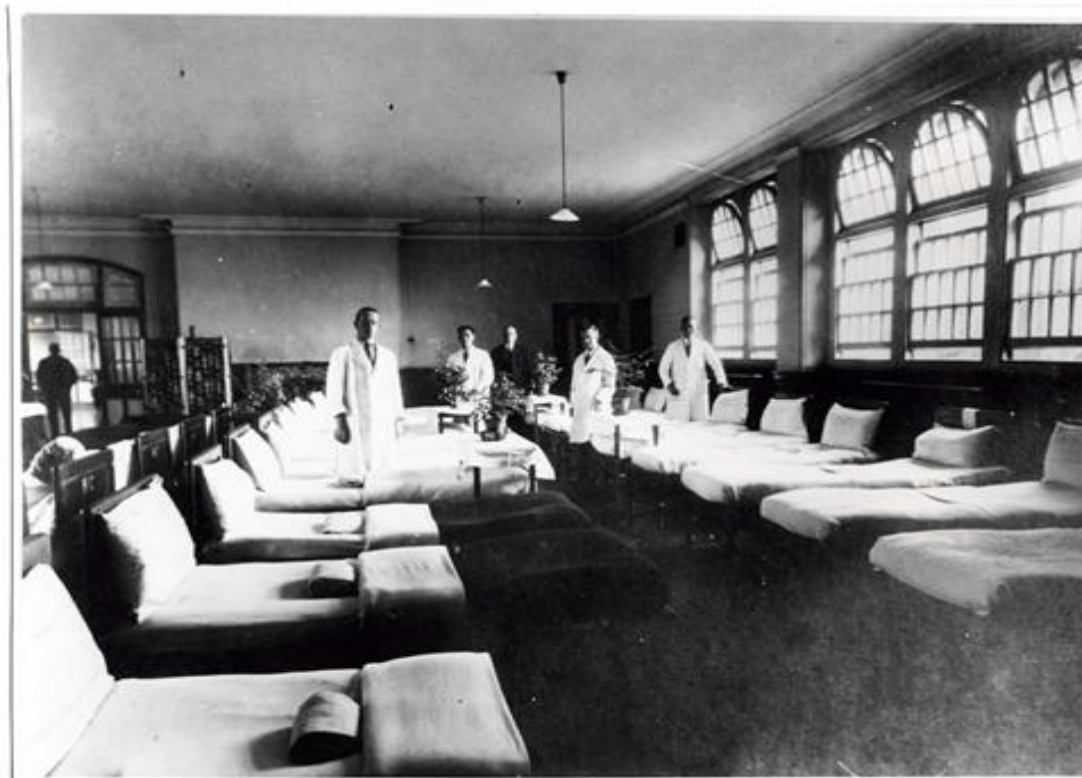


Figure 8. Male ward circa 1946.

Source: Reprinted with permission from the Glenside Hospital Museum, Bristol.

### *Staffing the hospitals*

Despite the advent of the NHS, there was still the on-going problem of staffing the mental hospitals. The overcrowding and low staffing levels meant that large wards were sometimes left with only one nurse on duty. In 1945 a speaker at the 22<sup>nd</sup> meeting of the National Advisory Council for the Recruitment and Distribution of Nurses and Midwives pointed to the ‘loneliness and responsibility of ward duty’.<sup>125</sup> Unna Drinkwater recalls how she was often the only nurse on night duty: ‘There’d only be me on duty sometimes for about fifty patients, it was difficult when you had patients on insulin treatment; sometimes they would go into a coma and not come out of it’.<sup>126</sup>

<sup>125</sup> Chatterton “*The weakest link in the chain of nursing?*”, p. 67.

<sup>126</sup> Unna Drinkwater, interviewed 29<sup>th</sup> December 2009.

Chatterton posits several reasons for the shortage of mental nurses. These included: the isolation of the mental hospitals; stigma and low status; the negative attitude of the general public; prejudices from general nurses; low pay; female nurse wastage due to marriage; poor working conditions; shifts; strict discipline; competition from other fields, i.e. teaching and clerical work; and lack of promotion.<sup>127</sup> This enduring staffing problem can begin to ‘explain how nursing staff on some of the more overcrowded wards began to develop time-saving practices which compromised the dignity of those in their care’.<sup>128</sup>

### *Conveyer-belt care*

One of the main priorities of nursing care was to manage large numbers of patients, with the least risk of harm. Hospital routines and hierarchical systems of supervision allowed the nurses to process large numbers of patients with comparative safety.<sup>129</sup>

Bathing, for example, was a very organised activity:

It was like a production line in a factory at bath time – there were naked bodies everywhere. Staff in one room would undress the patients and pass them through the door to me in the bathroom. I would bathe them, wash their hair and pull them out of the bath. I’d then push them through the door to another set of nurses who would dry them and check them for any injuries. The next lot was usually in before the dirty water had fully drained out of the bath. Everything was ultra, ultra safety and routine and very little personal dignity or whatever. But because it was the norm you didn’t question it.<sup>130</sup>

On the “back wards” nearly all the patients were incontinent, and you were on the go all night, changing beds and toileting patients. We used to put buckets all around the ward so the

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<sup>127</sup> Chatterton “*The weakest link in the chain of nursing?*”, pp. 77 – 103.

<sup>128</sup> Hopton, ‘Prestwich Hospital in the Twentieth Century’, p. 349.

<sup>129</sup> Adams, *Challenge and Change in a Cinderella Service*, p. 195; Prebble, ‘*Ordinary Men and Uncommon Women*’, p. 120.

<sup>130</sup> Susan Traherne, interviewed 30<sup>th</sup> December 2009.



patients could urinate in them. It would make me heave [almost vomit] having to empty those out in the morning.<sup>131</sup>

Hopton argues that some of these practices may have been implemented to facilitate nurses to cope with enduring staff shortages. He goes on to suggest that they may have continued for longer than was required because staff were suffering from ‘burnout’.<sup>132</sup> However, he also suggests that it is important to note that as late as 1957, the only remark which the Commissioners of the Board of Control made about the modernization of the central male bathroom at Prestwich Hospital, Manchester, was to express reservations about the use of showers in some ward bathrooms during the carrying out of the scheme for the modernization of the male bathroom.<sup>133</sup> This could be interpreted as an implicit endorsement of sustained use of the general bathroom, such as that pictured below (Figure 9).

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<sup>131</sup> Peter Mellor, interviewed 8<sup>th</sup> August 2010.

<sup>132</sup> “Burnout” can be described as physical and emotional exhaustion and loss of compassion and empathy owing to intense involvement with other people over a prolonged period of time: Hopton, ‘Prestwich Hospital in the Twentieth Century’, p. 355.

<sup>133</sup> City of Salford Local History Library, Manchester Regional Hospital Board Minutes, Report of Buildings and Works Committee, 3 May 1957 in Hopton, ‘Prestwich Hospital in the Twentieth Century’.



**Figure 9. Communal bathroom at Glenside Hospital, Bristol circa, 1950s.**  
**Source: Reprinted with permission from the Glenside Hospital Museum, Bristol.**

Many of the things that have been described above are evidence of an immense gulf between the prescriptions of theory, the intentions of policy and the realities of practice. For example, even though dignity, compassion and privacy were not accentuated in mental health nursing literature until much later, the 1923 edition of *The Handbook for Mental Nurses* stated that ‘bathing should not be too hurried’.<sup>134</sup> Hopton argues, however, that in situations where up to forty individuals were expected to bath in a matter of a few hours using only five or six baths, it was impossible to conform to the demands of this injunction.<sup>135</sup> Prebble suggests that ‘Conveyer belt care, at its best,

<sup>134</sup> Royal Medico-Psychological Association, *Handbook for Mental Nurses* (London, 1923/1939).

<sup>135</sup> John Hopton, ‘Daily life in a 20<sup>th</sup> Century Psychiatric Hospital: An Oral History of Prestwich Hospital’, *International History of Nursing Journal* 2 (3) (1997), p. 33.

achieved standardisation and protection from harm'.<sup>136</sup> Mental nurses took pride in their standard of care of severely infirmed patients, which included conducting regular bed changes and toileting to prevent pressure sores. Nevertheless such practices rarely upheld an individual's privacy or dignity.<sup>137</sup>

### *Discipline*

Mental nurses' working lives were conducted within a comprehensive and custodial framework where a breach of discipline could lead to instant dismissal. When staff joined the asylum payroll they were typically issued with a long list of rules and also asked to sign 'obligation forms'.<sup>138</sup> The rules tightly circumscribed staff actions when managing high-risk situations such as bathing, mealtimes, fires and "constant observations". Infringement of them could lead to instant dismissal.

Carpenter argues that living in and working long hours allowed the Medical Superintendents 'almost absolute power' over their nursing staff, and the Superintendent was seen as a figure of great prestige and power.<sup>139</sup> The majority of nurses in this study established a subordinate relationship with medical staff and this notion will be taken further in Chapter IV when we are introduced to the "subordinate nurses" within the study. Carpenter goes on to posit that 'nursing is, of course, an occupation noted for its authoritarian management'.<sup>140</sup> Within mental hospitals the Matron or Chief Male Nurse (CMN) was at the top of the nursing hierarchy. Furthermore, individual wards were the undisputed territory of their individual Charge Nurse or Sister who might have worked on that ward for decades and thereby defined

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<sup>136</sup> Prebble, *Ordinary Men and Uncommon Women*, p. 113.

<sup>137</sup> Prebble, *Ordinary Men and Uncommon Women*, p. 113.

<sup>138</sup> Mick Carpenter, *They Still Go Marching On* (London, 1985), p. 12.

<sup>139</sup> Carpenter, *They Still Go Marching On*, p. 10.

<sup>140</sup> Carpenter, *They Still Go Marching On*, p. 15.

its culture. If such a person became embittered or ‘burnt out’, their indifference to those in their care could be ‘infectious’:<sup>141</sup>

The Charge Nurses were in complete control of their wards and nobody ever challenged them. Many of them spoke in a bullying way to patients; they were arrogant and always spoke down to staff. They were men who were familiar with violence because of the War and took it for granted. I was a coward – I should have done something about it, but those to whom I would have had to complain were part of the same system. Patients who were beaten were seen by the Medical Superintendent who invariably accepted the account of the incident given by the Charge Nurse which was always untrue.<sup>142</sup>

### *A divided profession*

Towards the end of the 1940s, there was a status divide, in so far as the female Matron was senior to the CMN. She was in charge of nurse training; she was a member of the Hospital Management Committee, and there were instances where she earned £120 a year more in pay than her male counterpart.<sup>143</sup> This was markedly different from other professions, as before 1970, it was common practice in the private sector and some parts of the public sector for there to be separate and lower women's rates of pay.<sup>144</sup> In the pre-Rushcliffe era, the CMN was known as the ‘Head Attendant – a person resplendent in braid and brass buttons who could be relied upon to produce male “nurses” who could move beds and bodies about, fill coal bunkers, empty dustbins, and any other job which required strength rather than skill’.<sup>145</sup> CMNs began to feel isolated, as they were not involved with the training of nurses or in policy making. Furthermore, they could not join the Royal College of Nursing (RCN) and were refused entry to the

<sup>141</sup> Hopton, ‘Daily life in a 20<sup>th</sup> century psychiatric hospital, p. 33.

<sup>142</sup> Testimony of a male nurse in: Nolan, *Psychiatric Nursing Past and Present*, p. 215.

<sup>143</sup> Nolan, *Psychiatric Nursing Past and Present*, p. 204.

<sup>144</sup> For example, at the Ford Motor Company, before a new pay structure was introduced in 1967, there were four grades for production workers: male – skilled; male - semi-skilled; male – unskilled; and female: National Union of Teachers, ‘*Equal Pay & The Equal Pay Act 1970*’ available at: <http://www.teachers.org.uk/node/12977> [last accessed 27 January 2012].

<sup>145</sup> Nolan, *Psychiatric Nursing Past and Present*, p. 205.

Matrons' Association meetings. This led to the establishment of the National Association of Chief Male Nurses.

*Poor treatment of patients*

The treatment of patients was sometimes poor. Some were not discharged after making much improvement, and were kept in complete suspense about whether or not they would ever be discharged. Other patients appeared entirely sane to some nurses. However, they were not discharged, as they were perceived to be good workers. There were staff who were aggressive towards patients and others who took a delight in teasing and provoking the most vulnerable of patients.<sup>146</sup> Nolan found that some participants in his study had disapproved of the treatment of patients. However, behaviours such as senior nurses announcing that they were coming onto wards by tapping on pipes to give a warning, in order to avoid getting a true impression of what was going on, affirmed to the participants that complaints would not be properly investigated, if at all.<sup>147</sup>

Alexander Walk and Richard Hunter have argued, however, that some mental nurses had a very influential role in effecting the positive changes that occurred during this time period.<sup>148</sup> In 1959 Teodoro Allyon and Jack Michael reported on a project in which mental nurses were utilised as 'behavioural engineers' to change patients who 'failed to engage in normal activities'. These activities included not tending to their personal hygiene needs and expressing their anger in 'inappropriate' ways.<sup>149</sup> Further, following a

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<sup>146</sup> Nolan, *Psychiatric Nursing Past and Present*, p. 216.

<sup>147</sup> Nolan, *Psychiatric Nursing Past and Present*, p. 217.

<sup>148</sup> Richard Hunter, 'The Rise and Fall of Mental Nursing', *The Lancet*, 1 (1956), p. 3; Walk, 'The History of Mental Nursing', pp. 1-17.

<sup>149</sup> Teodoro Allyon & Jack Michael, 'The Psychiatric Nurse as Behavioral Engineer', *Journal of Experimental Analysis of Behavior*, 2 (1959), pp. 323-333.

transformation at the Glasgow Royal Mental Hospital, it was noticed that those patients:

Paid more attention to their appearance, and some began to sew, draw, or make rugs. Most of them took over small jobs which they jealously insisted on doing themselves. Thus, at tea-time, one patient made the tea, another laid out the cups, a third put the sugar on the table, another the milk, yet another spread the table-cloth, and so on.<sup>150</sup>

The transformation discussed above was initiated by doctors, however, and involved patients and nurses spending time together. Nurses were allocated to the same patients each day and gradually the patients began to know them and relax in their company. Patients were encouraged to read, talk to each other and do things for themselves. Therefore, it could be argued that some nurses during this period were possibly beginning to identify themselves as autonomous therapeutic practitioners, who could have a positive outcome on the patients, as opposed to merely containing them.<sup>151</sup>

However, for the majority of nurses there was little room for independent decision-making, as Elliot Whitman recalled: ‘The Charge Nurse told you what you were doing that day, you just did what you were told.’<sup>152</sup> Meanwhile, Terry Orchard recalls the minimal thinking he did while practising as a nurse: ‘My thinking was done for me by the doctors, because I had no evidence to counter it.’<sup>153</sup> Most were guided almost entirely by verbal instructions from ward charges or the next most senior nurse:

It seemed as if we were marooned in time – nothing much ever happened, nothing much ever changed – and every task was repeated each day over and over again.<sup>154</sup>

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<sup>150</sup> John L. Cameron & Robert D. Laing, ‘Effects of Environmental Change in the Care of Chronic Schizophrenics’, *The Lancet*, (1955), pp. 1384-1386.

<sup>151</sup> See also Peter Nolan, ‘Reflections of a Mental Nurse in the 1950s’, *Royal College of Nursing History of Nursing Journal* 5 (1994), pp. 150-156.

<sup>152</sup> Elliot Whitman, interviewed 20<sup>th</sup> March 2010.

<sup>153</sup> Terry Orchard, interviewed 10<sup>th</sup> August 2010.

<sup>154</sup> Testimony of a male nurse in: Nolan, *Psychiatric Nursing Past and Present*, p. 205.

I didn't find the staff that knowledgeable – management, control, reduction of conflict, running a smooth ward – that was the order of the day. I remember saying: “Tell me more about mental illness, and what can I do about it?” They were very good on describing mental illness, but I don't think they were terribly clever on what to do about it.<sup>155</sup>

Within most mental hospitals the order of the day was for nurses to get on with their jobs in an unquestioning and unreflective manner. Hopton argues that there was an entrenched ideology by nurses in mental hospitals, which held that nursing was learnt ‘by watching the example of others, based on “common sense” assumptions and concern with neatness rather than on research-based theory’.<sup>156</sup> This notion will be explored further in Chapters IV and V.

#### *Domestic work*

Mental nursing was hard work, both physically and mentally. In addition to the physical work involved in caring for patients, a lot of nurses' time was also taken up with domestic duties.

There is usually no domestic staff for these wards, and it is not uncommon for nurses to do all the domestic work that patients are unable to do. This has so often been stressed that we will not labour it, but some jobs which nurses do are not so commonly spoken of, such as hauling large bales of laundry without trucks or baskets, emptying pig-swills etc. The male staff are in an even worse case. They do farming, gardening and work of the crudest types, with squads of patients.<sup>157</sup>

Luke Vanston recalled the preoccupation with cleanliness: “The staff were obsessed with cleanliness and hygiene – obsessed with patients being up at a certain time and being

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<sup>155</sup> Luke Vanston, interviewed 23<sup>rd</sup> June 2010.

<sup>156</sup> Hopton, ‘Prestwich Hospital in the Twentieth Century’, p. 360.

<sup>157</sup> Griffiths, Reid and Scott, ‘Reconstruction Scheme for Mental Nursing’, p. 46.

washed, the washing ritual in the morning was terribly important [...].<sup>158</sup> As well as being physically demanding, the work could also be emotionally distressing. Peter Mellor recalls his time on a male long stay ward where patients were expected to spend most mornings walking without purpose around “airing courts” (enclosed courtyards adjacent to wards): ‘It upset me to see those poor lads wandering around the airing courts in the morning. I could not see the point of it. Snow, ice, rain, desert heat: they were out there’.<sup>159</sup> However, the Minister for Health in 1952 portrayed a very different picture of therapeutic approaches being utilised in mental hospitals which, he said meant that, ‘like the general nurse, the mental nurse has the satisfaction of seeing a large proportion of patients cured of their ailments and returned to happy and useful lives’.<sup>160</sup> There was a dissonance between reality and rhetoric.

### *“Dirty work”*

Everett Hughes first coined the term “dirty work” in 1951. He expanded this further in 1958 when he referred to occupations that were considered as socially, morally or physically degrading or disgusting.<sup>161</sup> These occupations are not inherently “dirty” but carry the social construction of “dirtiness”. Prebble suggests that the definition can usefully be applied to mental hospital nursing. Physically, the nurses were intimately involved with the socially unpleasant aspects of bodily function: toileting, washing and hand-feeding.<sup>162</sup> Socially, they were marred by their regular interactions with stigmatised people; this has been known as ‘courtesy stigma’.<sup>163</sup> Dutifully, mental nurses were

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<sup>158</sup> Luke Vanston, interviewed 23<sup>rd</sup> June 2010.

<sup>159</sup> Peter Mellor, interviewed 8<sup>th</sup> August 2010.

<sup>160</sup> British Journal of Nursing, ‘Conference of Mental Hospital Authorities’, *British Journal of Nursing* April 25, p. 26.

<sup>161</sup> Everett C. Hughes, *Men and their Work* (Glencoe, 1958); Everett C. Hughes, ‘Work and the Self’, in John H. Rohrer & Muzafer Sherif (eds.), *Social Psychology at the Crossroads* (New York, 1951), pp.313-323.

<sup>162</sup> Prebble, ‘*Ordinary Men and Uncommon Women*’, p. 199.

<sup>163</sup> The phrase “courtesy stigma” was first posited by Erving Goffman. It refers to the stigma experienced by family, friends and health professionals who closely associate with a person from a stigmatised group: Erving Goffman, *Stigma: Notes on the Management of Spoiled Identity* (Harmondsworth, 1963).



expected to control and contain others; tasks which society demanded but also regarded with vacillation.<sup>164</sup>

Blake Ashforth and Glen Kreiner argue that members of a group who carry out 'dirty work' come to personify the work itself, and therefore become "dirty workers". They go on to posit that people involved in dirty work employ a range of strategies to construct an affirmative shared identity.<sup>165</sup> Prebble suggests that one of the central strategies is that of social cohesion and the emergence of a strong occupational and work group. She argues that mental nurses developed strong networks that traversed work, sport and social activities. These networks were strengthened by the social isolation engendered by physical distance and shift work.<sup>166</sup> Nurses were expected to care for people in severe psychological distress whom society had turned their back on. Nurses were exposed to extraordinary sights, sounds, smells, and patients presenting with bizarre behaviour. Both the former patients and nurses in this study reflected on the "mismatch" of patients on the wards where they worked or received their treatment. Gregory Gregson recalls, 'I remember thinking: "Am I mad like these other people?" There were depressed people, schizophrenics, and a young boy with anorexia. It was crazy'.<sup>167</sup> Endeavouring to generate a "therapeutic environment" in these conditions created a sense of incongruity. For nurses to survive, they had to become resilient and view their work as normal.<sup>168</sup>

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<sup>164</sup> Prebble, *Ordinary Men and Uncommon Women*, p. 199.

<sup>165</sup> Blake E. Ashforth & Glen E. Kreiner, "How can they do it?" Dirty Work and the Challenge of Constricting a Positiver Identity', *Academy of Management Review* 24 (1999), pp. 413-434.

<sup>166</sup> Prebble, *Ordinary Men and Uncommon Women*, p. 200.

<sup>167</sup> Gregory Gregson, interviewed 2<sup>nd</sup> January 2010.

<sup>168</sup> Prebble, *Ordinary Men and Uncommon Women*, p. 202.

## Living and working on the fringe: the hidden history of gay life in mental hospitals

Not only was there great disparity in the mix of patients within mental hospitals: the staff who worked within them also came from varied sections of society.<sup>169</sup> By virtue of their position on the fringes of “respectable society”, mental hospitals appeared to represent a space where variation not only within the patients but also within the workforce could be relatively accepted. For some staff, their difference was their “counter-cultural”<sup>170</sup> lifestyle or a problem with substance misuse.<sup>171</sup> However, for others it was their sexual orientation. For some nurses, deciding to place themselves among an already stigmatised population was a fairly easy choice, as one nurse in Diana Gittins’ study of Severalls Hospital in Colchester, Essex deliberated, ‘Where better to hide the stigma than in a stigmatised population?’<sup>172</sup>

There is evidence to suggest that there was a lesbian nurse sub-culture within some mental hospitals.<sup>173</sup> However, there is a dearth of literature, which discusses the sub-culture of homosexual male nurses in mental hospitals. Indeed, Prebble found that homosexual male nurses were not as visible as lesbian nurses in the psychiatric nursing community of New Zealand in the 1960s, and that the dominant culture on the male nursing side was ‘blokey’ and, on the whole, not supportive of sexual difference.<sup>174</sup> Conversely, despite the culture of toughness and sporting prowess amongst some male staff in UK mental hospitals,<sup>175</sup> and the pathologising attitudes towards homosexuality discussed in the previous chapter; on analysis of the testimonies of the nurses

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<sup>169</sup> See, e.g. Chatterton “*The weakest link in the chain of nursing?*”; Gittins, *Madness in its Place*.

<sup>170</sup> “Counter-culture” is a sociological term used to describe the values and norms of behaviour of a cultural group, or subculture, that run counter to those of the social mainstream of the day. Counterculture can also be described as a group whose behaviour deviates from the societal norm.

<sup>171</sup> Prebble, ‘*Ordinary Men and Uncommon Women*’, p. 203.

<sup>172</sup> Gittins, *Madness in its Place*, p. 155-156.

<sup>173</sup> See, e.g. Jivani, *It’s Not Unusual*, p. 71-72; Prebble, ‘*Ordinary Men and Uncommon Women*’, pp. 203-207.

<sup>174</sup> Prebble, ‘*Ordinary Men and Uncommon Women*’, pp. 197 & 204.

<sup>175</sup> Tommy Dickinson & Karen M. Wright, Stress and Burnout in Forensic Mental Health Nursing: a review of the literature *British Journal of Nursing*, 17 (2) (2008), p. 85.

interviewed in this study, it appears that there may have been an overt homosexual male sub-culture among nurses in some mental hospitals in the UK, and these men were generally accepted. Indeed, four of the nurses I interviewed identified themselves as gay men.

While the nature of this study may have attracted more gay volunteers, which could perhaps give a distorted impression of a sizeable proportion of gay men in the workforce, Charles Dance who, is heterosexual, reflected:

[...] there was a very strong gay contingent of staff. Moreover, their behaviours were quite overly gay most of the time too, but because it was an enclosed community and, you know, in the sense that it was ten miles from town in the middle of a forest, it didn't matter, nobody bothered that much about it.<sup>176</sup>

A mental hospital could be a refuge, a workplace or a holiday camp,<sup>177</sup> and as such within these hospitals, some gay men found a lively atmosphere, a culture and a community to which to belong. With their network of wards, underground tunnels and departments, mental hospitals created an ideal space and a unique climate where homosexual male nurses could meet lovers and a social climate of fleeting love, romance and sexuality. The homosexual male sub-culture within the mental hospitals was multifaceted, with different types of nurses having their own implicit rules and behaviours; this included status distinctions, for example, between the lower ranking SENs and the nursing officers in the higher ranks. The level of acceptance these men experienced has important implications for this study, as there appears to be a

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<sup>176</sup> Charles Dance, interviewed 5<sup>th</sup> December 2010.

<sup>177</sup> It has been argued that the introduction of holiday-camp type activities within mental hospitals, which included the formation of cricket and football teams amongst staff and patients in the 1920s and 1930s, can be attributed to the holiday camps which were becoming popular at the time. See e.g. Nolan, *A History of Mental Health Nursing*, p. 96.

dichotomy as Emily Whitbread reflects:

[...] it was a very, very odd contradiction. Mental hospitals were a refuge for male gay nurses, but looking back, quite horrendous for gay patients. Ironically, I don't ever recall any of them [gay male nurses] refusing to administer the treatments either. Very interesting.<sup>178</sup>

Concurring with the above testimony, all the homosexual nurses interviewed in this study administered distressing treatments to “cure” homosexual patients in their care, and this contradiction warrants further exploration. In parallel with Barker and Stanley's work exploring gay life at sea, there are three important points that need to be understood in order to examine what life was like for homosexual male nurses in mental hospitals. First, it is important to note that each nurse experienced these institutions differently. The nurse's openness regarding his homosexuality, his social class and the job he did were important factors. Secondly, mental hospitals offered a special kind of culture, even a community. Finally, they also offered spaces that homosexual (and heterosexual) nurses could use to their advantage.<sup>179</sup>

### *Identity boundaries*

In order to understand the relationship between these nurses and their mental hospitals, we need to first consider the level of openness that individual nurses displayed regarding their sexuality. In parallel with the higher-ranking officers in the army during World War II, discussed in the previous chapter, the homosexual nursing officers within mental hospitals also had to be very covert regarding their sexuality. Meanwhile the lower ranking nurses such as nursing assistants, SENs and staff nurses could be more overt regarding theirs and still be accepted. In addition, mental hospitals were very

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<sup>178</sup> Emily Whitbread, interviewed 7<sup>th</sup> January 2010.

<sup>179</sup> Baker & Stanley, *Hello Sailor!*, p. 66.

hierarchical places to work and many gay nursing officers felt that they could not mix with gay men of lower rank.<sup>180</sup> Peter Mellor, who was a nursing officer, recalls:

I remember thinking that it would ruin everything I had worked so hard to achieve if I came out as gay to my colleagues. I could get quite jealous sometimes at some of the nursing assistants' and SENs' freedom, and their ability to be blatantly homosexual. I mean some of them, looking back, were totally outrageous! There were others, however, that I actually found very attractive, but I knew if I was seen chatting to them in the hospital social club, for instance, it could incriminate me.<sup>181</sup>

Carol Warren defined the polarities between covert and openly gay men, which correspond with the situation we see amongst the homosexual male nurses in this study. She recognised men who perceived themselves as 'essentially normal, deviating only in the choice of sexual partner, a deviance that they could conceptually minimise'.<sup>182</sup> I would argue that this was the arrangement for the homosexual nursing officers. Conversely, Warren identified gay men on the opposite end of the spectrum, who saw 'themselves as completely outside society... [They] organise their entire lives, including the working lives, around the self-definition and the deviance'.<sup>183</sup> In essence, she suggests that these individuals cope with being part of a frequently stigmatised group by flaunting their difference. These traits tended to be most popular with the lower ranking staff, as Adam Carter, an SEN, recalls:

We [other homosexual lower ranking nurses] had a fabulous time and I was never ashamed of my sexuality. We were at it like rabbits too; there were lots of places to have fun in a mental hospital without others seeing... [Laughs]... I also remember me and some other SENs, who I had been friends with since we were pupil nurses together, used to get "dragged up" when the hospital social club was having a fancy dress party. We were the

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<sup>180</sup> A similar pattern has been noted in gay men at sea. Robert, a purser, knew it would be 'career suicide' if he were found chatting up a crewman he fancied. On his first ship he noticed that 'the strange thing was in the Merchant Navy [that]...while it was quite accepted for stewards and cooks and all those people to be gay, as an officer you really had to keep it covered up': Baker & Stanley, *Hello Sailor!*, pp. 62-63.

<sup>181</sup> Peter Mellor, interviewed 8<sup>th</sup> August 2010.

<sup>182</sup> Carol A. B. Warren, *Identity and Community in the Gay World* (New York, 1974), p. 39.

<sup>183</sup> Warren, *Identity and Community in the Gay World*, p. 43.

“belles of the ball”... [Laughs]... We always went down a storm and I don’t really remember anyone complaining.<sup>184</sup>

It is clear from the above testimonies that lower ranking nurses could be very open in the way they expressed their sexuality; however, the higher-ranking nursing officers appeared to have believed that they had to be exceptionally furtive regarding theirs. This echoes the behaviour of homosexual men in the armed forces during World War II, which I discussed in Chapter II. Houlbrook argues that among the working class culture, individuals were more accustomed to sexual openness. Young workingmen were not labelled ‘queer’ or ‘pansies’ because they had sex with men. He argues that such encounters were sufficiently accepted, and that ‘men could openly look for, enjoy, and talk about male partners without worrying about any potential repercussions.’<sup>185</sup> This offers a context to explain why the lower ranking “working class” nurses may have been more overt in how they expressed their sexuality.

*The mental hospital as a community*

The insularity of the mental hospitals, coupled with the fact that many nurses lived within the confines of the hospital walls, created a lifestyle in which social networks were strong and the boundaries between work and “home” were porous.<sup>186</sup> Mental hospitals could offer a homosexual male nurse a community where they could be open regarding their sexuality and sometimes very overt in how they demonstrated this. Baker and Stanley also found this with gay men at sea, as they were able to express feelings, explore outlawed desires, gain new knowledge, and belong to a culture as well as a community.<sup>187</sup> Within the mental hospitals, this culture had its own rules regarding how one should behave, as we have seen above. It also had its own rituals. One such

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<sup>184</sup> Adam Carter, interviewed 25<sup>th</sup> March 2010.

<sup>185</sup> Houlbrook, *Queer London*, p. 168.

<sup>186</sup> Prebble, ‘*Ordinary Men and Uncommon Women*’, p. 192.

<sup>187</sup> Baker & Stanley, *Hello Sailor!*, pp. 65.

ritual was for the homosexual nurses to try to have their breaks together while they were on duty:

There was a table in the staff canteen. It was known as “The Queens’ Table”...[Laughs]...That is because we [other homosexual lower ranking gay nurses] all used to sit together on it at break times. We would go to great lengths so we could all have a break at the same time.<sup>188</sup>

Furthermore, twelve of the nurses I interviewed in this study commented on the emphasis that many homosexual male nurses placed on domesticity, particularly on their wards:

I remember \*\*\*\* [Name of nurse], he was an SEN on \*\* [Name of ward]. It was a female ward and he took great pride in it. He would use the ward funds to buy flowers to put round the ward and at meal times, he insisted on arranging napkins on the tables. When it was time for the staff to sit down and have a “brew” together, the best China would come out with a matching teapot. It had a very homely feeling and I loved working there.<sup>189</sup>

Despite the ward in Figure 10 looking rather institutionalised with the beds all in line, I would argue that there is some attempt to domesticate it with the flowers that have been arranged around the ward.

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<sup>188</sup> Elliot Whitman, interviewed 20<sup>th</sup> March 2010.

<sup>189</sup> Julian Glover interviewed, 4<sup>th</sup> January 2010.



**Figure 10. Female ward circa 1960s.**

**Source: Reprinted with permission from the Glenside Hospital Museum, Bristol.**

For some homosexual male nurses, to be open regarding their sexuality within a mental hospital meant that not only could they express their personal feelings, but that they also joined a collective that emphasised the importance – moreover the normality – of being homosexual. Newly gay male nurses, as with newly gay seafarers, became part of the process of making publicly visible what was ashore or outside the hospital boundaries, illegal and offensive. It was an affirmation both of the individual and the newly visible culture of which he was part.<sup>190</sup>

However, not all men who had homosexual sex within mental hospitals became part of this culture, as we have seen with the testimony of Peter Mellor. There were others who may also have had a wife or a girlfriend outside or even inside the hospital. Therefore, their membership status within this culture may have only been temporary or non-

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<sup>190</sup> Baker & Stanley, *Hello Sailor!*, pp. 66.



existent. Houlbrook argues that opportunistic ‘homosex’<sup>191</sup> and intimacy was very common prior to the gay liberation movement in the 1970s. He goes on to indicate that ‘homosex and intimacy were integrated within erotic and affective lives that encompassed male *and* female partners’.<sup>192</sup> This could have been exacerbated by the fact that in the early asylums, male nurses often occupied all-male residential, labour or leisure spaces, given the strict segregation between males and females in mental hospitals, meaning that their interactions with women were limited.<sup>193</sup>

### *Contradictions*

Arguably one of the most interesting paradoxes with this finding, however, is the fact that all the homosexual male nurses interviewed administered treatments to cure patients of the same “illness” as they themselves had. Terry Orchard reflects on this contradiction:

The men I nursed had all been referred from their GP or another psychiatrist. So I thought they must have already been asked to explore the notion of accepting their sexuality. I just assumed, therefore, that they couldn’t do that. I then thought: “Well I have got to try and help that person.” Because you have to realise, they were usually very distressed about it. I guess that was the different thing between me and them. I wasn’t distressed by my sexuality. These men included priests for whom their sexuality was a great contention with their religious beliefs. Or there were married men who were willing to try anything to get rid of their homosexual desires. All of these men were willing to do or try anything to make them straight. Although my experience of being gay was very different, I suppose I just thought: “I’ve got to help them.” There were others on a court order so they had to have the treatments really. I have to be honest too, only being an SEN I don’t really know how I would have been able to get out of doing it anyway. I didn’t really want to question my superiors.<sup>194</sup>

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<sup>191</sup> Houlbrook uses the term “homosex” as an amalgam that indicates sexual activities of various sorts between two males without making any assumptions about the motivations of those activities – without e.g. viewing the individuals who engaged in such acts as “gay”.

<sup>192</sup> Houlbrook, *Queer London*, p. 168.

<sup>193</sup> Arton, *The Professionalization of Mental Nursing*, p. 57.

<sup>194</sup> Terry Orchard, interviewed 10<sup>th</sup> August 2010.

However, Peter Mellor believed that objecting to the treatments or refusal to assist with them could bring his sexuality in to question:

Being a nursing officer my time doing “hands-on” nursing care was limited. However, I remember the winter of 1961. We had a lot of staff sickness that year and we were really short-staffed on the wards, so I was helping out on one of them. That is where I nursed the young chap who was being treated for homosexuality. Some of the nurses appeared to enjoy what they were doing to him. This confirmed what I probably already knew: some of the male nurses were very homophobic. This made me even more determined not to draw any attention to myself. I remember feeling sickened by what we did to him, and it still haunts me to this day. I was a coward and selfish. I just didn’t want anyone to know I was gay so I just went along with it.<sup>195</sup>

Furthermore, Adam Carter perceived the introduction of treatments for sexual deviations as a positive and sympathetic move from the government:

To be honest, at the time, I was quite pleased that they [the government] had started to say that treating homosexuals and transvestites was the way forward. I mean I originally thought that putting them [homosexuals and transvestites] in hospital and supporting them was a lot more humane than putting them in prison.<sup>196</sup>

For Peter Mellor, the irony is that he was just as willing to do anything to hide his sexuality as some of his patients were willing to do anything to change theirs. However, for Terry Orchard and Adam Carter, their justifications for partaking in the administration of the aversion therapy appear to be embedded in the notion of beneficence and the inability to question their superiors. Nevertheless, homosexual male nurses appear to have been broadly accepted within mental hospitals. Prebble proposes that the marginalisation of the mental nursing community created an

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<sup>195</sup> Peter Mellor, interviewed 8<sup>th</sup> August 2010.

<sup>196</sup> Adam Carter, interviewed 25<sup>th</sup> March 2010.

environment in which difference could be both understood and accommodated. By choosing to work with people who were on the margins of ‘respectable society’, she posits that mental nurses made room for their own ‘queer folk’.<sup>197</sup>

I would argue that the sense of community and acceptance these homosexual male nurses experienced within mental hospitals may also have inured them from objecting to the treatments. Chapters IV and V explore the abusive tactics that were sometimes used to force nurses to leave the hospital if they became oppositional or questioned higher authority. Furthermore, Chapter II explored the oppression many homosexuals faced. Therefore, it could be reasoned that the homosexual nurses in this study would have had a lot to lose if they were no longer part of this safe and accepting culture. This could offer a context to explain their participation in aversion therapy. Moreover, an interesting finding with the homosexual male nurses in this study is that all, except one, were SENs, and as discussed above, SENs were also known as “subordinate” nurses. The implications of these nurses being known as subordinate, and the notions of beneficence and subservience, will be explored in Chapter IV.

### **Mental Nurse Education, 1925 – 1951**

As discussed in the introduction to this thesis, the GNC introduced their own alternative training programme leading to registration as a Registered Mental Nurse (RMN) in the early 1920s. Therefore, there were two routes leading to mental nurse registration between the early 1920s and 1951, provided by the MPA (RMPA from 1926) and the GNC. However, there was a bitter conflict throughout this period between the two organisations regarding who should have overall responsibility for training mental nurses.

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<sup>197</sup> Prebble, *‘Ordinary Men and Uncommon Women’*, p. 192.

After the end of the “period of grace”, discussed in the introduction to this thesis, in June 1925, the GNC stated that they would no longer recognise the MPA certificate for the purpose of registration, although members of the MPA would still be instrumental in acting as examiners for them.<sup>198</sup> The rationale behind this decision was that ‘the time had come for a statutory body, such as the GNC, to stand on its own two feet and not delegate any of its work or responsibilities to another body’.<sup>199</sup> However, the MPA/RMPA refused to renounce their role and the two organisations ‘kept up a bitter conflict through the pages of various journals and committees of enquiry throughout the 1920s and 1930s’.<sup>200</sup> Harrington suggests that gender differences contributed to the opposition between the two organisations. She argues that the GNC were keen to promote the image of the nurse as predominately middle class and female. Conversely, mental nurses were mainly male and were perceived to be lower in regard to both general calibre and professional status, and ‘thus trailed behind their “Sisters” in general hospitals’.<sup>201</sup>

On 4<sup>th</sup> November, 1943, the Society of Mental Nurses was founded. Initially it consisted of 70 mental nurses and they met under the auspices of the Royal College of Nursing’s (RCN) London Branch to discuss organisational and educational matters.<sup>202</sup> The notes of the first meeting suggest that there was a widely held view amongst the nurses present, and mental health nurses in general, that training should be controlled by a single nursing body – the GNC; it was also hoped that general trained nurses could

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<sup>198</sup> Chatterton, “Caught in the Middle?”, p. 32.

<sup>199</sup> General Nursing Council for England and Wales, minutes of Mental Nurses Sub Committee, 1<sup>st</sup> December 1926, in Chatterton, “Caught in the Middle?”, p. 32.

<sup>200</sup> Robert Dingwall, Anne Marie Rafferty & Charles Webster, *An Introduction to the Social History of Nursing* (London, 1988), p. 125.

<sup>201</sup> Harrington, *Voices Beyond the Asylum*, p. 8.

<sup>202</sup> The birth of the Society of Mental Nurses was symptomatic of the fact that in 1943, some mental nurses felt they had no forum in which to voice their opinions. However, as the years passed, membership began to fall, and in 1972, the society was terminated. The rationale behind this was that it was felt that there was no longer any need to have a separate organisation for mental nurses, as the RCN had adopted a more open policy towards them: Nolan, *Psychiatric Nursing Past and Present*, pp. 197-198.

be attracted to work in psychiatric and mental handicap hospitals, thus raising the standards and status of nursing therein.<sup>203</sup>

However, the majority of nurses appeared to choose the RMPA's course. Nolan argues that this was due to it being a more practical course and more prestigious due to it being controlled by doctors.<sup>204</sup> Conversely, the society favoured the GNC's training scheme, leading to Registered Mental Nurse status, on the grounds that it was a more rigorous course, and was more like the training of general nurses. The RMPA course was seen as inferior and lacking credibility:

The quality of those recruits [for the RMPA] makes it doubtful if they would be accepted for training by the General Nursing Council, even as Enrolled Nurses. If the RMPA stopped examining, we should be left with a group of nurses for whom no training was possible.<sup>205</sup>

The Interdepartmental Nursing Committee, chaired by Lord Athlone, had been set up in 1937 by the government in response to concern about shortages and wastage of nurses, with a subcommittee specifically to examine mental nursing. However, due to the War, the Committee's report was delayed until 1946, when it recommended the cessation of the two systems of training.<sup>206</sup> In May and June 1946 the GNC and the RMPA both held meetings, and agreement was finally reached that the RMPA would discontinue their training scheme. The last cohort of students to qualify under the RMPA's scheme started their training in 1948, and by 1951, training for mental nurses had passed entirely into the hands of the GNC.<sup>207</sup> In addition, the GNC agreed to

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<sup>203</sup> Arton, *The Professionalization of Mental Nursing*, p. 71; Nolan, *Psychiatric Nursing Past and Present*, pp. 195-196.

<sup>204</sup> Peter Nolan, 'Mental Nurse Training in the 1920s', *History of Nursing Group of the Royal College of Nursing* 10 (1986), p. 18.

<sup>205</sup> 'A Brief History of The Society of Mental Nurses, 1943-1972', in Nolan, *Psychiatric Nursing Past and Present*, p. 197.

<sup>206</sup> Chatterton, "'Caught in the Middle'?", p. 32.

<sup>207</sup> Nolan, *A history of mental health nursing*, p. 104.

recognise holders of the RMPA certificate for admission to the register. They also agreed to the inclusion of psychology in the syllabus, at the request of the RMPA.<sup>208</sup>

*Educating mental nurses regarding “sexual deviations”*

There is a dearth of literature in nursing textbooks during this period which discuss sexual deviations. The texts that do discuss homosexuality and transvestism do so under the auspices of “Sexual Perversions”, “Sexual Anomalies” or “Sexual Disorders”.<sup>209</sup> Furthermore, the emphasis in these texts appears to be on describing these disorders rather than educating nurses how to actually care for this patient group. Some of the nurses in the study recalled the education they received regarding homosexuality and transvestism, and its limitations in regard to equipping them with the skills required to actually nurse these patients. Pat Mullins recalls, “They were very good at describing sexual deviants, but not so good at giving us the skills to actually nurse these patients’.<sup>210</sup> Other nurses recalled their education regarding sexual deviants:

In lectures the tutors would lump abnormal sexuality into a common pot, so the fact that you might have paedophile tendencies, or you might be gay, was all the same, it was all deemed to be wrong. They would be lumped into this bag of, you know, deviants if you like.<sup>211</sup>

I do remember a lecture that was given at the \*\*\*\*\* [name of the hospital]. This lecture was on deviancy, and as part of deviancy, homosexuality and transvestism came up. It was talked about in the same vein as criminality. Homosexuality and transvestism were included in a bunch of lectures that were given by a consultant. Now how it was presented to us was that these behaviours were deviancies, and they came as part of a package of deviancies. They were seen as a denial of who you were, an adoption of a lifestyle that you chose, rather than had to. There was also gain to be had from behaving and acting as a

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<sup>208</sup> Chatterton, “Caught in the middle?”, p. 34.

<sup>209</sup> See, e.g. Brain Acker, *Handbook for Psychiatric Nurses* (London, 1964), pp. 108-116; Ivor R. C. Bachelor, *Henderson and Gillespie’s Textbook of Psychiatry* (Oxford, 1962), pp. 197-209.

<sup>210</sup> Pat Mullins, interviewed 14<sup>th</sup> July 2010.

<sup>211</sup> Emily Whitbread, interviewed 7<sup>th</sup> January 2010.

homosexual or a transvestite, but they were not normal – that was the point that was trying to be got across.<sup>212</sup>

These testimonies highlight that the education nurses received regarding homosexuality and transvestism had a clear emphasis on viewing these people as abnormal, with little importance paid to actually educating nurses on how to care for these individuals. Indeed Jackie Fletcher recalled, ‘I remember my colleagues and I being totally unprepared for dealing with and talking to them [homosexuals and transvestites] when they arrived on the ward’.<sup>213</sup> This was further compounded by the wider debate regarding how to view the sexual deviant that was being pressed by the media and literary works, as discussed in Chapter II. Nurses were not receiving an education that presented a coherent and robust knowledge regarding these individuals.

### **The 1950s: mental hospitals under attack**

During the 1950s, the tradition of caring for the mentally ill within large institutions came under intense criticism both from inside and outside the system. Karen Jones posits that the 1950s was a hopeful period for the mentally ill. During this period, new drugs, particularly Chlorpromazine, came onto the scene; the open-door policy became established in mental hospitals and a Royal Commission was appointed to review the law relating to mental illness.<sup>214</sup> However, for staff working within these institutions, the greater emphasis on community care and pharmacological advances meant that there could be a threat to their jobs.<sup>215</sup>

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<sup>212</sup> Luke Vanston, interviewed 23<sup>rd</sup> June 2010.

<sup>213</sup> Jackie Fletcher, interviewed 12<sup>th</sup> February 2010.

<sup>214</sup> Karen Jones, *The Culture of the Mental Hospital*. In German E. Berrios & Hugh Freeman (eds.) *150 Years of British Psychiatry 1841-1991* (London, 1991), p. 124. For a detailed discussion regarding a personal history of the demise of the asylums see Barbara Taylor, ‘The Demise of the Asylum in Late Twentieth-Century Britain: A Personal History’, *Transactions of the Royal Historical Society* XXI (2011), pp. 193-216.

<sup>215</sup> Taylor, ‘The Demise of the Asylum in Late Twentieth-Century Britain’, p. 194.

The first public acknowledgment by the government that psychiatry was under scrutiny came from Enoch Powell as Minister of Health at the annual conference of the National Association of Mental Health in 1961. Here, he stated that mental hospitals were part of a bygone age and these ‘doomed institutions’ must disappear. He argued that what was required in order to remove them was a completely new approach to the mentally ill and their welfare.<sup>216</sup> On 31<sup>st</sup> May 1961, Powell officiated at the opening of a Nurse Training School at Littlemore Hospital. According to Nolan, he emphasised again here the Government’s intention to cut the number of psychiatric beds, especially on long-stay wards. Powell is noted to have stressed that this was not part of a campaign to undermine psychiatry, but to strengthen it. He stated that more resources would be spent on improving the training of mental nurses, and this would lead to an improved standard of care for patients. He saw nurses as having the opportunity to play a leading role in the exciting changes ahead.<sup>217</sup> However, Nolan goes on to posit that despite this upbeat political rhetoric, mental nurses were not convinced that their lot was likely to improve.<sup>218</sup>

### *Community care*

The population of mental hospitals had continued to increase and by 1955 there were over 150,000 patients within the United Kingdom’s mental hospital system.<sup>219</sup> Furthermore, had this number been allowed to increase, it would have threatened the NHS, due to the fact that doctors and administrators seemed unable to stem this rising tide of patients.<sup>220</sup> Something had to be done and caring for patients beyond the boundaries of the hospital was high on the political agenda. Community care is an

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<sup>216</sup> Enoch J. Powell, *Speech by the Minister of Health, the Rt Hon. Enoch Powell. Report of the Annual Conference of the National Association for Mental Health* (London, 1961).

<sup>217</sup> Nolan, *A History of Mental Health Nursing*, p. 125.

<sup>218</sup> Nolan, *A History of Mental Health Nursing*, p. 125.

<sup>219</sup> Harrington, *Death of the Asylum*, p. 27.

<sup>220</sup> Nolan, *A History of Mental Health Nursing*, p. 120.



elusive concept whose meaning changes over time. It is most simply defined as the policy of treating mental disorder outside the mental hospital, and in 1950s Britain, when it was adopted as national policy; this was the dominant overriding meaning.<sup>221</sup>

Community care was primarily about services for people who could be discharged from the mental hospital and about expanding these services so that more people, especially those with chronic problems, could be discharged, and at an earlier stage. The contemporary interpretations of community care in this period had, according to Busfield, three facets: it meant services *outside* the mental hospital, it particularly meant *after-care* services for those with long-standing problems, and it meant services provided in the *public sector*.<sup>222</sup>

The policy shift away from the mental hospital was further reinforced by the introduction of anti-psychotic drugs in the 1950s. The new drugs reawakened assumptions about the curability of mental illness and led to (over) optimistic discussion about the eradication of the old long stay patients.<sup>223</sup> It was believed that patients with chronic disorders would disappear with time as they died, and many claimed that there would be no new generations of long stay patients. Therefore, mental hospitals would no longer be needed and could arguably be closed.<sup>224</sup> Furthermore, Nolan argues that some mental nurses were apprehensive about the new psychotropic drugs and worried that they might spell the end for nursing care for mentally ill patients, or at least drastically reduce the need for nursing input.<sup>225</sup>

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<sup>221</sup> Adams, *Challenge and Change in a Cinderella Service*, pp. 308-309; Busfield, 'Restructuring Mental Health Services', p. 18.

<sup>222</sup> Busfield, 'Restructuring Mental Health Services', p. 19.

<sup>223</sup> Shorter, *History of Psychiatry*, p. 387.

<sup>224</sup> Harrington, *Death of the Asylum*, p. 25; Busfield, 'Restructuring Mental Health Services', p. 19.

<sup>225</sup> Nolan, *A History of Mental Health Nursing*, p. 123.

*The Percy Commission & The 1959 Mental Health Act*

The Royal Commission on Mental Illness and Mental Deficiency, which would become known as “The Percy Commission”, was developed to review the legislation surrounding the admission, certification and detention of the mentally ill in 1954. Harrington argues that the commission was tasked with examining the relationships between hospital and community, health service and local authority. The commission advocated a less legalistic framework for admissions, with more responsibility on doctors implementing compulsory detentions, rather than the courts, and its recommendations were embedded into the Mental Health Act of 1959.<sup>226</sup>

The new Act placed a new emphasis on community care, and its aims were to reduce the number of in-patients immediately and, in the long term, to change the course of mental health care provision. The Act unreservedly damned overcrowding as an organisational malpractice, productive in itself of a great deal of ill health. Further, it introduced the concept of ‘informal’ patients; these were to be treated in outpatient clinics, by GPs and in the community.<sup>227</sup> Nolan has argued that the impetus for the Act was definitely economic; however, it also embodied the dissatisfaction that had been mounting for years amidst those concerned with the care of the mentally ill.<sup>228</sup>

*Power imbalances*

The introduction of the new Act witnessed changes in the balance of power between professional groups. Within the mental hospitals themselves the overriding power of the Medical Superintendent was diminished and the post began to be phased out. Moreover, integration of psychiatry with other parts of medicine often led to a loss of power to other health bodies. Further, the development of community mental health

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<sup>226</sup> Harrington, *Voices Beyond the Asylum*, p. 39.

<sup>227</sup> Jones, *A History of Mental Health Services*, p. 307.

<sup>228</sup> Nolan, *A History of Mental Health Nursing*, p. 120.

services arguably led to a diffusion and gradual diminution of psychiatry's power as other mental health facilities became more widespread. Within these facilities, psychiatrists were often in more direct competition with other mental health professionals, such as social workers. All of the above were deemed a threat to psychiatrists.<sup>229</sup> Nurses' jobs were also under increasing threat. This was due in part to two new professional disciplines assuming direct responsibility for mental patients: social workers and occupational therapists, whose numbers were increasing rapidly.<sup>230</sup> Therefore, in this precarious climate and in view of the emphasis on reducing patient numbers, it is inevitable that both the medical and nursing professionals feared for their job security.

*Broadening definitions and conceptions of mental illness*

Jo Phelan and her colleagues argue that the definitions and conceptions of mental illness were broadened during the 1950s. This included a greater proportion of neurotic or non-psychotic disorders being treated, such as alcoholism.<sup>231</sup> Indeed, in 1949, the sixth edition of the World Health Organisation's *International Statistical Classification of Diseases, Injuries and Causes of Death* was published.<sup>232</sup> This included a section on mental disorder for the first time. Prior to this edition, it had only been a manual of causes of death (mortality): *International Classification of Causes of Death*. The American Psychiatric Association (APA) followed suit in 1952 and issued the first version of the Diagnostic Statistical Manual (DSM), which listed and categorised mental disorders.<sup>233</sup> Both these diagnostic tools began to be utilised interchangeably in the UK. Moreover, both tools

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<sup>229</sup> Busfield, 'Restructuring Mental Health Services', p. 19.

<sup>230</sup> Nolan, *A History of Mental Health Nursing*, p. 118.

<sup>231</sup> Jo C. Phelan, Bruce G. Link, Ann Stueve, Bernice A. Pescosolido, 'Public Conceptions of Mental Illness in 1950: What is Mental Illness and is it to be Feared?', *Journal of Health and Social Behaviour* 41 (2) (2000), p. 188.

<sup>232</sup> World Health Organisation, *The International Statistical Classification of Diseases, Injuries and Causes of Death*. (Geneva, 1949).

<sup>233</sup> American Psychiatric Association, *Diagnostic Statistical Manual Version I* (Arlington, 1952).

listed homosexuality and transvestism as mental disorders. Some of the nurses in the study recalled such broadening of the definitions of mental illness and offered their own interpretations for the reasons behind this:

I recall psychiatry in the mid to late 1960s as a branch of medicine that was desperately in need of some sort of affirmation, opting for anything or anyone that it could take on. And the more it could please the government, and the more it could be seen to get people to conform, the better. That is why I believe it took on sexual deviants and drug addicts, the government were at a loss at what to do with both of them at the time. Psychiatry held the notion that they were social fixers – that they could fix the problem for society. But what they were about essentially was about identifying and labelling, and once people had these labels, they had done their job as far as they were concerned.<sup>234</sup>

Meanwhile, Faith Ashley reflected how she perceived that psychiatry utilised homosexuals to gain credibility with the government:

I think psychiatry made a stance following the introduction of the Mental Health Act 1959, which was insistent on reducing patient numbers in mental hospitals. I think that they felt that their credibility as a profession was being undermined, and they felt threatened. So, I think, psychiatry saw a niche in the market [treating homosexuals] of how they could get back in the government's good books.<sup>235</sup>

Moreover, Unna Drinkwater reflects how some nurses' salaries were based on the occupancy of the hospital and the pressure that reducing patients numbers could have had on these nurses:

Doctors were convincing in how they were thinking and behaving at the time. On the one hand, we were made very much aware that admitting people now had to be the last resort, as community care was coming into force; however, not many people, myself included, actually knew what community care was. And of course, there was a fear in some of the senior staff that if the numbers were going to reduce, that would affect their

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<sup>234</sup> Luke Vanston, interviewed 23<sup>rd</sup> June 2010.

<sup>235</sup> Faith Ashley, interviewed 17<sup>th</sup> July 2010.

salary. Particularly the Chief Male Nurse, the Assistant Chief Male Nurse, and the Matron: they were paid on the number of beds that they had. So there was this fearing that if you start reducing the numbers, their pay would reduce. So there was a surge I think...I don't know whether it was done consciously, although it seemed to happen around the same time, that there were other forms of mental illness being created.<sup>236</sup>

Indeed, Philip Thomas and Patrick Bracken argue that the government influenced psychiatry to cast its gaze on 'antisocial and immoral behaviours'.<sup>237</sup> Therefore, I would argue that some psychiatrists – and nurses – responded to the government's uncertainty regarding the most effective way of dealing with sexual deviants by developing and implementing treatments to "cure" these individuals. This could have been a tacit but pragmatic way of bringing "new" patients into hospital, at a time when patient numbers were ever decreasing. Meanwhile mental nurses were worried that new psychotropic drugs and the introduction of social workers and occupational therapists might reduce the need for nursing input. It may have seemed that developing and implementing treatments for sexual deviations would prove their worth to the government, who at the time were reducing spending on mental health services.<sup>238</sup>

## Conclusion

The period this chapter explored witnessed many changes for practicing mental nurses in both legislation and practice. The Mental Treatment Act 1930 brought with it a

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<sup>236</sup> Unna Drinkwater, interviewed 29<sup>th</sup> December 2009.

<sup>237</sup> Philip Thomas & Patrick Bracken, 'Critical Psychiatry in Practice', *Advances in Psychiatric Treatment* 10 (2004), p. 366.

<sup>238</sup> It is interesting to note that a similar phenomenon to this had already occurred in psychiatry in the late nineteenth century. During this period, asylum doctors' professional status remained distinctly questionable. They were very eager to have their medical (psychiatric) skills recognised by their hospital-based colleagues as equal in status to that of general medicine. In order for asylum doctors to achieve their aim, an attempt was made to 'hospitalise' the asylums. This included proving their worth by deliberately changing the names of the institutions into hospitals, and by labelling and defining mental illnesses and developing 'treatments' to 'cure' the insane: See, e.g. Andrew Scull, *The Most Solitary of Afflictions: Madness and Society in Britain, 1700-1900* (New Haven, 1993). Michael Arton argues that a further aspect as this 'hospitalisation' was the transformation of the attendants into a body of trained asylum nurses who would have the same relationship to these 'hospitals for the insane' as general trained nurses had to the general hospitals: Arton, *The Professionalization of Mental Nursing*, p. 14.

therapeutic optimism, due to the possibility of curative treatment for mental patients; this led to the introduction of new somatic treatments. One important consequence of these new treatments was that they helped to undermine any remaining belief, which had been so important to the initial establishment of the asylums, that a stay in the institution had therapeutic value in itself. With the introduction of such treatments some nurses took on more advanced roles. However, for the vast majority they had no theoretical underpinning for the interventions they were implementing. Essentially, nurses were unaware that what passed for treatment in their workplace might represent no more than the penchant of their particular Medical Superintendent, based on no firm evidence at all. Moreover, I would argue that by exposing nurses to these somatic treatments, it normalised them to implementing “therapeutic” interventions that caused distress to the patients receiving them. This could offer a context to explain some nurses’ later acceptance of aversion therapies.

During this period, mental nursing attempted to improve its public image, but was generally aggravated by lack of resources. Its direction was primarily transformed by the absorption of psychiatry into the NHS and the RMPA’s relinquishing responsibility for training of mental nurses. Mental nursing was also significantly affected by World War II. The rapid and ill-organised discharge of large numbers of patients from one hospital to another, in order to make way for wounded soldiers, led to mass overcrowding. This was compounded by gross understaffing as many nurses were called up for military service.

Furthermore, with the inception of the 1959 Mental Health Act, oratory regarding community care, the introduction of new health and social care practitioners and reducing patient numbers, many nurses and psychiatrists felt that their profession was under threat. Moreover, when we revisit the rhetoric in the previous chapter regarding

the lack of consensus on the optimal way to deal with the problem of sexual deviants, I would argue that some psychiatrists – and nurses – developed and implemented treatments for these individuals as a tacit way of bringing “new” patients into the mental hospital. This could have been in a pragmatic and perhaps not even acknowledged attempt to protect their jobs, and increase their profile positively with the government. It further marked out a specialism and a specialist discourse.

Within some mental hospitals there also appeared to be a homosexual male nurse sub-culture. These men developed their own routines, community and rituals, and appear to have been accepted by their heterosexual colleagues. The finding that all of the homosexual nurses in this study also administered treatments to “cure” patients suffering from the same “illness” they had themselves appeared to be justified under the notions of beneficence and subservience. I also argued that the sense of community and acceptance these nurses experienced in mental hospitals may have also inured them from objecting to the treatments, as they would have had a lot to lose if they were no longer part of this community. This could offer an interpretation for why the homosexual nurses in this study participated in aversion therapy.

Finally, while there is some evidence of nurses implementing dynamic new approaches to care for patients during this period, the vast majority of nurses were not party to the wider debate about treatments, which was taking place outside mental hospitals, nor, within their hospitals, did they generally participate in case conferences, discuss patients’ treatments or diagnoses, or assess the progress of patients.<sup>239</sup> The culture of many mental hospitals – and their nurses – was still custodial, ritualised and impersonal. Nurses working within such establishments were expected to provide therapeutic interventions with little, if any, consideration of their efficacy or theoretical

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<sup>239</sup> Nolan, *A History of Mental Health Nursing*, p. 118.

underpinning. The majority of nurses accepted that their role was to carry out uncritically and without question, whatever medical staff or their nursing superiors had prescribed. The notion of obeying doctors' and superiors' orders was a strong theme from many of the participants in the study. The next chapter seeks to explore this notion further.



## CHAPTER IV

### “SUBORDINATE NURSES”

I didn't really understand what we were doing, none of us nurses did. We knew we were trying to get him to go for women instead of the men, but that was about it. The doctor brought the young man in and told us what we were going to do. I didn't really think any more about it, just got on with it – it was my job. I thought the doctor knows what he is doing, so it must be in the patient's best interests. In those days you didn't really ask questions, and you just did what the doctor told you to do really. When I think about it, we did not have any real knowledge to base this practice on, other than it was very experimental, not like you have now: my granddaughter is a nursing student and is trained to “question practice” [laughs], even doctors! My god! You would never do that in my day, you would not have dared. They had overall superior knowledge, or at least that is what we were trained to believe, and subsequently thought. That is what they thought of themselves too; we did what they said, because they could not possibly have been wrong.<sup>1</sup>

#### **Introduction**

The motivations of the majority of nurses in this study to administer treatments for sexual deviation appeared to rest on the notion of obedience to higher authority. Some nurses sensed that there was something wrong in what they were doing but participated because they were “following orders”. These nurses appeared to salve their conscience in relation to their participation in administering these treatments by diffusing the individual responsibility that they could take for their actions. Some used humour to do this, while others assumed that the doctors' knowledge was superior to their own. Meanwhile, other nurses actually believed that the treatments were helpful and genuinely believed that they were acting beneficently. This chapter seeks to explore these notions further in an attempt to offer an interpretation of some nurses' acceptance of and participation in aversion therapy for sexual deviations.

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<sup>1</sup> Jackie Fletcher, interviewed 12<sup>th</sup> February 2010.

### Nurses, experimentation and obedience to orders

In the original paper by Basil James discussed in Chapter II, he expressed his ‘appreciation of the way in which the nursing staff co-operated so fully in the treatment’.<sup>2</sup> In a time when nursing could be seen as subservient to the medical profession, it is arguable whether this was co-operation or obedience to orders. One of the nurses to whom the paper refers is Edward Lyons. He was interviewed as part of this study, and was asked about his thoughts on this statement:

Erm...I suppose it was coercion rather than co-operation really when I think about it because...erm...we didn't know what else to do. Our job to all intents and purposes was to follow the doctors' order...[pause]...I mean you have to understand the power the doctors, Nursing Officers and Matron had in those days. You stood up to attention with your thumbs down your creases, for example, when the doctor came on the ward. Likewise when the Matron or Nursing Officer came on your ward, they were checking that all beds were in line, with the wheels pointing in exactly the same direction...erm...the beds, well they had to be turned down from there to there [shows distance with hands] exactly – they even measured to make sure it was. No one ever told me why we had to do that. I don't suppose anyone ever thought to ask. It was the same with aversion therapy, I didn't ask why – I just did it. It was the doctor who needed to know the why's, what if's and maybe's in my day.<sup>3</sup>

However, an article published in the *Nursing Times* in 1965 entitled ‘Aversion Therapy in Psychiatry’ suggested that there was a dissonance between reality and rhetoric.<sup>4</sup> The quote from the article below urges nurses not to merely accept doctors' orders, but make the decision to partake in this aspect of their clinical practice only after they have reflected on their own values regarding it:

If a nurse is asked to participate in this type of treatment it is most important that she considers her view on the matter rather than merely accepting orders. One must consider one's own

<sup>2</sup> James, ‘Case of Homosexuality Treated by Aversion Therapy’, p. 770.

<sup>3</sup> Edward Lyons, interviewed 10<sup>th</sup> February 2010.

<sup>4</sup> Charles P. Seager, ‘Aversion Therapy in Psychiatry’, *Nursing Times* 26 (1965), pp. 421-424.

motives when applying this treatment. There may be conscious or unconscious reasons for wishing to inflict pain, either on people in general or on a particular group, such as homosexuals in particular. [...] In its present stages the treatment is experimental, and until it has been found either to fulfil its purpose or, on the other hand, to be unsuccessful, it must remain a necessity for all concerned with its administration to look at it carefully and make their own decisions about their participation.<sup>5</sup>

Further, in 1941 a working party was set up by the Ministry of Health, under the chairmanship of Sir Robert Wood, to review the position of the nursing profession. The working party set out to address two fundamental questions: ‘What is the proper task of the nurse?’ and ‘What training is needed to equip her for her task?’<sup>6</sup> The working party reported in 1947 and it was the responsibility of the Chief Nursing Officer, Dame Elizabeth Cockayne, to set about implementing the report’s recommendations.<sup>7</sup> Cockayne was convinced that nursing was in need of radical reform and posited that such reform had to be instigated by the nurses themselves:

We do not want stereotyped nurses trained in a groove, but nurses capable of thinking for themselves on the wider issues of life...As a profession, we need to become increasingly self-analytical, to examine what we are doing and why. In these days of limited financial resources, we need to be sure that the money we have is being used in the best possible way.<sup>8</sup>

Interestingly, only one nurse in this study recalls reading the above article in the *Nursing Times*, and the impact this had on her clinical behaviour will be discussed in Chapter V. However, what these two documents do is highlight the immense gulf between the prescriptions of theory, the intentions of policy and the realities of practice. The way

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<sup>5</sup> Seager, ‘Aversion Therapy in Psychiatry’, p. 424.

<sup>6</sup> Nolan, *Psychiatric Nursing Past and Present*, p. 201.

<sup>7</sup> Nolan, *Psychiatric Nursing Past and Present*, p. 202.

<sup>8</sup> A Brief History of the Society of Mental Nurses, 1943-1972, in Nolan, *Psychiatric Nursing Past and Present*, p. 202.

nurses worked on the wards appeared to rest on the preference of the supervising doctors, sister or charge nurse. Furthermore, rationales as to why things were done in a particular way or done at all were never provided:

They would tell us what had to be done but never why. I can't ever remember being given an explanation for what I was doing or why I was doing it. In the same vein, I was never really thanked for what I did; therefore, I was never really sure if I had done something right. I just thought: "if no one is complaining then it must be right" so I just carried on with it.<sup>9</sup>

Some nurses in this study felt completely unskilled to nurse the homosexuals or transvestites when they were admitted to their wards. However, despite this, they did not appear to accept the limitations of their skill set and carried on administering the treatments regardless:

I remember \*\*\*\* \* [name of nurse] coming on shift the day he [male homosexual patient] was admitted. \*\*\*\* [name of nurse] was reporting for night duty. Well he was getting on – was too old for it really. He had never seen this treatment before, just like me. I explained it all to him in the office at handover, and I said: "Are you alright with this?" and he said: "Yes. Clear as mud." The patient was still there in the morning so he must have got on with it alright. [Laughs] I mean a good nurse then was one who kept their head down, didn't ask questions, did as they were told and just got on with their work. [...] There were also some nurses who you could tell enjoyed administering these aversion treatments. There were others, myself included, who never enjoyed this aspect of their role and considered it barbaric. But, a lot of psychiatric treatments were barbaric, and the doctors had such enthusiasm for them. I suppose we just went along with it and allowed the doctors to do all the thinking.<sup>10</sup>

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<sup>9</sup> Susan Traherne, interviewed 30<sup>th</sup> December 2009.

<sup>10</sup> Julian Glover, interviewed 4<sup>th</sup> January 2010.

Moreover, when nurses did ask questions they were often regarded as, ‘[...] audacious and impudent’.<sup>11</sup> Luke Vanston muses on the reasons for this:

I mean to think back, the treatments were so contrived! I mean to see a doctor coming in with a slide projector and a handful of slides, and setting it up, and then putting a couple of electrodes on this lad’s body, and plugging him to this machine – it was even crueller than ECT. I remember the first time I saw it [aversion therapy for transvestism] I thought it was barbaric. And I remember asking the Charge Nurse: “By administering the shock where is the treatment?” And of course this was regarded as an insolent and impertinent question at the time. Because it went outside the training and the training was set pieces of knowledge you regurgitated in exams, and if you were able to do that you were a competent nurse and not awkward. So it was in fact an education and training in avoiding awkwardness, because that is how you ran a very stable institution. So I just got on with it. I think the nurses and patients blinded themselves to the doctors’ treatment.<sup>12</sup>

In many cases information was not made available to nurses working on the wards. They were often kept unaware about the patients and the reasons they had been admitted. Case-notes were kept off the wards in the central office and only doctors had access to them.<sup>13</sup> Staff discipline was inconsiderately managed and nurses often obeyed their superiors’ orders to avoid being publicly humiliated in front of colleagues and patients:

I remember seeing a colleague of mine severely reprimanded for not doing as he was told. He was supposed to take the patients out to the airing-court, but he hadn’t, as he argued that it wasn’t fair on them, as it was freezing cold outside. Firstly the Charge Nurse “bollocked” him in front of everyone including the patients. He was then seen by the Senior Nurse and then the Superintendent. His card was marked from then on as a trouble maker and they made his life pretty bad. He didn’t last much longer at the hospital and left about six months later. I was

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<sup>11</sup> Elizabeth Granger, interviewed 3<sup>rd</sup> May 2010.

<sup>12</sup> Luke Vanson, interviewed 23<sup>rd</sup> June 2010.

<sup>13</sup> Nolan, *Psychiatric Nursing Past and Present*, p. 227.

pretty sure I didn't want to go through that, so I just kept my head down and did as I was told.<sup>14</sup>

*Nurses and obedience: a comparison with nurses in Nazi Germany*

Nurses' involvement in aversion therapy is not the only example of their adoption of arguably unethical practices and behaviours due to obedience to higher authority. This justification has been used as a shield by nurses in supporting their unethical practices in a number of historical contexts, not least nurses in Nazi Germany.<sup>15</sup> While it is of course critical to emphasise the different context and that none of the nurses in this study knowingly murdered patients in their care as the nurses under Nazi rule did, both sets of nurses did, nevertheless, administer what could now be deemed to be brutal treatments.<sup>16</sup> Indeed, the patients who received aversion therapy were making this connection and using the Gestapo in Nazi Germany as a metaphor to describe the treatment they received, as we witnessed with the testimony of William Newman at the beginning of this thesis. Further, nurses in this study commented that, 'I was just doing what the doctor told me to do'.<sup>17</sup> Therefore, given that many nurses under Nazi rule offered the same reason for their behaviour during World War II,<sup>18</sup> there could be something to be learnt from a comparison.

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<sup>14</sup> Terry Orchard, interviewed 10<sup>th</sup> August 2010.

<sup>15</sup> For a detailed exploration of the nurses' role in Nazi Germany, see, e.g. McFarland-Icke, *Nurses in Nazi Germany*; Alison J. O'Donnell, *A New Order of Duty: A Critical Genealogy of the Emergence of the Modern Nurse in National Socialist Germany*. Unpublished PhD thesis, The University of Dundee (Dundee, 2009). Hilde Steppe has also published some seminal work in this area. See, e.g. Hilde Steppe, *Krankenpflege im Nationalsozialismus*, Mabuse-Verlag, Frankfurt am Main (Berlin, 1989). However, to mitigate any potential problems with translation, I have decided not to refer to her work within this thesis unless it has been published in English.

<sup>16</sup> While it is important to note that the aim was never to murder patients who were receiving treatments for their sexual deviations, there is at least one reported case where a patient died as a result of the chemical aversion therapy he received to "cure" him of his homosexuality. See, e.g. Smith, King & Bartlett, 'Treatments of homosexuality in Britain since the 1950s – an oral history: the experience of patients', p. 3.

<sup>17</sup> Pat Mullins interviewed, 14<sup>th</sup> July 2010.

<sup>18</sup> See, e.g. McFarland-Icke, *Nurses in Nazi Germany*.

As head of the National Socialist Party, Adolf Hitler was elected as leader or “Reichskanzler” of Germany on 30<sup>th</sup> January 1933. On appointment, he almost immediately implemented a series of drastic measures to promote National Socialist health policy based on the concept of social hygiene and racial purity (eugenics).<sup>19</sup> This included the opening of the first concentration camp in Dachau and, in July 1933, the passing of a law to prevent hereditary diseases (“Gesetz zur Verhütung erbkranken Nachwuchses” or GVeN).<sup>20</sup> This resulted in the forced sterilisation of 400,000 people between 1934 and 1939 in order to eugenically prevent illnesses such as ‘feeble-mindedness, schizophrenia, manic-depressive illness, epilepsy, Huntington’s chorea, hereditary blindness, deafness and physical deformity’.<sup>21</sup>

On the day that German troops invaded Poland, 1<sup>st</sup> of September 1939, Hitler signed the Euthanasia Decree (the “Euthanasie-Erlass”). This meant that patients in Polish asylums began to be murdered. The following month, “Aktion T4” began with the founding of a central organisation in Berlin, which received reports on all psychiatric patients and where judgements were made on whether or not they would be put to death, described in official documentation as being granted a ‘mercy killing’.<sup>22</sup> Those who met the criteria to be killed were collected together with the direct help of nurses and transported to designated extermination institutions in groups of 40-120. They were undressed, photographed and led naked into specially constructed carbon monoxide gas chambers and to their death.<sup>23</sup>

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<sup>19</sup> Steppe, ‘Nursing in Nazi Germany’, p. 745.

<sup>20</sup> Biley, ‘Psychiatric nursing: Living with the Legacy of the Holocaust’, p. 365.

<sup>21</sup> McFarland-Icke, *Nurses in Nazi Germany: A Moral Choice in History* p. 130.

<sup>22</sup> Benedict & Georges, ‘Nurses and the Sterilization Experiments of Auschwitz: A Postmodernist Perspective’, pp. 227-288; Biley, ‘Psychiatric Nursing: Living with the Legacy of the Holocaust’, p. 365.

<sup>23</sup> McFarland-Icke, *Nurses in Nazi Germany*, p. 134.

This genocide went on for the next two years until August 1941 when the T4 programme was officially halted; 70, 273 psychiatric patients were killed in this way.<sup>24</sup> Although the programme was ended in 1941, it was replaced with the “Hungerkost” or starvation programme, which resulted in an estimated further 90,000 deaths, the development of the “Ostarbeiter-Sammelstellen” forced labour plan, with the resultant murder of unproductive forced labourers and, most significantly, the development of the “Wilde Euthanasie” or wild euthanasia programme, where the choice of patients to be killed was decentralised and patients were killed in one of fifteen specially created killing wards in hospitals.<sup>25</sup> Moreover, Maria Berghs and her colleagues argue that the clandestine euthanasia programs involved more than 296 mental, nursing and medical institutions in Poland, Germany, Russia, Austria and the Czech Republic, as well as healthcare professionals in those countries at all levels.<sup>26</sup>

Nurses were involved in differing phases of the euthanasia programmes.<sup>27</sup> In the children’s euthanasia programmes they actively assisted in exterminating children through injections of morphine and scopolamine, by starvation, or by overdoses of other medications.<sup>28</sup> Nurses assisted in the selection and elimination of concentration camp prisoners in the later “Operation 14 f 13”; they also participated in the implementation of the “Final Solution” and in the mass sterilization programme.<sup>29</sup> They assisted with compulsory medical experiments on people, refused to admit and

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<sup>24</sup> O’Donnell, *A New Order of Duty*; Biley, ‘Psychiatric nursing: Living with the Legacy of the Holocaust’, p. 365.

<sup>25</sup> Biley, ‘Psychiatric nursing: Living with the Legacy of the Holocaust’, p. 366.

<sup>26</sup> Maria Berghs, Bernadette Dierckx de Casterle & Chris Gastmans, ‘Practices of Responsibility and Nurses During the Euthanasia Programs of Nazi Germany: A Discussion Paper’, *International Journal of Nursing Studies* 44 (2007), p. 846.

<sup>27</sup> McFarland-Icke, *Nurses in Nazi Germany*, p. 132.

<sup>28</sup> Berghs, Dierckx de Casterle & Gastmans, ‘Practices of Responsibility’, p. 849; Susan Benedict & Jochen Kuhla, ‘Nurses’ Participation in the “Euthanasia” Programmes of Nazi Germany’, *Western Journal of Nursing Research* 21 (1999), p. 247.

<sup>29</sup> Henry Friedlander, *The Origins of Nazi Genocide: From Euthanasia to Final Solution* (Chapel Hill, 1995), p. 67.



treat Jewish and homosexual people, and were, overall, 'involved in all phases of the systematic annihilation of masses of people'.<sup>30</sup>

This brief depiction of some of the events of the Holocaust cannot do justice to the extent of the suffering that was experienced. However, it does begin to draw some similarities with the nurses and patients in this study, as William Newman, who received treatments for homosexuality, reflected on his treatment as being like 'a barbaric torture scene by the Gestapo in Nazi Germany trying to extract information from me'.<sup>31</sup> Moreover, when we revisit the descriptions of some of the treatments administered for sexual deviations in Chapter II, it is not surprising to see why William might have made this connection. There are definite parallels, as Pattinson states that amongst other torturous interventions, the Gestapo deprived their prisoners of sleep and made them stay awake, subjected them to electric currents surging through their bodies, denied them light, food and medical treatment, and kept them in solitary confinement.<sup>32</sup> The treatment of sexual deviations with aversion therapy used a combination of all of the above.

### *Avoiding responsibility*

In order to make the situation tolerable for nurses in Nazi Germany to participate in the practices described above, and the nurses in this study to participate in aversion therapy, I would propose that their clinical practice had to be acceptable to them and their moralities. The role of morality had to be limited, and in some cases, this was done by diffusing the individual responsibility that the nurses could accept for their actions.<sup>33</sup> I would argue that in parallel with the nurses in Nazi Germany, some of the nurses in this

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<sup>30</sup> Biley, 'Psychiatric Nursing: Living with the Legacy of the Holocaust', p. 366; Steppe, 'Nursing in Nazi Germany', p. 748.

<sup>31</sup> William Newman, interviewed 29<sup>th</sup> April 2010.

<sup>32</sup> Pattinson, *Behind Enemy Lines*, p. 163.

<sup>33</sup> Berghs, Dierckx de Casterle & Gastmans, 'Practices of Responsibility', p. 849.

study also attempted to limit their culpability by ensuring that they were not responsible for individual patients. This was done by dehumanising and objectifying the affiliation between patients and care-givers through language and administrative tasks.<sup>34</sup> Meanwhile other nurses in this study discussed the distribution of specific tasks involved in nursing homosexuals and transvestites. Further, as with the nurses in Nazi Germany, the nurses in this study were also encouraged not build up strong therapeutic relationships with their patients.<sup>35</sup>

The nurses in this study experienced little difficulty in recollecting the displeasing aspects of their work caring for patients receiving treatments for sexual deviations. Pat Mullins remembers how challenging the patient receiving chemical aversion therapy was to nurse:

[...]cause [sic] it was dammed hard work looking after those homosexuals, you were on the go all night, you had to keep on at this bloke to keep taking this that and the other – observations – I mean blood pressure and testing his water, you know that went round the clock. I didn't give him the injections, we shared the jobs, my colleague gave the injections and I took his observations.<sup>36</sup>

Meanwhile Jackie Fletcher also recalls these challenges:

[...] nursing the sexual deviant was exhausting. We knew we had to “sort them out” but it wasn't easy. The smell amongst other things was probably the worst thing; imagine a few days of “sick”, “shit” and “piss” in one room. [...] It must have been awful for the other patients on the ward.<sup>37</sup>

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<sup>34</sup> Berghs, Dierckx de Casterle & Gastmans, 'Practices of Responsibility', p. 850.

<sup>35</sup> Biley, 'Psychiatric Nursing: Living with the Legacy of the Holocaust', p. 366.

<sup>36</sup> Pat Mullins, interviewed 14<sup>th</sup> July 2010.

<sup>37</sup> Jackie Fletcher, interviewed 12<sup>th</sup> February 2010.

The terminology that Pat Mullins and Jackie Fletcher utilised - i.e. 'those homosexuals', 'dammed hard work', 'the sexual deviant', 'sort them out' and 'It must have been awful for the other patients' - could suggest two things: firstly, that nurses were practicing in a very task-orientated manner, and secondly, that as with the nurses in Nazi Germany, they limited their integrity by using dehumanising and objectifying language and focused on administrative tasks, rather than the human beings in need of their care. Additionally, Pat Mullins also discusses the distribution of tasks involved in nursing these individuals. Edward Lyons casts further light on such distribution of tasks:

Nursing was very regimented and task orientated in those days – not least the care of patients receiving aversion therapy – particularly those receiving chemical aversion therapy. We seemed to have it pretty boxed off, and took in turns to either do and have responsibility for is [sic] obs or give the injections.<sup>38</sup>

The Nazi euthanasia projects had to be a furtive collective endeavour, with each individual nurse following orders, doing a very specialised administration or technical intervention.<sup>39</sup> McFarland-Icke posits that an absorption with very specialised interventions meant that such nurses began to focus on performances of the interventions and measuring their responsibilities as a nurse in the narrow terms of efficiency, productivity or competence.<sup>40</sup> Andrew McKie also proposes that a focus on the detached nature of an intervention allows an emphasis to be shifted from victims (patients) to perpetrators (nurses) and the focus is on the difficulties inherent in responsibilities for interventions and not responsibilities towards patients.<sup>41</sup> I would argue that these were also ways in which some nurses in this study limited their morality regarding the treatments they administered for sexual deviation, in order to make the

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<sup>38</sup> Edward Lyons, interviewed 10<sup>th</sup> February 2010.

<sup>39</sup> Berghs, Dierckx de Casterle & Gastmans, 'Practices of Responsibility', p. 850

<sup>40</sup> McFarland-Icke, *Nurses in Nazi Germany*, p. 221.

<sup>41</sup> Andrew McKie, "The Demolition of a Man": Lessons Learnt from Holocaust Literature for the Teaching of Nursing Ethics', *Nursing Ethics* 11 (2004), p. 141.

situation more tolerable and acceptable to them. This could offer an elucidation for the acceptance and participation in aversion therapy by some nurses in this study.

*Nurses' participation in medical experiments: a comparison with the Tuskegee syphilis study*

Although there had been some success treating alcoholics using aversion therapy,<sup>42</sup> aversion therapy to treat sexual deviations was very experimental.<sup>43</sup> Besides the compulsory medical experiments conducted in Nazi Germany, arguably one of the most infamous medical experiments in the twentieth century was the case of the Tuskegee Syphilis Experiment. In 1932 the USA Public Health Service (USPHS) commenced an experiment in Macon County, Alabama, to determine the natural course of untreated, latent syphilis in black males.<sup>44</sup> Investigators in the study enrolled a total of six hundred disadvantaged African-American sharecroppers from Macon County, Alabama: four hundred who had previously contracted syphilis before the study began and two hundred without the disease who would serve as controls.<sup>45</sup> In exchange for participating in the study, the men were given free medical care, meals and free burial insurance. However, they were never told they had syphilis. The men were told they were being treated for 'bad blood', a local term used to describe several illnesses, including fatigue, syphilis and anaemia.<sup>46</sup> Moreover, when penicillin became widely available by the early 1950s as the preferred treatment for syphilis, the men did not receive the drug. Indeed, on several occasions, the USPHS actually sought to prevent

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<sup>42</sup> Kantrovich, 'An Attempt at Associate Reflex Therapy in Alcoholism', p. 26

<sup>43</sup> King & Bartlett, 'Treatments of Homosexuality in Britain since the 1950s', p. 188.

<sup>44</sup> Allan M. Brandt, 'Racism and Research: The Case of the Tuskegee Syphilis Experiment', in Susan M. Reverby (ed.), *Tuskegee's Truths: Rethinking the Tuskegee Syphilis Study* (London, 2000), p. 15.

<sup>45</sup> James H. Jones, *Bad Blood: The Tuskegee Syphilis Experiment* (New York, 1981), p. 21.

<sup>46</sup> "The 40-year Death Watch", *Medical World News*, 18<sup>th</sup> August, 1972.

treatment.<sup>47</sup> Furthermore, in 1969, a committee at the federally operated Centre for Disease Control decided that the study should be continued.<sup>48</sup>

The first published report of the study appeared in the medical press in 1936, and papers were published regarding the study every four to six years.<sup>49</sup> However, it was only in 1972, when accounts of the study first appeared in the national press, that the Department of Health, Education and Welfare (DHEW) curtailed the experiment.<sup>50</sup> At that time, seventy-four of the test subjects were still alive; at least twenty-eight, but possibly more than a hundred, had died directly from advanced syphilitic lesions.<sup>51</sup> In August 1972, the DHEW appointed an investigatory panel, which issued a report the following year. The panel identified the study to have been ‘ethically unjustified’, and argued that penicillin should have been provided to the men.<sup>52</sup> Moreover, it was a nurse – Eunice Rivers – who played an instrumental role in perpetuating the experiment.<sup>53</sup>

It was Nurse Rivers’ job to serve as a liaison between the doctors who designed and ran the Tuskegee Study and the black men who were its subjects. She kept track of the men in the study, visited them and developed a trusting relationship with the men and their families.<sup>54</sup> James Jones argues that it was the men’s trust in Nurse Rivers that kept them

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<sup>47</sup> Jones, *Bad Blood*, p. 7.

<sup>48</sup> ‘The 40-year Death Watch’, *Medical World News*, 18<sup>th</sup> August, 1972.

<sup>49</sup> Brandt, ‘Racism and Research’, p. 26.

<sup>50</sup> ‘Why 420 Blacks with Syphilis Went Uncured for 40 Years’, *Detroit Free Press*, 5<sup>th</sup> November, 1972.

<sup>51</sup> The mortality figure is based on a published report of the study which appeared in 1955. See, e.g. Jess J. Peters, Sidney Olansky, John C. Cutler, & Geraldine Gleeson, ‘Untreated Syphilis in the Male Negro: Pathologic Findings in Syphilitic and Non-syphilitic Patients’, *Journal of Chronic Disease* 1 (1955), pp. 127-148. The article estimated that 30.4 % of the untreated men would die from syphilitic lesions.

<sup>52</sup> *Final Report of the Tuskegee Syphilis Study Ad Hoc Advisory Panel*, Department of Health, Education, and Welfare (Washington, 1973).

<sup>53</sup> See, e.g. Evelyn, M. Hammonds, ‘Your Silence Will Not Protect You: Nurse Rivers and the Tuskegee Syphilis Study’, in Susan M. Reverby (ed.), *Tuskegee’s Truths: Rethinking the Tuskegee Syphilis Study* (London, 2000), pp. 340-347; Susan, L. Smith, ‘Neither Victim nor Villain: Eunice Rivers and Public Health Work’, in Susan M. Reverby (ed.), *Tuskegee’s Truths: Rethinking the Tuskegee Syphilis Study* (London, 2000), pp. 348-364; Susan M. Reverby, ‘Rethinking the Tuskegee Syphilis Study: Nurse Rivers, Silence, and the Meaning of Treatment’, in Susan M. Reverby (ed.), *Tuskegee’s Truths: Rethinking the Tuskegee Syphilis Study* (London, 2000), pp. 365-387; Darlene Clark Hine, ‘Reflections on Nurse Rivers’, in Susan M. Reverby (ed.), *Tuskegee’s Truths: Rethinking the Tuskegee Syphilis Study* (London, 2000), pp. 386-398.

<sup>54</sup> Hammonds, ‘Your Silence Will Not Protect You’, p. 341.

in the study.<sup>55</sup> Nevertheless, while Rivers was supportive of the men in the study and provided care to them and their families, she also knew that they were being denied treatment for syphilis, yet in spite of this, she continued with her influential role in the study.<sup>56</sup> Interpretations of the rationale for her continued participation in the study have suggested that it was driven by obedience to higher authority, namely doctors.<sup>57</sup> However, another interpretation proposed rested on the notion of beneficence.<sup>58</sup>

*Beneficence: limiting the role of conscience*

Evelyn Hammonds argues that Nurse Rivers ‘straddled two worlds’.<sup>59</sup> Firstly, being a black woman from Alabama, she knew first-hand the world of poor black people living in this state, and how segregation was very oppressive for black people in the South. She knew she had to be mindful that her job put her in close contact with white people who were threatened by her professional status. Secondly, she had to consider and attend to the feelings of black people who might have been disdainful towards her because of her close working relationship with white people.<sup>60</sup>

Rivers always maintained that she was told by doctors that the purpose of the study was to make a comparison with a similar study that was being conducted on white men in order to determine if syphilis manifested itself differently in black people.<sup>61</sup> The distressing symptoms of the late stages of syphilis were obvious and apparent to all, and included tumours, ulcers on the skin, bone deterioration and often severe damage to the cardiovascular and central nervous system.<sup>62</sup> Therefore, there was a definite need for further research in this area. Furthermore, Jones argues that her acceptance in this

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<sup>55</sup> See, e.g. Jones, *Bad Blood*.

<sup>56</sup> Jones, *Bad Blood*, p. 24.

<sup>57</sup> Smith, ‘Neither Victim nor Villain’, p. 348; Jones, *Bad Blood*.

<sup>58</sup> Hammonds, ‘Your Silence Will Not Protect You’, p. 341.

<sup>59</sup> Hammonds, ‘Your Silence Will Not Protect You’, p. 344.

<sup>60</sup> Hammonds, ‘Your Silence Will Not Protect You’, p. 341.

<sup>61</sup> Reverby, ‘Rethinking the Tuskegee Syphilis Study’, p. 370

<sup>62</sup> Hammonds, ‘Your Silence Will Not Protect You’, p. 344.

study was also compounded by the fact that three doctors, two of whom were black men, approved and participated in the study.<sup>63</sup>

Rivers perceived the study and its impact by maintaining that while the men did not get treated for syphilis, they did receive “good medical care” – care they would not have received otherwise due to their socioeconomic status.<sup>64</sup> As Nurse Rivers saw it, the fact that the men were given cardiograms and other expensive tests over the course of the study meant that they had access to quality care that few of their position ever received.<sup>65</sup> I would argue, therefore, that she believed that at least she was acting beneficently by trying to do something for individuals whom others had abandoned.

I would propose that there are parallels with the dynamic of Rivers’ participation in the Tuskegee Study, in the sense that she was a black woman believing she was helping other black people, and the nurses in this study who administered treatments for homosexuality, but were also themselves homosexual. As discussed in Chapter III, some of these nurses also believed that they were acting beneficently. This could offer a possible interpretation for these nurses’ acceptance of and participation in aversion therapy. Further, some nurses in Nazi Germany believed in the moral correctness of the euthanasia killings, and argued that for humanitarian reasons, it was better for the patients to be put out of their misery.<sup>66</sup> In these cases, McFarland-Icke posits that perceiving euthanasia as ‘mercy-killing’ or ‘death as deliverance’ enabled nurses to combine their conventional morality with involvement in euthanasia practices.<sup>67</sup>

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<sup>63</sup> Jones, *Bad Blood*, p. 45.

<sup>64</sup> Neither the Tuskegee Institute nor other local hospitals had provided adequate care for the poor black people in Macon County: Hammonds, ‘Your Silence Will Not Protect You’, p. 345.

<sup>65</sup> Hammonds, ‘Your Silence Will Not Protect You’, p. 345.

<sup>66</sup> Berghs, Dierckx de Casterle & Gastmans, ‘Practices of responsibility and nurses during the euthanasia programs of Nazi Germany’, p. 849.

<sup>67</sup> McFarland-Icke, *Nurses in Nazi Germany*, p. 227.

*Beneficence versus non-maleficence*

Michael Cooper and his colleagues suggest that the crux of a mental health nurse's role is to display unconditional positive regard and empathy to the patients in his or her care.<sup>68</sup> This was also argued by Richard Hunter in 1956 to be 'the very function to which mental nursing owes its inception – that is, to counter alienation by sustained, kindly human understanding and contact'.<sup>69</sup> Therefore, the concept of nurses displaying such interpersonal characteristics is not a contemporary notion. However, some nurses in this study, for whatever reason, were not displaying empathy to the patients in their care; indeed, it could be argued that they were displaying the opposite – antipathy. Moreover, in the paper by Oswald discussed in Chapter II, his aim was to produce 'maximum emotional crises' in his patient, as the treatment was believed to have a better outcome when this occurred.<sup>70</sup> The following statement from Edward Lyons corroborates the above:

We didn't have to talk to 'em [sic]. If he was emotionally distressed it still went on. As long as his body was alright...I mean as long as you were shaking 'em [sic] up you know? Well, you were doing the work. The work's being done if he was shook up. I suppose we were being cruel to be kind.<sup>71</sup>

Luke Vanson agrees and recalls the lack of empathy this patient group received:

I don't ever recall any meetings or ward rounds to discuss these [homosexual and transvestite] patients. There was a distinct lack of empathy and sensitivity to this patient group. They were seen as trouble-makers and deviants, who were put on this earth to annoy and cause trouble for everyone around them. There was a

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<sup>68</sup> Michael Cooper, Christine Cooper & Margaret Thompson, *Child and Adolescent Mental Health Nursing Theory and Practice* (Oxford, 2005), p. 17; see also Carl Rogers, *Becoming a Person: A Therapist's View on Psychotherapy* (New York, 1995), p. 12.

<sup>69</sup> Hunter, 'The Rise and Fall of Mental Nursing', p. 99.

<sup>70</sup> Oswald, 'Induction of Illusory and Hallucinatory Voices with Consideration of Behaviour Therapy', p. 198

<sup>71</sup> Edward Lyons, interviewed 10<sup>th</sup> February 2010.



belief that they were fully responsible for entering into the culture in which they drifted.<sup>72</sup>

The testimonies of both the patients and nurses concur, suggesting that the nurses' role was to make it as unpleasant as possible for the patient, and in parallel with the nurses in Nazi Germany, not to 'build up a strong relationship between patients and caregivers'<sup>73</sup>:

It was always quite furtive. They were kept in a side room and not given any real "care" you could say. [...] It wasn't so much the hard work, but the unpleasantness of it. Put it this way, the cleaner didn't go into his room. You were not allowed to clean his "sick" up, and he had to go to the toilet in his room, by that I mean he had to go in a bowl in the corner. So you get the picture, after a couple of days, the smell was nauseating. I remember retching every time I opened the door to his room, all the other patients on the ward started to complain too. [...] Now I know we can look back on this a barbaric, but this is what we were told the cure was for these people. We were just trying to make them better and help them in the only way we knew possible at the time. All the patients consented too, even if they were sent from court, they were given a choice of coming to us or going to prison.<sup>74</sup>

While I would argue that these nurses accepted and participated in aversion therapy because they believed they were acting beneficently, I would conversely propose that by relying on the notion that they were doing well by administering aversion therapy, the nurses were not upholding the principle of non-maleficence. As the treatments were very traumatic and painful for the patients receiving them.<sup>75</sup> Furthermore, no former patients in this study reported any efficacy having received the treatments; and all stated that these treatments have had a negative long-term impact on them. Albert Holliday

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<sup>72</sup> Luke Vanson, interviewed 23<sup>rd</sup> June 2010.

<sup>73</sup> Berghs, Dierckx de Casterle & Gastmans, 'Practices of Responsibility', p. 850.

<sup>74</sup> Elliot Whitman, interviewed 20<sup>th</sup> March 2010.

<sup>75</sup> See Chapter II for the reflections regarding the treatments of the patients in this study; see also Smith, King & Bartlett, 'Treatments of homosexuality in Britain since the 1950s – an oral history: the experience of patients', pp. 1-4; Dickinson, Cook, Playle, & Hallett, "'Queer' Treatments', p. 1349.

reflects on the treatment he received to “cure” him of his homosexuality:

I have never come to terms with it. I desperately wanted the treatments to work, but they didn't. [...] I can still have terrible flashbacks of my time in hospital and the barbaric treatments I received.<sup>76</sup>

Meanwhile Oscar Mangle remains ‘troubled by the treatment’<sup>77</sup> he received and Gregory Gregson does not ‘know how something so tortuous could have been concealed under the term “health care”’.<sup>78</sup> It appears from the literature that negative effects from the treatment were fairly common. In a feasibility study of ten men treated by the psychiatrist John Bancroft, one developed phobic anxiety to attractive men and attempted suicide; one became aggressive, attempted suicide and was anorgasmic in homosexual relationships; one developed serious depression after rejection by women; one became psychotically depressed and wandered into the streets removing his clothes and one became disillusioned by the homosexual world and could no longer sustain emotionally rewarding relationships.<sup>79</sup> I would suggest, therefore, that relying on the principle of beneficence led the nurses to become paternalistic. Paternalism is the idea that one person – in this case the nurse or the doctor – believed that they knew what was best for their patient.<sup>80</sup> Indeed, Raanan Gillon couches this notion as ‘beneficent paternalism’: when health care providers tell patients what is good for them without regard to the patient’s own expressed needs or interests.<sup>81</sup>

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<sup>76</sup> Albert Holliday, interviewed 27<sup>th</sup> January 2010.

<sup>77</sup> Oscar Mangle, interviewed 21<sup>st</sup> June 2010.

<sup>78</sup> Gregory Gregson, interviewed 2<sup>nd</sup> January 2010.

<sup>79</sup> Bancroft, ‘Aversion Therapy of Homosexuality’, pp. 1417 – 1143.

<sup>80</sup> Graham Rumbold, *Ethics in Nursing Practice* (Edinburgh, 1999), p. 214.

<sup>81</sup> Raanan Gillon, *Philosophical Medical Ethics* (London, 1986), p. 87.

*Consent*

I would argue that it was not only nurses who were potentially being coerced into administering these treatments: the patients themselves also appear to have been pressured in to receiving them. An example of this is demonstrated in the introduction to this thesis, when William Newman was given the option of imprisonment or being remanded provided he was willing to undergo psychological treatment. In addition, the negative messages homosexuals and transvestites were receiving about themselves, which were explored in Chapter II, could all be claimed to have implicitly coerced men into receiving these treatments. Moreover, all of these issues raise important questions regarding the validity of the patients' consent to treatment.

It has already been established that utilising aversion therapy to treat sexual deviations was very experimental and arbitrary.<sup>82</sup> Bridget Dimond argues that there are two types of medical experiment: 'therapeutic' and 'non-therapeutic'. Therapeutic experiments are those designed to benefit the subject, to find a cure for their illness or alleviate their suffering. Non-therapeutic experiments are designed not to help the research subject directly but to benefit others suffering from the same disease.<sup>83</sup> Graham Rumbold proposes that the judgement as to whether an experiment is therapeutic or non-therapeutic has to be based on the original intention. If the intention is to benefit the subject directly then the experiment is therapeutic. If the intention is not so, then the experiment is non-therapeutic.<sup>84</sup> I would propose that the medical experiments carried out in Nazi Germany and the Tuskegee Syphilis Experiment were non-therapeutic experiments.

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<sup>82</sup> King & Bartlett, 'Treatments of Homosexuality in Britain since the 1950s', p. 188.

<sup>83</sup> Bridget Dimond, *Legal Aspects of Nursing* (London, 2004), p. 78.

<sup>84</sup> Rumbold, *Ethics in Nursing Practice*, pp. 134-135.

Whether aversion therapy to treat sexual deviations was a therapeutic or a non-therapeutic experiment is arguably a contentious issue. The aim of aversion therapy was always maintained to be that it would directly benefit the patient by “curing” them of their deviant behaviours. Nevertheless I would suggest that the patients who received these therapies were experimental subjects being utilised to establish the efficacy of such treatments, as there were no robust evidence-based successful outcomes of using this particular therapy for people suffering from sexual deviations. In the study by King and his colleagues, the findings concur with the findings in this study in that the treatment did not appear to be successful in its intent to cure patients of their same sex-desires, and paradoxically it even had long-term detrimental effects for many.<sup>85</sup> Rumbold proposes that if any experiment may cause harm or inflict pain, discomfort, loss of freedom or loss of dignity in an individual, (and I would argue that aversion therapy to treat sexual deviations did all of these), then the experiment cannot be justified. This is because to do something deliberately which will cause harm to a patient is wrong.<sup>86</sup>

Crucial to any medical experiment or research is participant consent. That consent has to be freely given and fully informed. All the participants in this study had consented to the treatment. However, there appears to be some debate as to whether this was fully informed and uncoerced consent and whether the patients’ autonomy was respected. Delroy Heath recalls the information he received regarding the aversion therapy he consented to:

The psychiatrist told me what was going to happen. But in no way was it descriptive of what I was actually subjected to. I don’t recall them using the words “aversion therapy” and they made it sound like it was a definite solution to my problem. They made it sound like I had nothing to worry about, so I

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<sup>85</sup> King, Smith & Bartlett, ‘Treatments of Homosexuality in Britain since the 1950s’, p. 189.

<sup>86</sup> Rumbold, *Ethics in Nursing Practice*, p. 135.

agreed to it. I don't ever recall signing a consent form or anything like that, though.<sup>87</sup>

Furthermore, Adam Carter reflects on the legal issue of consent to treatment:

I think we must remember that these patients all consented to treatment, and because of this we were within our rights to administer the treatment. We never pinned anyone down and shocked them. Most were so desperate that they would have done anything.<sup>88</sup>

Meanwhile, Luke Vanson recalls the kind of information the patient would receive regarding aversion therapy and what could be argued to be coercion tactics some consultants would use:

I can recall patients being “talked to”; invariably this would be by the consultant. There were two consultants who seemed to...erm...have an interest in homosexuality. I do think that the form of all discussions took the form of an assessment that was essentially pointing out to the patients that their condition was in fact an illness. And...erm...even if patients didn't accept that it was an illness, there was a treatment that would rectify them. And the rectification was that they would become heterosexual. So the preparation was essentially talking, informing, and getting people to agree. Erm...I think the medical staff were not averse to saying: “Well of course if you do not have the treatment the alternative is imponderable, in the sense that you will be back out on the street and you will be very vulnerable.” It was a case of trying to convince the patient that it was much easier to be here [hospital], as outside they would be had by the police. And of course this was very frightening to the young homosexuals at the time because ending up in prison they would get very badly treated. Patients often stated: “If I had known what this treatment really was, I would never have agreed it”.<sup>89</sup>

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<sup>87</sup> Delroy Heath, interviewed 28<sup>th</sup> April 2010.

<sup>88</sup> Adam Carter, interviewed 25<sup>th</sup> March 2010.

<sup>89</sup> Luke Vanson, interviewed 23<sup>rd</sup> June 2010.

While it could be argued that the nurses in this study believed that because the patients had consented to aversion therapy it offered them both a rationalisation to administer it and a legal safeguard. The above testimonies could suggest, however, that patients were not fully informed regarding the treatment they opted for. Therefore, in these cases I would argue that the patients did not give fully informed consent. Furthermore, I would suggest that health care professionals, the media and the courts all held a paternalistic attitude towards sexual deviants, and employed implicit and explicit tactics that coerced them into receiving treatment by reducing their autonomy. Autonomy can be defined as ‘the capacity to think, decide, and act on the basis of such thought and decision freely and independently and without let or hindrance’.<sup>90</sup> Moreover, an autonomous decision is, ‘one which is undertaken voluntarily, and not under coercion, however covert that coercion may be’.<sup>91</sup> Therefore, I would propose that the strategies discussed above were an affront to the patient’s autonomy because they reduced the degree of voluntariness on the part of the patient.

### **Initiation**

Due to the unpleasantness of the nurses’ role, particularly when caring for a patient receiving chemical aversion therapy, requiring participation was sometimes used by senior nurses as an opportunity to test a new recruit’s suitability for mental nursing. Some nurses in this study recount anecdotes of how they were exposed to shocking sights or placed in an impossible position when their Charge Nurse delegated a task to them:

It was my first day as a student nurse on a new ward and the Charge Nurse said he had a “special patient” for me. He said it would be a good opportunity for me to craft my injection technique, and we went to the clinic and drew up some apormorphine. We then walked down to the side-room and he

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<sup>90</sup> Gillon, *Philosophical Medical Ethics*, p. 57.

<sup>91</sup> Rumbold, *Ethics in Nursing Practice*, p. 226.

gave me a rather pejorative description of the patient I was going to administer the injection to. I remember feeling uncomfortable about this, but I didn't want to oppose his views as I didn't want to create a bad impression on my first day. As we got closer to the side-room the smell became apparent, and I could feel myself beginning to feel nauseous. As I opened the door to the side-room I can only describe it as comparable to a zoo: there was faeces, vomit and urine everywhere. My emotions were all over the place, I felt so sorry for the poor lad in there, but I knew I had to keep them to myself... [Wipes tears from her eyes]...The Charge Nurse said: "Right on the bed \*\*\*\*\* [patients surname], time for your jab!" The patient just pulled down his trousers and lay on the bed. I had no time to object: the Charge Nurse just said: "Off you go, then!" I gave him the injection and we left, there was no communication with him. Nor was there any debriefing or rationale offered to me regarding the treatment. However, I believed that my ability to undertake this task without question and devoid of emotion meant that I could be "accepted" onto the ward.<sup>92</sup>

Nolan suggests that many student nurses were exploited. Nurse-Tutors addressed trainees as 'nurses', but on the wards, they were referred to merely as 'attendants'.<sup>93</sup> Emily Whitbread's testimony above could suggest that at times nursing students were also bullied. A similar incident was related by a female nurse in Nolan's study who commenced mental nursing after completing her general training:

I wanted to make a good impression on my first day, so I wore the best clothes I had. I had a hat I was especially fond of that I wore; it had a veil which came some way down my face. I must have looked like a duchess! I asked a nurse for the person in charge of the ward. She looked long and hard at me and said: "Oh laa-dee-daa, you must be the general nurse." I was left for a time just standing there in the middle of the ward by myself. After ten or fifteen minutes, the Sister came to me and gave me a key and told me to open side-room 3 and let the patient out. I dutifully marched along to the side-room and when I opened the door, a tall bewildered woman picked up a bucket of stale smelly urine and poured it over my hat and clothes. When I went back to the Sister, she expressed surprise in a mocking way and suggested that I must have provoked the patient. The other staff, I remember, found it hilariously funny. It was their way of

<sup>92</sup> Emily Whitbread, interviewed 7<sup>th</sup> January 2010.

<sup>93</sup> Nolan, *Psychiatric Nursing Past and Present*, p. 227.

dealing with someone they thought had airs and graces and needed taking down a peg or two. Though I was furious at the time and thought of storming out, I stayed.<sup>94</sup>

I suggest, therefore, that in their eagerness to be “accepted” and their inability to question their superiors, Emily Whitbread and the nurse in Nolan’s study had been ready to undertake anything required of them. However, in doing this, some nurses appeared to have given up their status as moral agents and become fully passive to their superiors within the institution in which they were working. Nolan argues that Charge Nurses often showed favouritism by holding back patients’ food or tobacco and dispensing them to staff they trusted. Staff who were friends would regularly play cards or dominos on the wards in the evening time. However, new staff members were excluded until they were considered ‘safe’.<sup>95</sup>

### **Humour**

Some nurses in this study commented that they used humour as a coping mechanism to deal with the incongruity they faced on a daily basis on psychiatric wards – not least when nursing patients receiving aversion therapy. Humour, as Unna Drinkwater commented, kept them going: ‘[...]without it, a lot of us would have crumbled under the pressure’,<sup>96</sup> and Charles Dance remarked, ‘[...] we needed a sense of humour to deal with the illogicality of what we were doing’.<sup>97</sup> Meanwhile Terry Orchard reflected that having a good sense of humour was a pertinent aspect of being a good mental nurse:

It was always a good sign for me if someone had a sense of humour. We were dealing with some pretty distressing things on a daily basis, especially nursing the patient receiving aversion therapy. Yes – a lot of the reasons why we administered these treatments was due to us not wanting or knowing how to

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<sup>94</sup> Testimony of a female nurse in Nolan, *Psychiatric Nursing Past and Present*, p. 178.

<sup>95</sup> Nolan, *Psychiatric Nursing Past and Present*, p. 178.

<sup>96</sup> Unna Drinkwater, interviewed 29<sup>th</sup> December 2009.

<sup>97</sup> Charles Dance, interviewed 5<sup>th</sup> December 2010.



question our superiors. But we also used humour as a way of normalising what we did. I'm not excusing what I did by saying we had a good laugh about it, but we had to develop a way of dealing with our stress and conscience before the advent of clinical supervision and the like. They [other nurses] would take the mickey out of my accent or where I came from. I never saw it as anything callous – it was just banter.<sup>98</sup>

Humour has been recognized as a mechanism by which emergency workers rearranged their work, released tension and created emotional alliances with their teams.<sup>99</sup> Furthermore, Thomas Kuhlman argues that 'black' or 'gallows' humour is widespread amongst groups who work in acute environments or where they experience incongruity. He also suggests that black humour is an 'illogical, even psychotic, response to irresolvable dilemmas and offers a way of being sane in an insane place'.<sup>100</sup> Prebble proposes that mental nurses experienced incongruity on a daily basis; however, they also experienced a gap between the rhetoric of therapeutic efficacy and the reality of crowded wards, limited resources and staff and the challenge of nursing chronically disabled patients.<sup>101</sup> I would suggest that the nurses in this study used humour as a way of coping with the absurdity of administering aversion therapy. Moreover, I would also posit that it was utilised as another way of limiting their conscience in relation to engaging in this aspect of their clinical practice. Nevertheless, it could also be argued that inappropriate humour is also part of the framework of abuse.

### **“Subordinate” State Enrolled Nurses**

In Chapter III, it was established that the “subordinate” State Enrolled Assistant Nurse (SEAN) was introduced with the Nurses' Act 1943. However, enrolled nurses were not

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<sup>98</sup> Terry Orchard, interviewed 10<sup>th</sup> August 2010.

<sup>99</sup> Carmen Moran & Margaret Massam, 'An Evaluation of Humour in Emergency Work', *The Australian Journal of Disaster and Trauma Studies* 3 (1997), pp. 176-179.

<sup>100</sup> Thomas L. Kuhlman, 'Gallows Humour for a Scaffold Setting: Managing Aggressive Patients on a Maximum Security Forensic Ward', *Hospital and Community Psychiatry* 39 (10) (1988), p. 1085.

<sup>101</sup> Prebble, *Ordinary Men and Uncommon Women*, p. 201.

introduced in mental nursing until 1964. There had been rhetoric to capitalise on the work-force of assistant or auxiliary nurses in mental hospitals in both the 1924 Departmental Committee and the 1926 Royal Commission, although these measures had never come to fruition. This has been considered to be due to the major opposition to this new role, not least by the Athlone Sub-Committee's report on mental nursing in 1945, which rejected this rhetoric.<sup>102</sup> Rosemary White proposes that the Athlone Sub-Committee was strongly against the SEAN entering mental nursing because the sub-committee perceived that the standard of mental nursing was not high enough for there to be second grade nurses in addition to the registered mental nurse.<sup>103</sup>

However, the notion of introducing a second grade of nurse into mental nursing would be severely pressed by the Ministry of Health in 1953 when they published a memorandum entitled 'Supply of Nursing Staff for Mental Hospitals and Mental Deficiency Institutions', more universally known as RHB (53) 54. Its purpose was to suggest, 'some courses of action designed to improve the staffing situation'.<sup>104</sup> Chatterton argues that the Ministry of Health wanted to dilute the mental nurse work force, in a purely economic move to reduce costs, by introducing 'subordinate nursing staff', which included nursing assistants and SEANs.<sup>105</sup> Eileen Baggott proposed that the Ministry of Health published the memorandum as an anticipatory intervention, as they believed many mental hospitals would struggle to recruit student nurses once the minimum standard of entry into the profession was implemented in 1966.<sup>106</sup> Prior to this, there was no minimum entry criterion, and Baggott argued that many of the

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<sup>102</sup> Chatterton, "'The weakest link in the chain of nursing?', p. 133.

<sup>103</sup> Rosemary White, *The Effects of the NHS on the Nursing Profession* (London, 1985), p. 25.

<sup>104</sup> Chatterton, "'The weakest link in the chain of nursing?', p. 128.

<sup>105</sup> Chatterton, "'The weakest link in the chain of nursing?', p. 128; Nolan & Hopper, 'Mental Health Nursing in the 1950s and 1960s Revisited', p. 334.

<sup>106</sup> Baggott, 'The SEN in Psychiatric Hospitals', p. 1478.

student nurses at the time would have fallen into the educational category of pupil nurses.<sup>107</sup>

There was strong opposition to RHB (53) 54 from the Confederation of Health Service Employees (COHSE), the main trade union for mental nurses during this period.<sup>108</sup> The COHSE argued that the need was for more registered nurses and feared that the introduction of the SEAN into mental nursing would overload the mental hospitals with unqualified or semi-qualified staff. They also believed that it would lead to ‘unqualified staff having to bear ward responsibilities after a few lectures in first aid and home nursing’.<sup>109</sup> Furthermore, the RMPA rejected this grade of nurse being introduced to mental nursing mainly for pragmatic reasons. They did not have the capacity to develop, write and implement a new nursing syllabus for these proposed nurses.<sup>110</sup>

Nevertheless, despite opposition, by the early 1960s the GNC had drawn up, and had approved by their “Mental Nursing and Enrolled Nurses Committee”, a draft syllabus, record of practical instruction and experience required to enable a pupil nurse to enrol with them. Once enrolled, these nurses would be known as the shortened State Enrolled Nurse (SEN) following the 1961 Amendment Act.<sup>111</sup> The SEN was officially entered into mental nursing in the 1964 Nurses’ Act. There was no question of a separate roll: mental SENs would be admitted to the existing roll. However, in 1969 the roll was divided into three parts: general, mental and mental sub-normality.<sup>112</sup> Most interesting for this study, however, is the concept of these nurses being known as “subordinate staff”.

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<sup>107</sup> Baggott, ‘The SEN in Psychiatric Hospitals’, p. 1478.

<sup>108</sup> Chatterton, “‘*The weakest link in the chain of nursing?*’”, p. 138.

<sup>109</sup> Chatterton, “‘*The weakest link in the chain of nursing?*’”, pp. 138-139.

<sup>110</sup> Chatterton, “‘*The weakest link in the chain of nursing?*’”, pp. 140-141.

<sup>111</sup> An interesting perception of the GNC’s views regarding mental nursing and mental sub-normality nursing was that both the EN Mental Nurses’ and EN Mental Sub-Normality Nurses’ syllabuses were the same, as they determined that a different syllabus was not required: Chatterton, “‘*The weakest link in the chain of nursing?*’”, pp. 142-143.

<sup>112</sup> Chatterton, “‘*The weakest link in the chain of nursing?*’”, p. 143.

The testimony of three of the SENs in this study has already been explored in Chapter III; these nurses were also homosexual. One of the explanations they offered for their participation in administering aversion therapies for patients in the same situation as themselves, in parallel with Nurse Rivers discussed above, was that they believed they were acting beneficently. This was further compounded by the fact that the nurses did not always possess the medical knowledge that they perceived the doctors to have, so they believed that it was pertinent for the well-being of a patient that nurses obey orders.

Moreover, all four SENs in this study suggested that the overriding reason why they participated in this aspect of clinical practice rested on the perception of subservience to higher authority:

I think we [SENs] had a harder time than most on the wards. Although we were very skilled and experienced nurses we were never rewarded monetarily or with much respect at all. We were seen as subordinate and had to take orders from the doctors and from the registered nurses. We were even seen as subordinate to third year student nurses and subsequently had to take orders from them too. I found that really difficult sometimes. Some of them were OK and valued our opinion, others thought they were a cut above the rest and went on to develop what I called “staff nurse itus”. By that I mean the day they qualified and donned their blue uniform they conducted themselves in a haughty manner, thinking they knew it all. They invariably soon fell from grace and I would sometimes have to pick up the pieces. [...] Our training was very practical and it was more around skills than underpinning knowledge. So even if I had had the professional status to question practice, my lack of knowledge gave me little information to be able to put forward a valid argument. It was easier to just get on with the task I had been given.<sup>113</sup>

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<sup>113</sup> Pat Mullins, interviewed 14<sup>th</sup> July 2010.

Meanwhile, Elliot Whitman recalls how he felt SENs were often exploited:

We [SENs] were often left in charge of wards at night. It “took the piss” really as even though we were seen to be subordinate and not competent to make clinical decisions we were often left in charge and had to do the job of a staff nurse for the money and status of an SEN. [...] I suppose subservience was drummed into me from day one as I started off as a nursing assistant. I was also in the first cohort of SENs to qualify in mental nursing following a long debate about whether we were needed in mental hospitals. There was initially some hostility to us as we were an unknown quantity and I think some staff nurses felt we were going to take their jobs so they were keen to keep us in our place I suppose. We were seen as inferior to higher ranking staff and given that there was a big emphasis on the hierarchical structure in mental hospitals, I identified myself as being quite low down this structure and, therefore, never really thought I could say “no” to a superior.<sup>114</sup>

Baggott published a paper in the *Nursing Times* in 1965 regarding the decision the previous year to introduce SENs into mental nursing. She argued that this decision was essentially positive, but only if handled appropriately. She proposed that she would like to see pupil nurses, student nurses, enrolled nurses and registered nurses all working together in ‘harmony’ as a team. Additionally, Baggott advocated that a pupil nurse should ‘learn at the bedside but she will know something about the patient’s condition and about the nursing procedure beforehand’. Furthermore, she suggested the potential risk of leaving enrolled nurses in charge of wards.<sup>115</sup> On analysis of the above testimonies, there appears to be evidence of an immense gulf between the prescriptions of theory, the intentions of policy and the realities of practice.

It seems that SENs were often exploited and gained little respect from some staff in higher-ranking positions. In addition, they appear to have received a very pragmatic education, which placed little emphasis on underpinning theories, and this led them to

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<sup>114</sup> Elliot Whitman, interviewed 20<sup>th</sup> March 2010

<sup>115</sup> Baggott, ‘The SEN in Psychiatric Hospitals’, pp. 1478-1480.

feel unable to question practice. Moreover, the above testimonies could suggest that referring to these nurses as “subordinate” was a self-fulfilling prophecy. By doing this, I would argue that it was only inevitable that they might take on such an obedient role. This and the notion of beneficence, could offer a possible interpretation for why the SENs in this study participated in aversion therapy for sexual deviations.

### **Militarisation of nursing**

As discussed in Chapters II and III, many mental nurses in the early 1940s were called up and assigned to the Royal Army Medical Corps, and many ex-service personnel who had not previously worked in mental health entered mental nursing after World War II due to limited employment opportunities.<sup>116</sup> I will argue in Chapter V that some nurses’ experiences during the war also had a positive impact upon their attitude towards homosexuals and transvestites in their care. Nevertheless, there were also some arguably negative influences that “leaked” into civilian nursing from mental nurses’ military service during the Second World War.

Nolan argues that mental nursing had much in common with military service, as it offered a regimented life, where nurses had to do little thinking for themselves and where there was plenty of company always available, particularly ex-servicemen.<sup>117</sup>

Indeed, Julian Glover remarked:

I was amazed at the number of other ex-military personnel there were at the hospital when I started my nurse training. I suppose it could have been due to the parallels: like the military, the only real thinking we had to do was to make sure we followed the rules and orders.<sup>118</sup>

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<sup>116</sup> See, e.g. Nolan, ‘Jack’s Story’; Peter Nolan, ‘Attendant Dangers’, *Nursing Times* 85 (12) (1989), pp. 56-59; Nolan, *Psychiatric Nursing Past and Present*; Chatterton, “‘The weakest link in the chain of nursing?’”.

<sup>117</sup> Nolan, ‘Jack’s Story’, p. 25.

<sup>118</sup> Julian Glover, interviewed 4<sup>th</sup> January 2010.

Other individuals appeared to enter the profession after the war as a form of self-prescribed therapy to help them deal with the atrocities that they had experienced during the war:

I suppose I needed it. I left the army all confused and totally unprepared for “civvy” street. I suppose you could say I used nursing as a form of rehabilitation.<sup>119</sup>

Bourke argues that many health care professionals witnessed the war as an immense laboratory for experimentation and the testing of theories, and techniques of fear management learnt within the military context were applied, essentially unaltered, to entire populations. She proposes that the ‘total environment of control’ which was accepted as inevitable within the armed forces was overlaid onto civilian society.<sup>120</sup> Moreover, a doctor publishing in the *British Medical Journal* in 1940 stated, ‘the civilian population must be treated as if they were combatant troops; they must be under authority’.<sup>121</sup> This could provide a possible interpretation for some nurses’ acceptance of the experimental nature of aversion therapy to treat sexual deviations.

Penny Starns argues that militarisation became a distinct and deliberate feature of nursing policy during the 1940s. This was pioneered by Dame Katherine Jones, a military nurse since 1916. She was mobilised on 11<sup>th</sup> September 1939 as Senior Principle Matron on the staff of general headquarters of the British Expeditionary Force. As Matron-in-Chief of the Army, she proposed explicitly that militarisation provided an opportunity to resolve nurse status issues once and for all.<sup>122</sup> Jones was noted to instigate a full-blown militarisation programme for Army nurses, subjecting them to types of training such as drill and route marching three miles into the desert and

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<sup>119</sup> Nolan, ‘Jack’s Story’, p. 27.

<sup>120</sup> Bourke, ‘Disciplining the Emotions’, p. 226.

<sup>121</sup> Maurice B. Wright, ‘Psychological Emergencies in War Time’, *British Medical Journal* 9 (1940), p. 576.

<sup>122</sup> Starns, ‘Fighting Militarism?’, p. 194.

back to improve their fitness. Starns advances that while some nurses viewed the introduction of such activities as ‘fun and games’; there were others who took the military procedures very seriously. In some cases these nurses would allocate beds and examine patients according to their rank – the lowest rank was last to receive medical attention – irrespective of the severity of their medical need. There was a huge emphasis placed on discipline and obedience to orders from higher-ranking officers.<sup>123</sup>

Hopton argues that this model of militarisation extended to civilian nursing and nurse discipline became more severe and stressed the importance of class distinction, duty and self-sacrifice.<sup>124</sup> Indeed, Prebble argues that the language and routines of mental nurses had parallels with military life. For example, staff rooms were called ‘staff quarters’ and staff dining rooms were called ‘mess rooms’.<sup>125</sup> Furthermore, civilian nurses’ uniforms were increasingly regimented: stripes on sleeves were adopted to distinguish rank. Nurses were also noted to become obsessed with punctuality in ward routines and a military attitude toward personal appearance. Their shoes were expected to be shined, shoulder epaulettes had to align with creases on sleeves, and stiffly starched aprons had to be worn.<sup>126</sup>

In spite of the nurses in the picture in Figure 10 looking fairly jolly, it could also attest to the regimentation discussed above as the nurses appear to all have black shoes, their stiffly starched aprons are all calf-length and they all appear to be wearing bow ties. Furthermore, they appear to be strategically arranged alternately with either their cape straps criss-crossing their chest or their cape straps not on show. I would also argue that this picture illustrates a sense of camaraderie between these nurses.

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<sup>123</sup> Starns, ‘Fighting Militarism?’, p. 196.

<sup>124</sup> Hopton, ‘Prestwich Hospital in the Twentieth Century’, p. 355.

<sup>125</sup> Prebble, *Ordinary Men Uncommon Women*, p. 52.

<sup>126</sup> Starns, ‘Fighting Militarism?’, p. 197.





**Figure 10. Mental nurses circa 1950s.**

**Source: Reprinted with permission from the Glenside Hospital Museum, Bristol.**

“Jack”, who was interviewed in Nolan’s study, took part in the 1940 Campaign in France during World War II and was taken prisoner after a matter of weeks. He spent the rest of the war in POW camps in Poland and Germany. However, he entered mental nursing after the war when his old army friend who was working as a mental nurse persuaded him to enter the profession. Jack’s testimony demonstrates how daily inspections of the nurses by the superintendent meant that they were considered akin to soldiers being assessed on a parade:

[...] there were times when I thought I was still in the army. I must admit there were times when it was all that I had hoped army life would be. I felt very proud of my uniform and it meant a great deal to me when the Superintendent used to remark how smart I looked.<sup>127</sup>

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<sup>127</sup> Nolan, ‘Jack’s Story’, p. 25.

In the present study, Faith Ashley recalls a Sister who had gained military experience in the Second World War:

One Sister I worked under had served in the army during the war; she ruled her ward with an iron fist and with military precision. No one ever dared to question her. I will never forget her daily inspections. She was very nit-picky, and my heart used to be going ten to the dozen as she examined me from head to toe.<sup>128</sup>

Many nurses who had served during the war returned to clinical practice in a civilian role once it had ended. Therefore, it was inevitable that they might also bring with them some of the military ideologies discussed above. This could offer a further context within which to explain the subservient role that some nurses in this study adopted.

### **Psychological insights into the subordinate nurses' actions**

Daniel Goldhagen proposes that in some instances obedience to higher authority is pursued due to an individual's self-interest, which is 'conceptualised as career advancement or personal enrichment' in total disregard of other considerations.<sup>129</sup> However, I would argue that this explanation is untenable for the majority of nurses in this study – not least the SENs – and those who remained staff nurses for their whole careers. These nurses had no organisational or career interests to advance by their involvement in aversion therapy. They were not striving for promotion, especially the SENs, as this would have meant retraining as a registered nurse, and all expressed their unease with that prospect. Therefore, as an interpretation to participate in aversion therapy, this "self-interest" argument fails to accord with the majority of nurses' testimonies in this study. These nurses did not have any career or material incentives to

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<sup>128</sup> Faith Ashley, interviewed 17<sup>th</sup> July 2010.

<sup>129</sup> Daniel J. Goldhagen, *Hitler's Willing Executioners: Ordinary Germans and the Holocaust* (London, 1996), p. 384.

make them want to say “no” to their superiors regarding their participation in aversion therapy.

Stanley Milgram proposes that humans in general are blindly obedient to authority, and that in some cases they reflexively obey any order, regardless of its content.<sup>130</sup> However, Herbert Kelman and Lee Hamilton argue that this interpretation is indefensible, as they claim that all obedience depends upon the existence of a favourable social and political context, in which individuals deem the commands that have been issued not to be a gross transgression of their intrinsic values and their central morality.<sup>131</sup> Indeed, Goldhagen suggests that if favourable social and political contexts are not in place, people will seek ways, ‘granted with differential success, not to violate their deepest moral beliefs and not to undertake such grievous acts’.<sup>132</sup>

Moreover, when we revisit the political rhetoric and media headlines discussed in Chapter II, I would suggest that these were broadly in favour of aversion therapy to treat sexual deviations. Therefore, I would argue that there was a favourable social and political context to these treatments. This could corroborate the influential impact that the media and political rhetoric had on the nurses’ morality in relation to their participation in aversion therapy, and can offer further a context upon which to explain their subservient behaviour in regard to this aspect of their clinical practice. Indeed Jackie Fletcher remarked, ‘I remember the press discussing “how a doctor had cured a homosexual”...I suppose the fact it was printed for all to see was confirmation of the good work we were doing.’<sup>133</sup>

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<sup>130</sup> Stanley Milgram, *Obedience to Authority: An Experimental View* (New York, 1969), p. 76.

<sup>131</sup> Hebert C. Kelman & Lee Hamilton, *Crimes of Obedience: Toward a Social Psychology of Authority and Responsibility* (New Haven, 1989), 78.

<sup>132</sup> Goldhagen, *Hitler's Willing Executioners*, p. 385.

<sup>133</sup> Jackie Fletcher, interviewed 12<sup>th</sup> February 2010.

## Conclusion

Despite literature at the time warning nurses not to merely accept orders in relation to administering aversion therapy; there appears to be a dissonance between reality and rhetoric. Some nurses in this study appeared to have behaved in a subservient, unenquiring and unquestioning manner that resulted in, or at least contributed to, their behaviour and participation in what could now be perceived as professionally incongruent activities. There appear to be several interpretations that could help to explain why some of the nurses in this study developed a passive obedience to higher authority. The passivity referred to here is around the nurses accepting orders from a superior.

I argue that because orders to the nurses were given from a doctor, sister, nursing officer or charge nurse, or in the case of SENs from a registered nurse or third year student nurse, this stood as a kind of guarantee of medical quality and ethical correctness of those orders. Additionally, due to the media sanguinely reporting cases of doctors “curing” homosexuals, this also affirmed the appropriateness of the treatment for some nurses. Therefore, I would suggest that the combination of the media, the culture of mental hospitals during this period, discussed in the previous chapter, the effect of militarisation in nursing and fear of harsh discipline created a fertile and receptive environment where nurses understood their ethical responsibilities in terms of a strong commitment to obedience.

It was identified that there were parallels between some nurses in this study and Nurse Rivers in the Tuskegee study. This was due to some nurses believing that they were acting beneficently because the patient had consented to the treatment and due to their perception that aversion therapy was the most effective intervention to cure sexual

deviance at the time. However, I argued that by acting based on their notions of beneficence, they were not upholding the principle of non-maleficence.

Furthermore, I would propose that patients were implicitly coerced into receiving aversion therapy by the law, when they were given an option of prison or hospital, the media, discussed in Chapter II, and the paternalistic attitudes of nurses and doctors. The reasons for such paternalistic attitudes could have been the result of the factors discussed in the Chapter III, including the broadening definitions and conceptions of mental illness, and the psychiatrists' – and nurses' – endeavour to bring “new” patients into the hospital at a time when numbers generally were being reduced. These could all have led, however, to the health care professionals not upholding the patients' autonomy in relation to their decision to consent to the treatment.

While I noted the different historical context and that none of the nurses in this study knowingly murdered patients, as nurses under Nazi rule did, I identified that there was an issue here of a replaying, in a minor key, of some of the dynamics between Nazi nurses and their role in the euthanasia projects, and the nurses in this study and their role in aversion therapy. As with the Nazi nurses, there is evidence to suggest that some nurses in this study overcame any reservations they may have had in relation to administering aversion therapy by focussing on specific tasks and using dehumanising language, while others used humour. This could offer a strand of analysis to help explain some nurses' participation in aversion therapy.

Finally, the predominant theme among the nurses in this study was that they appeared to develop a passive obedience to higher authority, and the chapter gives us clues as to the negative ways in which obedience to higher authority can work. There were others, however, who were able to covertly undermine their superiors by engaging in some fascinating subversive behaviours. The next chapter introduces the “subversive nurses”

in this study, and seeks to explore their testimonies, to discover how some nurses appeared to resist the powerful influences discussed above.

## CHAPTER V

### “SUBVERSIVE NURSES”

Thinking critically does not mean simple criticism. It means not simply accepting information at face value in a non-critical or non-evaluating way. The essence of critical thinking centers *not* on answering questions but on questioning answers, so it involves questioning, probing, analyzing and evaluating. The most subversive people are those that ask questions.<sup>1</sup>

#### Introduction

In the previous chapter, various accounts of “subordinate” nursing behaviours were analysed and it was reasoned that some nurses in this study appeared to have adopted a predominantly subservient, unenquiring and unquestioning relationship with those in higher authority. While no nurses in this study steadfastly objected and refused to administer treatments for sexual deviations, some nurses, nevertheless, took huge professional risks, and did covertly question the orders they were given. These nurses did this by engaging in what can be described as furtive and subversive behaviours to avoid administering treatments for sexual deviations.

In this chapter, I will seek to analyse these “subversive” nurses’ testimonies and examine the nature of their behaviours. Were these cases of gross misconduct, or could they be seen as empathetic, autonomous practitioners who believed they were acting in their patients’ best interests? I will also explore how some of these behaviours can be seen as being gendered in nature: nurses were not simply passing as a nurse, they enacted particular types of masculinity and femininity which they deemed to be appropriate to evade being caught or suspected of disobeying those in higher authority. Finally, due to the self-report nature of some of the evaluations of treatments used to cure sexual

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<sup>1</sup> Jostein Gaarder, *Sophie's World: A Novel about the History of Philosophy* (London, 1995), p. 128.

deviations, a number of former patients who participated in this study also managed to subvert their treatment process by feigning heterosexuality or repulsion with their transvestism in order to be discharged. I will explore their testimonies to highlight the variation and limited rigour of the treatments utilised for sexual deviations.

### **Subversion and nursing**

#### *The Special Operation Executive and the First Aid Nursing Yeomanry*

Nursing is not known for being a subversive profession and unsurprisingly there is a paucity of literature that explores nurses engaging in subversive and resistive practices. There are, however, a few examples in historical records that can illuminate this aspect of nursing history. They will be included here for comparative purposes. During World War II, women in the British First Aid Nursing Yeomanry<sup>2</sup> (FANY) were employed by the Special Operations Executive (SOE), a clandestine organisation with the sole aim of subverting and sabotaging the enemy overseas. Women SOE agents were given commissions in the FANY as a cover for their furtive war work. It was also envisioned that their commission would enable these agents, if captured in the line of duty, to be treated as prisoners of war under the Geneva Convention.<sup>3</sup> At the height of the SOE's activities in mid-1944, over half of the FANY's strength was devoted to the SOE. Of particular importance to the SOE was that the FANY had no restrictions on the use of arms as in other women's services.<sup>4</sup>

In 1938, the British Secret Intelligence Service (SIS, also known as MI6) established a section called Section D; it gained its name due to the 'destruction' caused by sabotage and subversion undertaken in the Balkans. Military Intelligence Research established

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<sup>2</sup> The FANY was a voluntary civilian women's organisation established in 1907 to bridge the divide between the front line and medical stations. During the First World War about 400 FANYs drove ambulances and other vehicles in England, France and Belgium: Marcus Binney, *The Women who Lived for Danger* (London, 2002), p. xiii.

<sup>3</sup> Binney, *The Women Who Lived For Danger*, p. 8.

<sup>4</sup> Kathryn J. Atwood, *Women Heroes of World War II* (Chicago, 2011), p. 4.



that insurgent warfare could assist in diverting the enemy troops if used in juxtaposition with the regular armed forces.<sup>5</sup> Following the Nazi “blitzkrieg” of the Low Countries, the withdrawal of the British Expeditionary Force from Dunkirk and the surrender of France, the new British War Cabinet under Winston Churchill sanctioned a higher priority for acts of sabotage and subversion. On 27<sup>th</sup> May 1940, they agreed to a reorganisation of bodies concerned with subversive activities; this led to the establishment of the SOE on 1 July 1940.<sup>6</sup> Sabotage and subversion were given a very high profile in Churchill’s war strategy. He regarded this form of activity as of the very highest importance and put plans in place for its immediate implementation.<sup>7</sup>

The SOE was organised according to territories, with each country having its own section and staff: F (independent of de Gaulle), RF (the Gaullist section), EU/P (Poles in France) and D/F (escape lines and clandestine communications).<sup>8</sup> F Section built up a network of independent circuits throughout France with the sole aim of sabotaging and subverting the enemy.<sup>9</sup> In total, 480 British agents were sent to France by F Section. Despite heavy losses and German penetration, F Section agents played an important role in increasing the pace of resistance against the Nazi regime, especially in the run-up to D-Day, by conducting sabotaging and subverting operations which delayed German troops reaching the Normandy beaches.<sup>10</sup> Of the 480 agents sent over to occupied France, 39 were women.<sup>11</sup>

The SOE capitalized on nursing links in a lot of its female agents’ cover stories.<sup>12</sup> Indeed, under “Operation Nurse” Noor Inayat Khan was the first woman radio

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<sup>5</sup> Binney, *The Women who Lived for Danger*, p. xiii.

<sup>6</sup> Pattinson, *Behind Enemy Lines*, p. 2.

<sup>7</sup> Pattinson, *Behind Enemy Lines*. The original document is on pp. 2-3.

<sup>8</sup> Pattinson, *Behind Enemy Lines*, p. 3.

<sup>9</sup> Atwood, *Women Heroes of World War II*, p. 4.

<sup>10</sup> Pattinson, *Behind Enemy Lines*, p. 3.

<sup>11</sup> Shrabani Basu, *Spy Princess: The Life of Noor Inayat Khan* (Stroud, 2006), p. 14.

<sup>12</sup> Atwood, *Women Heroes of World War II*, p. 3.

operator to infiltrate occupied France on the night of 16/17 June 1943, under the code name Jeanne-Marie Renier, a children's nurse.<sup>13</sup> Working under her nursing cover story, she made an important contribution to the war effort by maintaining communications between England and France, and was able to evade the Germans on numerous occasions. However, Noor was arrested by the Gestapo on 13<sup>th</sup> October 1943, and was subjected to a torturous and protracted interrogation. Nevertheless, she remained silent and gave the enemy no information. The SOE were unaware of her capture and continued to play into the hands of the Germans who had her radio set and they sent supplies of arms and money, as they believed it was being requested by Operation Nurse.<sup>14</sup> Tragically, Noor was eventually transported to Dachau on 11<sup>th</sup> September 1943 with three other SOE agents. There are conflicting accounts of exactly what happened to Noor once she reached Dachau. However, Shrabani Basu argues that, 'whatever did happen on the night of the 12/13 September 1944, the only truth is that Noor and her colleagues died a horrible death at Dachau'.<sup>15</sup>

#### *Maria Stromberg and Irena Sendler*

While it was established in the previous chapter that many German nurses under Nazi rule engaged in some barbaric and unethical practices by obeying orders from higher authority, there are scattered accounts of at least one nurse and two social workers who engaged in resistive activities while working under this regime. Maria Stromberg was Oberschwester (head nurse) for the SS infirmary of Auschwitz, one of Nazi Germany's most infamous concentration camps. During her work at the infirmary, she risked her life on numerous occasions to save Polish inmates from torture and death.<sup>16</sup> Stromberg was able to gain the inmates' trust and smuggled food and medicine into the camp for

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<sup>13</sup> Basu, *Spy Princess*, p. 129.

<sup>14</sup> Basu, *Spy Princess*, p. 211.

<sup>15</sup> Basu, *Spy Princess*, p. 217.

<sup>16</sup> Benedict, 'Maria Stromberger', p. 189.

them. She also performed an astonishing act on Christmas day 1943 by smuggling wine, champagne and good food into the infirmary. She created a makeshift table in the attic and covered it with a clean white bed sheet. She then prepared and served a Christmas dinner to the Polish prisoners who worked in the infirmary – an act that would certainly have put her life at risk.<sup>17</sup> Stromberger was able to be so successful in her smuggling because she was easily identifiable as a nurse in her white coat and able to move freely around the camps without suspicion.

Irena Sendler was a social worker in Warsaw, Poland. In December 1942, she was made head of Zegota's (the code name for the Council for Aid to Jews) children's department. Irena and a colleague, Irena Schultz, were sent into the Warsaw ghetto with food, clothes and medicine, including a vaccine against typhoid. However, it soon became apparent to them that the ultimate destination of many of the Jews was to be the Treblinka death camp. Therefore, Sendler and Schultz disguised themselves as nurses (as social workers were later banned from entering the ghetto) and orchestrated an escape network to try to save as many children as possible from this deadly fate. Some children were transported in coffins, suitcases and sacks; others escaped through the sewer system beneath the city.<sup>18</sup>

The SOE, Stromberger, Sendler and Schultz appeared to monopolise on the perceived innocence and compliance of the nursing profession as a safeguard to avoid suspicion of their resistive work. Moreover, I will argue later in the chapter that there are some parallels with the tactics SOE agents and Stromberger used to avoid suspicion from the SS and the strategies the subversive nurses in this study utilised to avoid being caught or suspected of engaging in resistive practices.

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<sup>17</sup> Benedict, 'Maria Stromberger', p. 196.

<sup>18</sup> "Irena Sendler", *The Telegraph*, 12<sup>th</sup> May 2008; "Irena Sendler, Lifeline to Young Jews, Is Dead at 98", *The New York Times*, 13<sup>th</sup> May 2008.

## Questioning orders

Only two female nurses in this study engaged in furtive resistive practices to avoid participating in aversion therapy for sexual deviations, and both these nurses took huge professional risks to undertake these actions. Unna Drinkwater recalls her subversive work when she nursed a homosexual patient who had been admitted to her ward on a court order:

I was working nights in my last year before retirement when I nursed \*\*\*\*\* [name of patient receiving chemical aversion therapy for homosexuality]. I can still remember his name. Now I had always prided myself for showing the utmost of respect, courtesy and empathy for the patients in my care and it sickened me knowing what we had to do to him in the futile hope of making him heterosexual. I just thought: “Where is the treatment in that?” I just couldn’t see any benefit to it – it was punishment and torture. Especially because this particular patient was on a court order, and so he hadn’t really consented to the treatment. They were given a choice: prison or hospital? Many chose hospital as no one wants to go to prison do they? So I was desperate not to get involved with it, but I knew it would be more hassle than it was worth if I refused. Not only would my life have been made hard work, because I would have been seen as a troublemaker. I also thought it will only end up being someone else doing the dirty work and they probably wouldn’t have been as compassionate as me [...] So what I did, every two hours when I was supposed to give him the injections was this. [Pause. Takes deep breath] I went into his room and sat down on the bed next to him and asked him how he was feeling. He said he was feeling awful and burst into tears and said: “I just want to get out”. I gave him a hug and told him I was going to help him. I told him that I was not going to give him the injections, but that I would come into his room every two hours as prescribed with the injection and pretend to give him it...Every two hours I drew up the apomorphine went to his room, squirted it onto the floor, and told him to pretend to be sick in a couple of minutes, once I had left [...] I reported to the Charge Nurse that I had given the medication. I nursed him for two nights and I spent some time with him when the other nurses were on their break. I told him that if he wanted to get out he needed to start saying that he was feeling more attracted to women and that he felt the treatment was working. [...] I got a thank you card and letter from him a few months after he was discharged. He thanked me for all the support I had given him, and said he was living happily with “T”. He had confided in me that he was in love with a chap called Terrence, so I presumed it must have been him. It ended by saying he would never forget

me... [Pause]... I don't think I needed any special thanks. I just questioned things that a lot of nurses didn't.<sup>19</sup>

Unna's testimony corroborates the finding in the previous chapter that nurses who did not conform to the rules and orders they were given were often labelled as "troublemakers". However, her behaviour could be viewed in two ways: as a case of unprofessional conduct or a compassionate autonomous intervention. While Unna did not overtly question practice, she did covertly question and undermine her superiors. I would argue that Unna conscientiously objected to this treatment based on her intrinsic values and morals, which in turn reversed her "conditioning" as a nurse to obey the orders of higher authority. Furthermore, as mentioned in Chapter II, Unna recalled reading Rodney Garland's *The Heart in Exile* (1952), and she stated that this gave her 'an understanding of the challenges homosexual men faced.'<sup>20</sup> Therefore, it could be argued that her empathy towards this patient group was enhanced by reading this book. Nevertheless, her behaviour could bring her trustworthiness as a nurse into question, as she reported that she had administered a prescribed treatment when she had not. However, the card that her patient sent her demonstrates the positive impact that her subversive behaviour had on him.

Elizabeth Granger, a State Registered Nurse (SRN) who had undertaken a degree-level nurse education, recounts her resistive nursing practice as a student nurse on a conversion course to become an RMN when she was ordered to take a homosexual patient on a "date" as part of his treatment:

I suppose being a university nurse I was more inured to questioning practice and I also enjoyed reading...erm...Now I remember reading an article in the *Nursing Times* about aversion therapy...[Pause]...I was a general nurse at the time but was due

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<sup>19</sup> Unna Drinkwater, interviewed 29<sup>th</sup> December 2009.

<sup>20</sup> Unna Drinkwater, interviewed 29<sup>th</sup> December 2009.

to start my conversion course in mental nursing shortly. I would have done that training first, but at the time they only did the degree in general nursing and my parents wanted me to do the degree, so I did that first. Anyway, going back to the article. I recall it saying that if a nurse is asked to administer aversion therapy, and they didn't really want to for ethical reasons, then she should say "no". Now I distinctly remember thinking that that's what I would do if I had to do it [Administer aversion therapy] when I started my conversion course, as I thought it was barbaric, and I really had no faith in the treatment and the science it was based on was very weak if not non-existent. However, it wasn't as easy as that. The article failed to make reference to the complex hierarchical organisation of nursing and the covert and underhand bullying tactics that were used in mental hospitals to manage and get rid of oppositional people. So it was not as simple as just saying "no". [...] Luckily I only moved onto the ward once \*\*\*\*\* [Name of patient receiving chemical aversion therapy] had finished the actual aversion therapy and he was undergoing "social skills training". Now this meant that the patient would have to go on a pretend "date" with a female nurse to practice this ready for when they would do it for real – ridiculous! [Laughs]. Now they were not officially known as "dates", this is just what we jokingly referred to them as. It was essentially about building the patient's confidence around females. We certainly weren't supposed to have any intimacy with each other or anything like that. Nevertheless, being a pretty young girl I was considered the obvious choice. I went on several "dates" with the patient in the hospital grounds. I had a ball! He would do sarcastic impressions of the Matron and the doctor and be very effeminate – I would be in fits of laughter. He had told the doctor the treatment had worked and he was now attracted to women; but he confided to me that he had lied. I knew it hadn't worked, and he was still gay before he even told me. I wasn't bothered; I thought people should be who they are and want to be. I went back to the ward and reported that the "date" had gone well and that the treatment appeared to have had a good effect and there was no obvious homosexual behaviour.<sup>21</sup>

As with Unna's testimony, Elizabeth makes reference to the underhand bullying tactics that were utilised to 'manage and get rid of oppositional people'. Additionally, when recalling her narrative, Elizabeth was noted to laugh. This could support the finding, discussed in the previous chapter that nurses used humour to deal with the incongruent

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<sup>21</sup> Elizabeth Granger, interviewed 3<sup>rd</sup> May 2010.

interventions they were expected to implement when they were nursing patients receiving treatments for their sexual deviations. Furthermore, in contrast to the other nurses in this study, particularly the SENs, it could be argued that Elizabeth felt that her ability to question practice could be attributed to her university-based nurse education. This is an important finding and will be explored later in the chapter.

### **Interpreting the “subversive” nurses’ actions**

It could be argued that the behaviours of Unna Drinkwater and Elizabeth Granger amounted to unprofessional conduct, as both nurses reported that they had implemented a prescribed “therapeutic” intervention even though they had not. Nevertheless, the above testimonies suggest that these nurses reflected on and covertly questioned the orders they had been given. Moreover, I would propose that Unna Drinkwater and Elizabeth Granger believed that they were acting in their patients’ best interests when they chose to behave subversively. In 1973 the International Code of Nursing Ethics stated, “The fundamental responsibility of a nurse is to promote health, prevent illness, restore health and alleviate suffering...The nurse takes appropriate action to safeguard the rights of the individual.”<sup>22</sup> An essential part of a nurse’s role is to ensure that their patients’ rights are met.<sup>23</sup> These include the right to autonomy; the ability to make decisions about treatment following full information about it; safe and considered care; and to expect whatever is done to them to be in their best interests.<sup>24</sup>

However, it was established in the previous chapter that in the majority of cases, these rights were not upheld for patients receiving aversion therapy for sexual deviations. Virginia Beardshaw maintains that failure to ensure that nurses act in their patients’ best interests is a fundamental failure for a system designed to care for vulnerable

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<sup>22</sup> International Code of Nursing Ethics (1973) in Virginia Beardshaw, *Conscientious Objectors at Work* (London, 1981), p. 45.

<sup>23</sup> Dimond, *Legal Aspects of Nursing*, p. 65.

<sup>24</sup> Martin Benjamin & Joy Curtis, *Ethics in Nursing* (New York, 1992), p. 34.

individuals.<sup>25</sup> I would argue, therefore, that Unna Drinkwater and Elizabeth Granger furtively questioned the orders they had been given, identified that their patients' rights were not being upheld and acted in their patients' best interests. Furthermore, I would suggest that their actions were the result of an appeal to their conscience. Martin Benjamin and Joy Curtis suggest 'that an appeal to conscience is based on a desire to preserve one's integrity or wholeness as a person'.<sup>26</sup> Moreover, Rumbold argues that such conscientious objections should be reported to a person or authority at the earliest possible opportunity.<sup>27</sup>

However, both the testimonies allude to the multifaceted negative influences that were at play in mental hospitals. Unna Drinkwater 'knew it would be more hassle than it was worth' if she refused to administer the treatment.<sup>28</sup> In addition, Elizabeth Granger reflected on 'the covert and underhand bullying tactics that were used in mental hospitals to get rid of oppositional people'.<sup>29</sup> This could help explain why these nurses, and others in this study, did not overtly question these practices or refuse to participate in them. Beardshaw found that nurses working in mental hospitals frequently did not make complaints about ill-treatment of patients for fear of victimisation, fear of "cover-ups", and the perception that those complaints would achieve nothing.<sup>30</sup> Furthermore, many of the nurses in this study alluded to fears of reprisals if they made complaints or questioned the orders of higher authority. A senior trade union officer and former psychiatric Charge Nurse reported in Beardshaw's study what could happen when a complaint was made within a mental hospital:

The managers make the right kind of noises...the veil of respectability. Then the word will get around the institution, and

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<sup>25</sup> Beardshaw, *Conscientious Objectors*, p. 45.

<sup>26</sup> Benjamin & Curtis, *Ethics in Nursing*, p. 29.

<sup>27</sup> Rumbold, *Ethics in Nursing Practice*, p. 249.

<sup>28</sup> Unna Drinkwater, interviewed 29<sup>th</sup> December 2009.

<sup>29</sup> Elizabeth Granger, interviewed 3<sup>rd</sup> May 2010.

<sup>30</sup> Beardshaw, *Conscientious Objectors*, p. 45.



then the normal thing is to make the complainant see the error of his ways...start the process of denying his reality. That's done in a number of subtle ways, over a drink in the social club, on the wards, little chats: "You didn't really mean to do this..." It starts off normally friendly – then, if the nurse refuses to budge, it's a case of discredit the complainant. You will find commonly, people who have complained in mental hospitals – there will have been very strenuous attempts to find weaknesses in their own character, and use those weaknesses against them...And then I've known extremes, like anonymous telephone calls to the person telling them to shut their mouth or else – their car interfered with – and that's the process...You'll get personal physical abuse, verbal abuse, ridicule. I've seen every trick in the book used against nurses who have blown the whistle.<sup>31</sup>

The message was clear: opposition of any kind would not be tolerated in mental hospitals. Therefore, it is not surprising that most nurses in this study did not act on any concerns they may have had regarding practices in such institutions. The fundamental difference between Unna Drinkwater and Elizabeth Granger and other nurses in this study is that they did act on their concerns. While it could be argued that the way they acted on these concerns was unprofessional, I would also reason that they acted in the best way they believed they could. Indeed, Rumbold proposes that while one has a 'prima facie obligation' to obey the law and codes of conduct, 'that obligation can be overridden in order to comply with a higher, more stringent moral obligation'.<sup>32</sup> In parallel to some of the nurses in the previous chapter, Unna Drinkwater and Elizabeth Granger believed that they were acting beneficently. However, in contrast to some of the other nurses, Unna Drinkwater and Elizabeth Granger were also upholding the principle of non-maleficence.

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<sup>31</sup> Testimony of male Trade Union Officer and former Charge Nurse. In Beardshaw, *Conscientious Objectors*, p. 36.

<sup>32</sup> Rumbold, *Ethics in Nursing Practice*, p. 258.

*Subversive patients*

Interestingly, William Newman recounted a testimony which concurs with that of Elizabeth Granger regarding the social skills training he received in hospital:

Once they stopped the aversion therapy, because I lied, and told them that it had worked, I had to do the most preposterous thing ever. I had to go on a “date” with one of the nurses! I mean can you imagine how contrived this whole thing was...I thought it was going to be with the nurse who had been giving me the injections for the past few days. So I thought: “Great. I’m going on a date with ‘Nurse Ratched’. You’re meant to be reinforcing my ‘heterosexuality’, not turning me gay again!” Anyway, as it happens, it was a young student nurse who had just started on the ward who took me on my dates. I will NEVER forget her. She was fantastic; we had such a laugh together...I used to do impressions of the Matron, and we would be rolling about laughing. I trusted her so much that I actually told her that I had lied to the consultant and that I was still homosexual. Although from the way I behaved around her, which I have just described, it wouldn’t have taken a genius to work that out! [Laughs] Anyway, she mustn’t have said anything, as I was discharged a few weeks later.<sup>33</sup>

The testimonies of William Newman and Elizabeth Granger match as both recalled the same hospital, time frame and names; however, ethical implications dictated that I was unable to inform the individuals of this. Nevertheless, it does demonstrate the accuracy of their testimonies, and highlights the positive impact that Elizabeth Granger’s subversive behaviour had on her patient.

Interestingly William Newman framed his narrative around cultural constructions of psychiatry, namely the 1975 film, *One Flew Over the Cuckoo’s Nest*, when he made reference to “Nurse Ratched”. Summerfield argues that people do not simply remember what happened to them, but make sense of the subject matter by interpreting it through contemporary language and concepts available to them. Therefore, the

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<sup>33</sup> William Newman, interviewed 29<sup>th</sup> April 2010.

historian needs to understand not only the narrative offered, but also the meanings invested in it and their discursive origins.<sup>34</sup> Nurse Mildred Ratched is portrayed as a cold, psychopathic bully in the film. Moreover, she has become a popular metaphor for the corrupting influence of power and authority in establishments such as the mental hospital in which the film is set. This public representation may have shaped William Newman's memory of his time in hospital.

In these cases Summerfield goes on to argue that such formulations are inevitably selective and can make constructions of subjectivities problematic.<sup>35</sup> However, the analogy that William Newman makes between the nurse who administered his aversion therapy and Nurse Mildred Ratched can be seen as a positive aspect of his testimony, as it serves to reinforce the notion, discussed in the previous chapter, that the nurse's role in aversion therapy was to make the treatment as unpleasant as possible for the patient. Furthermore, William Newman and Elizabeth Granger both highlighted the incongruity of the situation they found themselves in when they were expected to go on a "date" with each other. However, even though this was a peculiar task to be assigned, it is not unique. During the Second World War, FANYs were expected to take trainee male SOE agents on dates and encourage them to drink alcohol. While on these dates, intoxicated trainees were then encouraged by FANYs to reveal personal details about themselves: if they did, they would be removed from the course as they were considered a 'security risk'.<sup>36</sup> Furthermore, Nolan argues that such therapeutic practices as 'habit training' and 'social rehabilitation programmes' (which the prescribed "date" between Elizabeth Granger and William Newman fell under the auspices of) were widespread in

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<sup>34</sup> Summerfield, 'Culture and Composure', p. 67.

<sup>35</sup> Summerfield, 'Culture and Composure', p. 69.

<sup>36</sup> Pattinson, *Behind Enemy Lines*, p. 53.

the 1960s.<sup>37</sup> Indeed, Nurse Therapist Peter Lindley stated that he gave the homosexual patient he was treating, ‘advice about dating girls and petting.’<sup>38</sup>

William Newman also states that his aversion therapy was stopped, ‘...because I lied, and told them that it had worked’.<sup>39</sup> Meanwhile Greta Gold recalls a similar narrative:

I suddenly had a “eureka moment” and thought, how do the doctors actually know what I’m thinking? I knew I would have to start lying about my feelings if I ever wanted to get out.<sup>40</sup>

Both testimonies allude to the patients’ ability to manipulate the system by feigning heterosexuality or repulsion with their transvestism. In Chapter II, I argued that there was no confirmation of the efficacy of the treatments beyond penile volume measurements in response to erotic stimuli. Moreover, in treatments that did not use a plethysmograph to measure penile volume measurements, the success of the treatment and, therefore, the patient’s discharge was based mainly on self-report from the patient.<sup>41</sup> Luke Vanson muses on the self-report nature of the treatments:

I remember the consultant saying: “How do you feel?” One of the best responses to the doctor at the time was to say: “I feel repulsed by who I am.” That was always seen as a very good sign. Or: “I have been thinking of some of the pictures you have shown me, and I realise now how distasteful that is.” That was always seen as a good response. As the patients were gaining insight, the patients were beginning to understand their own deviancy, and their own abnormality. Erm...there was never actually any way of checking whether the patients actually believed in what they were saying. Or whether they were just saying it because they knew, you know, that this is what they ought to say. Because I do remember them being quite bright people, they were witty.<sup>42</sup>

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<sup>37</sup> Nolan, *A History of Mental Health Nursing*, p. 124; see, also Allyon & Michael, ‘The Psychiatric nurse as Behavioral Engineer’, pp. 323-334.

<sup>38</sup> Peter Lindley, ‘Sexual deviation in a Young Man’, *Nursing Mirror* 8 (1977), p. 64.

<sup>39</sup> William Newman, interviewed 29<sup>th</sup> April 2010.

<sup>40</sup> Greta Gold, interviewed 24<sup>th</sup> March 2010.

<sup>41</sup> King & Bartlett, ‘British Psychiatry and Homosexuality’, p. 47.

<sup>42</sup> Luke Vanson, interviewed 23<sup>rd</sup> June 2010.

It appears that William Newman and Greta Gold used this to their advantage and, engaged in subversive behaviours in order to speed up their discharge from hospital. Once again, this highlights how treatments varied throughout the country, as some consultants chose to utilise a plethysmograph to measure penile volume measurements, while others did not. Furthermore, with no general protocol or ethical guidelines, the treatment of choice was often the unilateral decision of the consultant psychiatrist.<sup>43</sup>

Moreover, given the above testimonies, I would argue that the treatments lacked rigour: in some cases the patients were able to feign the effectiveness of the treatment in order to be discharged. Patients such as William Newman who were admitted to the hospital on a court order appear to have taken advantage of this. This could have been due to William already being ‘fairly accepting’<sup>44</sup> of his sexuality, and his perception that the treatment ‘was not going to make me straight, I didn’t want it to’.<sup>45</sup> Nevertheless, as previously discussed, many former patients self-referred for treatment due to the turmoil they found themselves in regarding their sexual desires. Therefore, not all patients took advantage of the ability to subvert their health care professionals and many endured the unpleasantness of the treatments.<sup>46</sup> In Albert Holliday’s case he endured the treatment for over a year, in the vain hope that it would be successful.<sup>47</sup>

### *Eluding suspicion*

Anxiety seems a reasonable response to Unna Drinkwater’s and Elizabeth Granger’s subversive behaviours. Therefore, my assumptions regarding the possible grave repercussions of being caught engaging in such behaviours prompted me to ask questions about whether their resistive activities caused them anxiety. Rather

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<sup>43</sup> Dickinson, Cook, Playle & Hallett, “‘Queer Treatments’, p. 1350.

<sup>44</sup> William Newman, interviewed 29<sup>th</sup> April 2010.

<sup>45</sup> William Newman, interviewed 29<sup>th</sup> April 2010.

<sup>46</sup> Dickinson, Cook, Playle & Hallett, “‘Queer Treatments’, p. 1349.

<sup>47</sup> Albert Holliday, interviewed 27<sup>th</sup> January 2010.

unexpectedly, both the participants claimed in their testimonies that they were not unduly worried and managed to undertake these activities without fear. Indeed, when Unna Drinkwater reflected on her subversive behaviour, she remarked, 'I have no regrets. I'm not bothered what others think about me. I did what I felt I had to do. I would do it again tomorrow if I had to!'<sup>48</sup> This short, insistent 'I would do it again tomorrow if I had to!' at the end of this statement, complemented by a conclusive nod of the head, gave closure to the topic of conversation. She appeared to have no professional repentance regarding her behaviour and states that other people's perceptions of her behaviour did not perturb her.

It appears that Elizabeth Granger relied on a feminine performance to enable her to evade being caught or suspected of disobeying those in higher authority. When Elizabeth Granger was asked how the date with the patient had gone by her Charge Nurse, she remarked:

I just put on my most innocent voice, gave him a big smile, fluttered my eyelashes and said: "It went fine. How could he possibly resist my charms?" I must have pulled it off, as I never got caught, and he [The Charge Nurse] just laughed flirtatiously.<sup>49</sup>

This interaction between Elizabeth and her superior demonstrates the powerful and effective use of conventionally feminine appearance and behaviours. By formulating her testimony in terms of "put on" and "pulled it off", it illustrates her ingenuity and the performative way she utilised her femininity. Elizabeth found it productive to accentuate her physical appearance, and her sexual attractiveness to the opposite sex, as a way of flirting with her superior in a bid to divert his attention onto her as a sexual object rather than a subordinate who should have carried out his orders. Beverley

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<sup>48</sup> Unna Drinkwater, interviewed 29<sup>th</sup> December 2009.

<sup>49</sup> Elizabeth Granger, interviewed 3<sup>rd</sup> May 2010.

Skeggs argues that flirtation is behaviour intended to arouse sexual feelings or advances without emotional commitment. It involves a combination of conventional femininity (in particular passivity, powerlessness and dependence on others), the stretching of traditional femininity (typified by directly engaging in dialogue), and the reproduction of heterosexuality.<sup>50</sup> Pattinson also found that many female SOE agents utilised their feminine appearance and flirted with German soldiers to avoid suspicion of their clandestine resistive work.<sup>51</sup>

Nevertheless, expressions of femininity by nurses sometimes had a paradoxical effect. This is demonstrated in the testimony of the female nurse in Nolan's study, discussed in the previous chapter.<sup>52</sup> This nurse dressed in a very feminine way, i.e. wearing a hat with a veil. In spite of this, she did not appear to be accepted by the other nurses on her new ward. However, I would argue that this may be due to her testimony alluding to the ward being staffed by other female nurses. It is possible that she may have had a different reaction if the dominant culture of the ward had been male.

Conversely, Unna Drinkwater utilised a less glamorous performance to elude suspicion of her subversive behaviours. When recalling how she orchestrated her resistive behaviour, she remarked:

Now you have to remember, I was in my final year before retirement, so I was getting on it bit. [Laughs] I was on shift with two other, much younger male nurses, one of whom was the Charge Nurse. So I said to the other two nurses: "I'll look after the homosexual chap. I'll leave you strapping lads to look after the others. I don't want to be grappling we [sic] any o [sic] them lot at my age!" So they just left me to it. In their eyes I was an old woman who came in with her knitting and homemade cakes

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<sup>50</sup> Beverley Skeggs, *Formations of Class and Gender: Becoming Respectable* (London, 1997), p. 128.

<sup>51</sup> Pattinson, *Behind Enemy Lines*, p. 149.

<sup>52</sup> Testimony of a female nurse in Nolan, *Psychiatric Nursing Past and Present*, p. 178. See Chapter IV for the nurses' testimony.

for them; they were more interested in “protecting” me than anything else.<sup>53</sup>

I would argue that Unna utilised her mundane appearance to coordinate her subversive work. By resting on and exploiting her perceived frailty (which may have been compounded by bringing in her knitting and homemade cakes), she constructed an identity of someone who should be “protected” rather than suspected of any seditious practices. Interestingly, there is a paradox between her performance of fragility and the psychological strength that her performance required. Outwardly Unna wanted to be perceived as frail, but intrinsically she was actually a very strong character who was able to manipulate a very controlled environment for the benefit of her patient.

Furthermore, Unna’s testimony could suggest that there were some potentially violent patients on the ward, and by suggesting that the male nurses tend to these patients, she not only reinforced her fragility by her comment, ‘I don’t want to be grappling we [sic] any o [sic] them lot at my age!’.<sup>54</sup> She also incited and appealed to traditionally masculine behaviours by implying that the two male nurses were the most appropriate to deal with aggressive patients and not the homosexual patient. Ironically Unna inverted traditional gender norms, despite apparently strengthening them. The above testimony could also suggest that the homosexual patient was perceived to be no physical threat – reinforcing stereotypes of weakness and effeminacy – but to subversive effect.

Once again, a similar phenomenon was noted with female SOE agents who utilised these special displays of delicateness when situations necessitated.<sup>55</sup> Furthermore, Maria Stromberger was so successful in her ability to smuggle food into Auschwitz because

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<sup>53</sup> Unna Drinkwater, interviewed 29<sup>th</sup> December 2009.

<sup>54</sup> Unna Drinkwater, interviewed 29<sup>th</sup> December 2009.

<sup>55</sup> Pattinson, *Behind Enemy Lines*, p. 151.



she rested on the perceived innocence of the nursing profession. She wore her white nurse's coat at all times, as it had a dual purpose: it allowed her to pass unnoticed around the camp and neighbouring village of Oswiecim, and it also enabled her to conceal match-boxes, pens and food containers.<sup>56</sup>

### *Performing masculinities*

While the most subversive nurses in this study appear to be Unna Drinkwater and Elizabeth Granger, discussed above, there were also two male nurses who engaged in resistive activities when they were nursing patients receiving treatments for sexual deviation. Despite their subversive activities not having the same professional implications as the female nurses, there may be something to be learned from a comparison. Luke Vanston recalls, 'Even though we were not really supposed to, I tried to sit down with the patient and offer them support'.<sup>57</sup> Further, in Chapter II, we were introduced to Julian Glover who served alongside a homosexual man during World War II. He recalls nursing patients receiving aversion therapy:

I have already told you about the chap I served with in the war who was homosexual, and we got on really well. So this made me really question the appropriateness of the treatments these men were given just because they were homosexual. Now we weren't supposed to talk to them [the patients receiving aversion therapy], but I always made time to talk to em [sic]. A lot were in because they believed that everybody thought that they were some dirty, predatory deviant, so I thought it was my job to let em [sic] know that was not the views of everyone. I would sit down with them and have a cigarette, but only when no one was looking. I didn't want to get into trouble you see. A Charge Nurse saw me doing this once, and quizzed me about it. He said: "You looked a bit friendly with that homosexual in the day room before?" ...I'm not proud of what I said next, but I did the best thing I could think of at the time. I just laughed and said: "What do you mean? As if I would want to talk to a dirty queer!" He [the Charge Nurse] just laughed and said: "You had

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<sup>56</sup> Benedict, 'Maria Stromberger', p. 197.

<sup>57</sup> Luke Vanson, interviewed 23<sup>rd</sup> June 2010.

me worried for a minute there.” He must have believed me, as he never said nowt [sic] no more about it.<sup>58</sup>

This testimony highlights the positive impact that Julian’s exposure to homosexuals during World War II had on his attitude towards these individuals in his care. Furthermore, it also attests that there were significant implications if you were caught disobeying those in higher authority. However, in contrast to the female nurses’ tactics to avoid suspicion of engaging in subversive behaviours, Julian’s defence was less resourceful and inventive. Nevertheless, his strategy was successful, as the Charge Nurse did not question him about his behaviour subsequently. I would suggest that Julian’s testimony was appropriate to his gender: he made a “macho” retort, which was aimed at reinforcing his masculinity and demonstrating that he “fitted” into the (possibly homophobic) culture of the ward. This also distanced him in the eyes of colleagues from any sympathy or collusion with the homosexual patient.

#### *University-based nursing education*

Elizabeth Granger’s testimony highlights that she attributed her subversive behaviour to the fact that she was a “university nurse”. Indeed, Elizabeth was one of the first nurses to graduate from the integrated Arts degree and SRN training at the University of Edinburgh. This course was one of the first attempts to educate nurses in university and ran between 1960 and 1965. Thereafter, it was changed to the BSc Social Sciences (Nursing) degree.<sup>59</sup> Other experimental courses combining degrees with nurse training were developed during the 1960s, notably Sheffield University, St George’s Hospital in co-operation with the University of Surrey, and the Brighton Hospitals Group with

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<sup>58</sup> Julian Glover, interviewed 4<sup>th</sup> January 2010.

<sup>59</sup> Jane Brooks, ‘The First Undergraduate Nursing Students: A Quantitative Historical Study of the Edinburgh Degrees, 1960-1985’, *Nurse Education Today* 31 (2011), p. 634.

Sussex University. However, Christine Hallett argues that none treated nursing itself as an academic subject and only Manchester University had a Degree in Nursing.<sup>60</sup>

A key driver in the development of university-based nurse education was Colin Fraser Brockington, Professor of Social and Preventative Medicine at the University of Manchester.<sup>61</sup> Brockington believed that the aims of establishing a degree programme for nurses would be twofold. Initially, it would improve the status and formalise the training of nurses and health visitors. Secondly, it would allow individuals who were of “superior intellect” to make use of their capacity for analysis and creativity. His perception was that, historically, if such individuals had wanted to pursue a nursing career, they had felt obliged to suppress their ‘capacity for intellectual and creative work, in order to become conventional, passive and compliant’.<sup>62</sup> Moreover, concurring with Elizabeth Granger’s testimony, one of the central functions of the university nurse was to question practice.<sup>63</sup> Indeed, Mrs Comber-Higgs, Matron of Crumpsall Hospital, Manchester (where the students on the University of Manchester “Manchester Scheme” undertook their clinical experience), was noted to remark:

Oddly enough, the presence of the diploma students seems to stimulate our own nurses to ask more questions. It has been stressed to the girls on the university course that they are students and that it is their job to ask more questions, while our own students [undertaking traditional nurse training] are often diffident about taking up the ward sister’s time, or feel that they themselves are too busy to ask questions.<sup>64</sup>

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<sup>60</sup> Christine Hallett, ‘The ‘Manchester Scheme’: A Study of the Diploma in Community Nursing, the First Pre-Registration Nursing Programme in a British university’, *Nursing Inquiry* 12 (4) (2005), p. 292.

<sup>61</sup> Christine Hallett, ‘Colin Fraser Brockington (1903-2004) and the Revolution in Nurse-Education’, *Journal of Medical Biography* 16 (2008), p. 89.

<sup>62</sup> Hallett, ‘The ‘Manchester Scheme’, p. 289.

<sup>63</sup> Joanne Howard & Julia I. Brooking, ‘The Career Paths of Nursing Graduates from Chelsea College, University of London’, *International Journal of Nursing Studies* 24 (3) (1987), p. 183.

<sup>64</sup> Comber-Higgs (1960) cited in: Hallett, ‘The ‘Manchester Scheme’, p. 291.

However, despite the fact that these were pioneering courses, the nursing students on them often met challenges; these included ‘stress in the face of resentment’<sup>65</sup> and the ‘burden of being different’.<sup>66</sup> Some nursing students felt that they did not “fit” on the wards and others believed that nurses undertaking the traditional nurse training were better prepared for a career in nursing.<sup>67</sup> Moreover, despite the aim of the university-based nurse education programmes being to create nurses who questioned practice, in a study which explored the experiences of nursing students who undertook the same nurse education programme as Elizabeth Granger at the University of Edinburgh, the majority of participants in this study noted that their questioning minds were not well received by the ward Sisters.<sup>68</sup>

Karen Luker argues that the university nurse was in some sense assigned to a category of ‘deviance’ because they challenged the essence of what most conventionally trained nurses had learnt to accept.<sup>69</sup> It seems that there are parallels here which can be made with Elizabeth and her patient William Newman, as both may have been perceived as “deviant”. This could have been because Elizabeth had become a nurse through an unorthodox route and William was homosexual. When students elected to read nursing at university they were uninformed that they were about to become members of a stigmatized group, therefore: in this sense they did not choose to be deviant.<sup>70</sup> This could offer a context to explain Elizabeth’s subversive behaviour – she may have easily empathised with William, as she identified what it was like to have an all-embracing feeling of being different through no fault of your own, thus strengthening the resolve to support the underdog.

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<sup>65</sup> Hallett, ‘The ‘Manchester Scheme’, p. 288.

<sup>66</sup> Karen, A. Luker, ‘Reading Nursing: The Burden of Being Different’, *International Journal of Nursing Studies* 21 (1984), pp. 1-17.

<sup>67</sup> Jo Brand, *Look Back in Hunger*, (London, 2009), p. 228; Brooks, ‘The first Undergraduate Nursing Students’, p. 635.

<sup>68</sup> Brooks, ‘The First Undergraduate Nursing Students’, p. 635.

<sup>69</sup> Luker, ‘Reading Nursing’, p. 2.

<sup>70</sup> Luker, ‘Reading Nursing’, p. 3.

In an occupation such as nursing, with its tradition of a hierarchical style of administration where experience in terms of years of service counts, and the quest of epistemology for its own sake is given a low priority, university nurses may have been seen to defy a moral order which formed the basis for the ranking system.<sup>71</sup> I would argue, therefore, that Elizabeth may have been perceived with a level suspicion by the mental nurses she was working alongside. Firstly, she was already an SRN, and these nurses were often viewed by mental nurses as predominately middle class and female, which was in contrast to themselves, who were principally working class and male.<sup>72</sup> Chatterton also argues that mental nurses were deeply suspicious of SRNs, as senior positions in mental hospitals were often denied to nurses unless they were dual qualified as a SRN and RMN.<sup>73</sup> Moreover, Elizabeth was a university-educated nurse, which was unusual within a mental hospital, as the first university-based mental nurse education programmes were not implemented until the late 1970s.<sup>74</sup>

It appears that many university nursing students developed dynamic ways to present themselves as “acceptable” and “gain favour” with the ward staff. This tactic involved information control concerning what they did or did not know and self-denigration, which they thought would undermine the pre-conceived expectations of the ward staff in relation to university nurses.<sup>75</sup> Luker proposes that the nursing students had to be particularly vigilant in controlling information about the university side of their life as, their knowledge of the theoretical underpinnings of nursing practice may have been seen by conventionally trained nurses as threatening.<sup>76</sup> This could offer a further context upon which to explain Elizabeth’s behaviour. By virtue of her educational

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<sup>71</sup> Luker, ‘Reading Nursing’, p. 2.

<sup>72</sup> Harrington, *Voices Beyond the Asylum*, p. 8.

<sup>73</sup> Claire Chatterton, “‘A thorn in its flesh?’ Maud Wiese and the General Nursing Council”, *The Bulletin of the UK Association for the History of Nursing* 1 (1) (2012), p. 41.

<sup>74</sup> Brand, *Look Back in Hunger*, p. 228.

<sup>75</sup> Luker, ‘Reading Nursing’, p. 4.

<sup>76</sup> Luker, ‘Reading Nursing’, p. 5.

background, Elizabeth may have been viewed as a “double threat” to the mental nurses. Therefore, it could be reasoned that she may have behaved subversively, not only because she made an appeal to her conscience but, moreover, to “fit in” to the compliant culture of the mental hospital. Elizabeth would have had a lot to lose; being a student nurse, her qualified colleagues could potentially have failed her. She may not have wanted to draw attention to herself or to be perceived as oppositional by her colleagues if she was seen to be questioning practice.

### **Conclusion**

Despite discussion of other historical examples of nurses engaging in clandestine resistive behaviours, there is a dearth of literature discussing subversion in nursing; this could explain why the subversive nurses in this study were in the minority. Nevertheless, there are some possible interpretations for why the nurses in this study may have behaved in this way. It appears from their testimonies that one of the main reasons was that they conscientiously objected to the treatments. However, due to the way oppositional people appear to have been “managed” within mental hospitals; these nurses did not feel that they could overtly question these treatments. In the case of Elizabeth Granger, her university-based nurse education may have also inured her to behave this way in order to be “accepted” into the culture of the mental hospital. Furthermore, it also appears that some patients were able to subvert their health care practitioners by pretending that the treatments had been successful in curing them of their sexual deviations.

An examination of the above testimonies also demonstrates that femininities and masculinities were sometimes utilised by the subversive nurses in this study to avert suspicion of engaging in resistive activities. In essence, these gendered performances were the “best cover” for their subversive behaviour. However, while these enactments

appeared to be successful for the participants in this study, there may have been other nurses who also engaged in subversive activities but were caught. Therefore, such performances may not have been infallible for all nurses. There may also have been nurses who steadfastly refused to participate in this aspect of clinical practice. However, the testimonies throughout this thesis concur insofar as, in this admittedly small-scale study, such nurses appeared to be the exception rather than the rule. Mental nurses had good reasons for keeping quiet about any conscientious objections they may have had. Conflict of loyalties and fears of victimisation inhibited free speech within many mental hospitals. Nevertheless, of the few nurses in this study who did question practice by engaging in resistive activities, I argue that these nurses behaved empathetically and acted in their patients' best interests. Furthermore, I argue that these nurses' actions had a positive long-term impact on their patients' sense of self-esteem.

## CHAPTER VI

### LIBERATION, 1957-1974.

Many members of the GLF [Gay Liberation Front] can testify to the ineffectiveness of aversion therapy in reorientation of their sexual desires and to the totally destructive effect [this] has had on their personality and adjustment. Our plan, therefore, is for homosexuals seeking advice from you to be given reassurances from you that they are fully capable of living a full, worthwhile and happy life and that many other men and women are doing just that. This positive attitude substituted for attempts to provide treatment and cure will spare many from intense and undue suffering.<sup>1</sup>

#### Introduction

The Sexual Offences Act became law in 1967, decriminalizing sex between two consenting male adults over the age of twenty-one in private in England and Wales.<sup>2</sup> However, for many gay<sup>3</sup> men who were not considered “respectable homosexuals”, this new legal climate provided little benefit to them because of where they were meeting men for sex and how they were conducting themselves in public. These “other” men remained socially excluded, subject to legal proceedings and medical treatments. Many gay men were unhappy with the conservative imperative of the 1967 Act and its exclusion and condemnation of gay men who did not express their sexuality through coupledness and domesticity. Through a fresh gay liberation movement, these aggrieved men created an attitudinal shift that led to a better understanding of sexual identity and community. They advocated for greater acceptance of sexual variance, for the removal

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<sup>1</sup> The Hall Carpenter Archives (HCA), London School of Economics, HCA/EPHEMERA/1148, Letter from the West London Gay Liberation Front’s Anti-Psychiatry Group to a local GP about treatment of homosexuality in 1972.

<sup>2</sup> Men in Scotland, Northern Ireland, Guernsey, Jersey and the Isle of Man had to wait until 1980, 1982, 1983, 1990 and 1993 respectively.

<sup>3</sup> As with the rest of the thesis, the terms “gay” and “homosexual” will be used interchangeably throughout this chapter. However, in keeping with the terminology used during the period, the term “gay” will be used more frequently.



of homosexuality from psychiatric diagnostic manuals and, as demonstrated in the letter above, the curtailment of medical treatments for homosexuality.

The period also witnessed a fresh Women's Liberation movement and a new stress on individual freedoms, which was, in part, inspired by the civil rights movement in the USA and other general "counter-cultural" shifts. This period also witnessed a shift in the media representations of sexually deviant individuals. The press were beginning to question the treatments utilised to "cure" these individuals. This chapter will explore the consequences of these piecemeal cultural and representational shifts as nurses came to see the treatments they were administering for sexual deviation as inappropriate as ideas of deviance shifted.

In parallel to this fresh gay visibility and radicalism, the nursing profession was also undergoing changes. The advent of "nurse therapists" witnessed nurses being trained in advanced clinical practice roles, enabling them to be more autonomous practitioners. This period also marked the era of public enquiries into the care of the mentally ill, and the plight of these individuals was moved up the political agenda. This chapter seeks to explore the implications of these changes.

### **Reform, 1957-1967**

Jivani argues that the conservative government's refusal to act on the Wolfenden report in 1957 was because they believed its recommendations were 'in advance of public opinion'.<sup>4</sup> The lack of action by the government in response to the report appeared to give the police confirmation that homosexuality was still not to be tolerated in any form – the police frequently raided the meeting places of homosexual men and employed secret surveillance tactics and *agent provocateurs* throughout the late 1950s and early

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<sup>4</sup> Jivani, *It's Not Unusual*, p. 141.

1960s.<sup>5</sup> Indeed, March argues that the report had a paradoxical effect and things actually became worse for homosexuals between 1957, when the report was published, and 1964 when the Director of Public Prosecutions intervened, and requested that the police ‘ease off’ these individuals.<sup>6</sup>

Resistance to homosexual law reform was observed in a number of ways and many reformers were ironically using the same language of illness, sin and despair as those opposing legal change.<sup>7</sup> However, British society was undergoing a rapid if uneven transformation by the mid-Sixties. The homosexual may have been considered unusual, but the unusual was in vogue, and gay men were at the forefront of ‘Swinging London’.<sup>8</sup> Dominic Sandbrook argues, however, that the swinging sixties did not create the extensive social and “cultural revolution” that has sometimes been supposed and was actually a decade of ‘caution, conservatism and convention’ marred by unemployment and recession.<sup>9</sup> Nevertheless, Cook argues that there was a change in attitudes which came with economic expansion and affluence, and a mounting frustration with puritanical moral codes.<sup>10</sup> These attitudinal shifts were being influenced by international notions of individual liberty. In the western world, individuals were beginning to question the definitions of “difference”.

The civil rights movement in the USA during the 1960s which put the onus on individual freedoms as well as the rights of certain groups, was filtering through into the UK. On both sides of the Atlantic, Women’s Liberation advocated for equality and sexual, cultural and social independence. Harold Wilson’s labour government of 1964

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<sup>5</sup> See, e.g. HCA/Grey Papers/1/2 (a) Sexual Offences: records relating to actions on homosexual law reform from the Departmental Committee on Homosexuality and Prostitution; HCA/GREY Grey Papers; Cook, *A Gay History of Britain*, p. 169; Jivani, *It’s Not Unusual*, pp. 137-138.

<sup>6</sup> March, *Gay Liberation*, p. 71; Jivani, *It’s Not Unusual*, p. 138. Jones, *Out in the City*, p. 59.

<sup>7</sup> Waters, *Disorders of the Mind, Disorders of the Body Social*, p. 135; Jivani, *It’s Not Unusual*, p. 119; Cook, *A Gay History of Britain*, p. 175; See also HCA/GREY material relating to the HLRS, 1958-1984; HCA/GREY/1/2 HLRS Executive Committee: agendas and minutes.

<sup>8</sup> Jivani, *It’s Not Unusual*, p. 141.

<sup>9</sup> See, e.g. Dominic Sandbrook, *White Heat: A History of Britain in the Swinging Sixties* (London, 2006).

<sup>10</sup> Cook, *A Gay History of Britain*, p. 169.

embarked on a series of social reforms on abortion, divorce and the death penalty.<sup>11</sup> There were student protests at the London School of Economics in 1967 and student riots in Paris in 1968, which suggested that groups that were not traditionally in the political mainstream were claiming the power and ability to express their specific concerns. Meanwhile the “summer of love”<sup>12</sup> and the professed sexual revolution led to deliberation around issues of sexual pleasure and monogamy.<sup>13</sup>

By 1965, arguably Britain’s most audacious playwright, its most commended avant-garde artist and its most esteemed composer – Joe Orton, Francis Bacon and Benjamin Britten – were all openly homosexual.<sup>14</sup> Television documentaries in 1965 and 1967 included homosexual men speaking on their own behalf.<sup>15</sup> Radio became more irreverent, and in the comedy *Round the Horne*, Kenneth Williams and Hugh Paddick traded in homosexual stereotypes and were sharp and self-confident.<sup>16</sup> More broadly along with the film *Victim* (1961), a tragic tale of homosexuality, blackmail and suicide, all the above covertly pressed the case for reform. Jones argues that visibility may have made homosexual men into easier targets after Wolfenden, but as the years went by, awareness also decreased public fear, which had been prompted by ignorance.<sup>17</sup>

This change in climate – and government – brought Wolfenden’s recommendations back into the political mainstream. In April 1966, Lord Arran reintroduced his bill to the Lords decriminalising homosexuality along the lines Wolfenden recommended. Leo Abse guided the bill through the Commons, where it passed by 244 votes to 100 on its

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<sup>11</sup> Mort, *Capital Affairs*, p. 155; Cook, *A Gay History of Britain*. p. 175.

<sup>12</sup> The Summer of Love was a social phenomenon that occurred during the summer of 1967. Individuals began experimenting with different lifestyles, which included communal living and the sharing of resources often with total strangers. It has been argued to have become a defining moment of the 1960s, as the hippie movement came into public awareness.

<sup>13</sup> Cook, *A Gay History of Britain*. p. 185.

<sup>14</sup> Jivani, *It’s Not Unusual*, p. 141; Jones, *Out in the City*, p. 57.

<sup>15</sup> Weeks, *The World We Have Won*, p. 67; Cook, *A Gay History of Britain*. p. 176.

<sup>16</sup> Ryan Powell, *Man Country: A Social History of 70s Gay Cinema*. Unpublished PhD thesis University College (London, 2010), p. 57; Cook, *A Gay History of Britain*. p. 175.

<sup>17</sup> Jones, *Tales from Out in the City*, p. 57; See, also Weeks, *The World We Have Won*, p. 57.

first reading. The Sexual Offences Act became law on 27<sup>th</sup> July 1967, decriminalizing sex between two consenting male adults over the age of twenty-one in private.<sup>18</sup> Higgins argues that the distinction between public and private was key: for purposes of the law “public” was anywhere where a third party was likely to be present; and it remained illegal for more than two men to have sex together.<sup>19</sup> Indeed, Lord Arran accentuated the conservative import of the act when he asked homosexual men ‘to show their thanks by comporting themselves quietly and with dignity’.<sup>20</sup> He went on to argue, ‘Homosexuals must continue to remember that, while there may be nothing bad in being homosexual, there is certainly nothing good’.<sup>21</sup>

The contentious Labouchère Amendment of 1885 had been expunged; however, for many homosexual men this change in the law was simply not substantial enough. The only beneficiary of the law reform was the middle-class “respectable” homosexual who expressed his sexuality through coupledness and domesticity. Many homosexual men did not fall into this category and refused to ‘comport themselves quietly’. These “other” men remained beyond the law because of where they were having sex, where they were picking up men and how they were conducting themselves in public.<sup>22</sup> Houlbrook maintains that homosexual men who could not or would not fit into the confines of the new Act remained the subject of ‘social opprobrium and regulatory intervention’.<sup>23</sup>

It is important to note that the 1967 Sexual Offences Act and the new legal climate it supposedly opened up did not appear to have a radical effect on reducing the numbers

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<sup>18</sup> Between 1958, when parliament first debated Wolfenden’s recommendations, and 1967, when the law was finally changed, the issue was raised in Parliament six times before the seventh attempt was successful and went on to its second readings.

<sup>19</sup> For example, the definition of “private” was such that a locked hotel room was deemed to be a public place: therefore, two men in such a situation could still be prosecuted. See, e.g. Higgins, *Heterosexual Dictatorship*, p. 157; Cook, *A Gay History of Britain*, p. 176.

<sup>20</sup> Weeks, *Coming Out*, p. 176.

<sup>21</sup> Jivani, *It’s Not Unusual*, p. 153; Weeks, *The World We Have Won*, p. 127.

<sup>22</sup> HCA/CHE/9/46 Police Harassment Working Party correspondence and papers on cottaging (seeking and engaging in sexual acts in public toilets); Cook, *A Gay History of Britain*, p. 177.

<sup>23</sup> Houlbrook, *Queer London*, p. 254.

of patients being referred for treatment of their sexual deviations. One rationale for this is because the recorded incidence of indecency between men in public actually doubled between 1967 and 1977.<sup>24</sup> This offers a context to explain why the treatments continued despite the new legal climate, as many men were referred for aversion therapy through a court order when they were given an option of imprisonment or remand provided they were willing to undergo psychological treatment.<sup>25</sup>

### **Gay liberation**

In the years after law reform, Cant argues that the gay voice was largely ineffective.<sup>26</sup> However, the Stonewall riots<sup>27</sup> in New York in July 1969 appeared to invoke a fresh gay liberation movement in both the USA and the UK. The gay activists in the USA eventually went on to disrupt several annual meetings of the American Psychiatric Association (APA) in the early 1970s, which provided the impetus for the eventual removal of homosexuality from its diagnostic manual; this will be explored later in the chapter.

In the UK, the riots across the Atlantic enthused student activists Aubrey Walker and Bob Mellors to hold meetings in the London School of Economics in October 1970. These weekly meetings subsequently led to the development of the Gay Liberation Front (GLF), which was governed by a philosophy of pride and publicised sexual and subcultural variance as positive and life enhancing.<sup>28</sup> Their policy included a number of immediate demands around issues of equality under the law, the end to workplace

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<sup>24</sup> Tim Newburn, *Permission and Regulation: Law and Morals in Post-War Britain* (London, 1992), p. 62.

<sup>25</sup> Dickinson, Cook, Playle, & Hallett, "'Queer' Treatments', p. 1349.

<sup>26</sup> Cant, *Footsteps and Witnesses*, p. 57; Jivani, *It's Not Unusual*, p. 161.

<sup>27</sup> The Stonewall riots were a number of unprompted, violent demonstrations against a police raid that took place in the early morning hours of June 28<sup>th</sup>, 1969, at the Stonewall Inn, in the Greenwich Village neighbourhood of New York City. They are often cited as the first instance in American history when people in the homosexual community retaliated against and challenged a government-backed system that discriminated against sexual minorities. Eisenbach argues that they have become the defining event that marked the start of the gay rights movement in the United States and around the world: See, e.g. David Eisenbach, *Gay Power: An American Revolution* (New York, 2006), pp. 80-115.

<sup>28</sup> See, e.g. HCA/EPHEMERA/1148 West London Gay Liberation Front; Cook, *A Gay History of Britain*. p. 180.

discrimination, the reform of sex education in schools and the right for gay people to 'be free and hold hands and kiss in public'.<sup>29</sup>

Although homosexual men had been individually defiant in the past, the existence of the GLF gave a united support to homosexuals, some of whom were very angry in relation to the exclusivity of the law reform.<sup>30</sup> Oscar Mangle recalls, 'The GLF voiced what we had all been thinking and feeling for so many years. It was an exciting time for us, there was a real feeling that things were changing for the better'.<sup>31</sup> However, there were other gay men who were not so in favour of the GLF. They believed that the radical GLFers made demands on all gay men and many felt underrepresented, as despite the GLF's open door policy, due to their other responsibilities, many men had too little time to dedicate to GLF activities. Other men simply disliked the disruption to the status quo and the challenge to an established scene.<sup>32</sup>

The GLF was behind the first Gay Pride event of July 1972, which saw 1,000 people march from Trafalgar Square to Hyde Park for a picnic and party.<sup>33</sup> Lisa Power argues, however, that despite this event being a success, the GLF had already started to falter due to internal conflicts, and by 1972, it had disbanded with considerable bitterness.<sup>34</sup> Nevertheless, by the time the GLF disintegrated in 1972, it had already made a huge impact.

There seemed to be shifts and changes on the part of the public, and many homosexual men were beginning to embrace the term "gay" as a form of self-definition.<sup>35</sup> Papers like the *Guardian*, the *Observer* and even the conservative *Daily Telegraph* began using the

<sup>29</sup> Jones, *Tales from Out in the City*, p. 21; Cook, *A Gay History of Britain*. p. 180.

<sup>30</sup> Davidson, *And Thus Will I Freely Sing*, p. 88; Jivani, *It's Not Unusual*, p. 201.

<sup>31</sup> Oscar Mangle, interviewed 21<sup>st</sup> June 2010.

<sup>32</sup> Davidson, *And Thus Will I Freely Sing*, p. 110; Cook, *A Gay History of Britain*. p. 187.

<sup>33</sup> HCA/EPHEMERA/1148 West London Gay Liberation Front; Cook, *A Gay History of Britain*. p. 180.

<sup>34</sup> Lisa Power, *No Bath But Plenty of Bubbles: Stories from the London Gay Liberation Front, 1970-73* (London, 1995), p. 87; See, also Cook, *A Gay History of Britain*. p. 182.

<sup>35</sup> Davidson, *And Thus Will I Freely Sing*, p. 61; Jones, *Tales from Out in the City*, p. 106; Cant, *Footsteps and Witnesses*, p. 51.

word to describe homosexuals and increasingly the word was utilised without quotation marks around it.<sup>36</sup> However, Cook argues that even this new terminology ‘raised heckles’.<sup>37</sup> Peter Dennis believed that the “queer” world ‘had lost its charm [...] now you’re either gay or you’re straight, you’re one or the other. It’s lost a certain amount of its colour for the fact that it’s no longer underground.’<sup>38</sup>

In the 1970s, gay men and transvestites began to appear in the arts and the media in a way in which they had never been portrayed before.<sup>39</sup> In 1975, Hollywood obtained the rights to the play *The Rocky Horror Show* and made it into a movie. In the same year, Thames produced *The Naked Civil Servant* – after the BBC turned it down – adapted from Quentin Crisp’s autobiography of the same title. The film was a huge success and went on to win a number of awards. Moreover, Weeks goes on to propose that there was minimal hostility to this film. A survey conducted by the Independent Broadcasting Authority revealed that, while three percent of viewers had switched off, eighty-five percent stated that they did not find the film shocking.<sup>40</sup>

### *Reaction*

Nevertheless, in spite of the gay liberation movement creating a new visibility of gay lives which helped to challenge antagonism towards homosexuality, British culture remained broadly hostile and grudging in its liberalism.<sup>41</sup> In an opinion poll for *Gay Times* in 1975, most participants supported the 1967 legislation. However, forty-five percent of them believed that there should be curbs on gay men working in teaching

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<sup>36</sup> Jones, *Tales from Out in the City*, p. 109; Weeks, *Coming Out*, p. 227; Jivani, *It’s Not Unusual*, p. 181.

<sup>37</sup> Cook, *A Gay History of Britain*. p. 183.

<sup>38</sup> Peter Dennis, *Daring Hearts: Lesbian and Gay Lives in 50s and 60s Brighton* (Brighton, 1992), p. 37.

<sup>39</sup> See, e.g. Powell, *Man Country*.

<sup>40</sup> Weeks, *Coming Out*, p. 228; Jivani, *It’s Not Unusual*, pp. 181-182.

<sup>41</sup> Cook, *A Gay History of Britain*. p. 191.

and medicine, and the notion of gay men being a danger to young people persisted.<sup>42</sup> Many men were still noted to struggle with isolation and rejection, and despite some parents working hard to ‘come to terms with having a gay son, many still viewed their “choice” as tragic and/or abhorrent’.<sup>43</sup> This could offer a further context to explain the reason for the continuation of treatments for homosexuality into the mid-1970s despite legal reform, gay liberation and the removal of “homosexuality” from the APA’s diagnostic manual. Men continued to seek treatment because of the shame that continued to be placed on them by society and their families.<sup>44</sup> Indeed, Faith Ashley remarked:

I breathed a sigh of relief when they changed the law, but it would take a lot more than a new law and a gay rights movement to wipe away people’s entrenched prejudices. I was treating homosexuals well into the 1970s, because they were still very troubled by their sexual desires.<sup>45</sup>

The fresh attitude and pride embraced by some gay men also had its roots in other new cultural, social and political movements.<sup>46</sup> Within this period, some individuals were beginning to live counter-cultural lifestyles, and the way people lived their lives in the UK were changing in a very visible, and for some, disturbing way. Protests against the Vietnam War and anti-racism grew in size and enthusiasm. Recreational drugs such as LSD and marijuana became more readily accessible and used. Superficial changes, such as colourful clothes, the mini-skirt and bikini for women and long hair for men, defied conventional norms of behaviour and appearance. Popular music was changing as the glam rock era emerged and David Bowie appeared as the flamboyant, androgynous alter

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<sup>42</sup> See, e.g. HCA/ALBANY TRUST/16/61 National Council for Civil Liberties Report 8: Homosexuality and the Teaching Profession, August 1975; Cook, *A Gay History of Britain*. p. 191.

<sup>43</sup> Jones, *Out in the City*, p. 89; Jivani, *It’s Not Unusual*, p. 162; Cook, *A Gay History of Britain*. p. 191.

<sup>44</sup> Dickinson, Cook, Playle, & Hallett, “Queer” Treatments’, p. 1349.

<sup>45</sup> Faith Ashley, interviewed 17<sup>th</sup> July 2010.

<sup>46</sup> Cook, *A Gay History of Britain*. p. 185.



ego Ziggy Stardust. Ackroyd argues that Bowie challenged traditional gender roles and made transvestism more broadly acceptable.<sup>47</sup> There was also the emergence of anti-establishment thinking, including challenges to the institution of psychiatry with the emergence of the “counter-psychiatry” movement.<sup>48</sup>

### **The “counter-psychiatry” movement**

Nick Crossley argues that counter-psychiatry<sup>49</sup> was essentially a movement which criticised psychiatry. It questioned the very basis of psychiatry itself: its purpose, its fundamental conception of mental illness and the very distinction between “madness” and sanity.<sup>50</sup> The movement challenged and criticised psychiatry and consequently influenced attitudes towards institutional psychiatric care. Crossley proposes that it was under the impact of counter-culture that the counter-psychiatry movement emerged.<sup>51</sup>

The movement was essentially pioneered through the seminal investigation by Erving Goffman into American psychiatric hospitals in the 1960s, which proved to be very critical of the mental health system. Goffman had personal experience of institutionalisation when he was a patient suffering from tuberculosis. In addition, he also had an interest in other people’s experience of this phenomenon. He found that the social structure of mental hospitals resembled that of a “total institution”. Here the primary concern of staff was to ensure that patients conformed; this was achieved by forcing patients to enact their lives within a confined and observable space. This corroborates the finding in Chapter V, which identified that many staff in mental hospitals held paternalistic attitudes to those in their care. Moreover, Goffman’s book

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<sup>47</sup> Ackroyd, *Dressing Up*, 17.

<sup>48</sup> Prebble, *Ordinary Men and Uncommon Women*, p. 193.

<sup>49</sup> “Counter-psychiatry” and “anti-psychiatry” are used interchangeably.

<sup>50</sup> Nick Crossley, ‘R. D. Laing and The British Anti-Psychiatry Movement: A Socio-Historical Analysis’, *Social Science Medical* 47 (7), p. 878.

<sup>51</sup> Crossley, ‘R. D. Laing’, p. 879.

*Asylums*,<sup>52</sup> published in 1961, along with the work of Thomas Szasz,<sup>53</sup> brought a radical re-thinking of care for the mentally ill in the USA and both had a considerable influence in Britain.<sup>54</sup>

A key figure in the counter-psychiatry movement in the UK was Ronald David Laing.<sup>55</sup> According to Crossley, Laing was a ‘charismatic counter-cultural guru and formed a nucleus of “movement individuals” around which the anti-psychiatry movement was formed in the UK and abroad’.<sup>56</sup> He challenged the fundamental assumptions and practices of psychiatry. He argued that the specific definitions of, or criteria for, hundreds of psychiatric diagnoses or disorders were vague and arbitrary, leaving too much room for opinions and interpretations to meet basic scientific standards.<sup>57</sup> Laing was also noted to develop and experiment with alternative treatments for mental health problems, such as “therapeutic communities”.<sup>58</sup>

In addition, the psychiatric and medical profession were being more broadly criticised by the likes of the playwright Joe Orton in his play *What the Butler Saw* in 1969.<sup>59</sup> Furthermore, in 1976, Ivan Illich argued in his book *Medical Nemesis: The Expropriation of Health* that the medical establishment had become a major and disabling threat to health and that this had ‘reached the proportions of an epidemic’. He named this new epidemic ‘iatrogenesis’. The name came from ‘iatros’, the Greek word for “physician”,

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<sup>52</sup> Erving Goffman, *Asylums* (New York, 1961).

<sup>53</sup> See, e.g. Thomas S. Szasz, *The Myth of Mental Illness: Foundations of Theory and Personal Conduct* (New York, 1961).

<sup>54</sup> Nolan, *A History of Mental Health Nursing*, p. 124.

<sup>55</sup> See, e.g. Ronald David Laing, *Sanity, Madness and the Family* (London, 1964).

<sup>56</sup> Crossley, ‘R. D. Laing’, p. 879.

<sup>57</sup> See, e.g. Laing, *Sanity, Madness and the Family*.

<sup>58</sup> Therapeutic communities aimed to establish a more self-governing, patient-led form of therapeutic milieu environment. They tried to avoid the controlling and demeaning practices of many psychiatric institutions of the time. The central philosophy was that patients were active participants in their own and each other's mental health care and that responsibility for the daily running of the community was shared among the clients and the staff. See, e.g. Maxwell Jones, *Social Psychiatry in Practice: The Idea of a Therapeutic Community* (Harmondsworth, 1968); David Cooper, *Psychiatry and Anti-Psychiatry* (London, 1967); Crossley, ‘R. D. Laing’, p. 885.

<sup>59</sup> The play is a farce and revolves around an unprofessional psychiatrist - Dr. Prentice – attempting to seduce his attractive prospective secretary: Alan Sinfield, *Out on Stage: Lesbian and Gay Theatre in the Twentieth Century* (New Heaven, 1999), p. 271.

and ‘genesis’, meaning “origin”.<sup>60</sup> He went on to argue that ‘deviance’ was now ‘legitimate’ only because it merits and justifies medical interpretation and treatment.<sup>61</sup> In essence, medical treatments had become a new form of punishment and social control.

### **“Psychiatrists in a shift. Declare Homosexuality no Mental Illness”**

A pioneer in the eventual removal of homosexuality from psychiatric diagnostic manuals was Evelyn Hooker, a psychology professor. She presented an important challenge to the sickness model in her 1957 article reporting that there was no difference in the psychological adjustment of groups of homosexual and heterosexual men.<sup>62</sup> Nevertheless, David Eisenbach argues that the medical profession perceived her methodology as weak and her research sample to be too small, and largely discounted her work.<sup>63</sup> However, with the advent of the US gay liberation movement in the early 1970s, assertive gay activists began using this work to challenge the “sickness” label that had been ascribed to homosexuality. During this time, activists began appearing on television talk shows to criticise the psychiatric establishment’s beliefs on homosexuality.<sup>64</sup> Indeed, one New York psychologist told the *New York Times* that ‘the Gay liberation movement is the best therapy the homosexual has had in years’.<sup>65</sup>

The most effective political tactic that the gay liberation movement utilised on both sides of the Atlantic was the “zap”.<sup>66</sup> Just as these activists had zapped political offices and fund-raisers; psychiatrists were also vulnerable to this. The Student Homophile

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<sup>60</sup> Ivan Illich, *Medical Nemesis: The Expropriation of Health* (London, 1976), p. 3.

<sup>61</sup> Illich, *Medical Nemesis*, p. 4.

<sup>62</sup> Evelyn Hooker, ‘Male homosexuality in the Rorschach’, *Journal of Projective Techniques* 21 (1957), pp. 18-31.

<sup>63</sup> Eisenbach, *Gay Power*, p. 229.

<sup>64</sup> Eisenbach, *Gay Power*, p. 231.

<sup>65</sup> “The Changing View of Homosexuality”, *New York Times*, 28 February, 1971.

<sup>66</sup> Zaps were public confrontations of individuals (mainly politicians) or organisations, aimed at forcing the recipients to address the issue of homosexuality and gay rights. Eisenbach argues that they not only accomplished the political feat of forcing individuals to address the issue of homosexuality, but they also enabled participants to feel a sense of power – ‘gay power’: Eisenbach, *Gay Power*, pp. 130-131.

League at Columbia University, USA, launched the first public demonstration against the psychiatric establishment in 1968; gay and lesbian revolutionaries from around the USA targeted meetings of mental health professionals. In the same year, these individuals held a press conference to condemn the US government's plans to build a centre for the cure of 'sexual deviants', a plan that the activists compared to 'the [Nazi] final solution'.<sup>67</sup>

The US GLF was noted to be very confrontational in its campaign against the sickness model, and in 1970, the GLF interrupted an APA convention. During this zap, a prominent psychiatrist was noted to remark, 'I never said homosexuals were sick – what I said was that they had displaced sexual adjustment'. The GLF activists were not happy with this and one member was noted to bellow, 'That's the same thing "motherfucker"!'<sup>68</sup> Furthermore, when an Australian expert on aversion therapy described his use of electric aversion therapy to make 'unhappy homosexuals' responsive to women, a protester remarked, 'Where did you do your residency? Auschwitz?'<sup>69</sup> Eisenbach argues that the GLF were not satisfied with shouting from the gallery during this zap and the demonstrators called for an official voice at the conference: 'We've listened to you, now listen to us.'<sup>70</sup> The majority of the psychiatrists in the audience were annoyed and demanded their money back from the APA. One asked the police to shoot the protesters.<sup>71</sup>

However, at the end of the demonstration, a liberal psychiatrist, Kent Robinson, approached one of the activists, Larry Littlejohn. Robinson agreed to lead an effort from within the APA to organise a panel of homosexuals to speak at the next

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<sup>67</sup> Henry Minton, *Departing from Deviance* (Chicago, 2002), p. 254; John DeEmilio, *Sexual Politics, Sexual Communities* (Chicago, 1998), p. 216.

<sup>68</sup> Dudley Clendinen & Adam Nagourney, *Out for Good: The Struggle to Build a Gay Rights Movement in America* (New York, 1999), pp. 201-203.

<sup>69</sup> 'Gays and Dolls Battle the Shrinks', *Washington Post*, 15<sup>th</sup> May, 1970.

<sup>70</sup> Eisenbach, *Gay Power*, p. 232.

<sup>71</sup> Minton, *Departing from Deviance*, p. 255; Eisenbach, *Gay Power*, p. 232.

convention.<sup>72</sup> Robinson was successful in his effort, and he managed to convince the APA to include a panel of gay men and women who rejected the sickness diagnosis in its 1971 annual convention in Washington D.C.<sup>73</sup> A key GLF member in their campaign to challenge the sickness diagnosis was Frank Kameny. In spite of the fact that he was invited to this convention, the GLF decided to zap it anyway to attract media attention. At the opening ceremony, Kameny sat in the audience as an honoured guest while dozens of GLF demonstrators burst into the hall from the door behind the stage. In the confusion Kameny seized the microphone and declared, 'Psychiatry is the enemy incarnate. Psychiatry has waged a relentless war of extermination against us. You may take this as a declaration against you!'<sup>74</sup> The activists were also noted to demand that a stall marketing aversion therapy equipment be immediately removed or they would tear it down. To avoid further disruption, it was dismantled. This event marked the alliance of Kameny and Robinson to persuade sympathetic psychiatrists to support a resolution to remove homosexuality from the APA's Diagnostic Statistical Manual (DSM).<sup>75</sup>

The following year, at its Dallas convention, Robinson was able to influence the APA to hold a discussion called "Psychiatry, Friend or Foe to Homosexuals? A Dialogue." People were only invited to the discussion if they were sympathetic to the removal of the sickness designation. Frank Kameny and Barbara Gittings (another prominent GLFer) were joined on the panel by Robert Seidenberg and Judd Marmor, who represented sympathetic psychiatrists.<sup>76</sup> Furthermore, Gittings managed to convince Marmor to include a homosexual psychiatrist on the panel. However, it proved very difficult to find someone who was willing to discuss his homosexuality in front of his

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<sup>72</sup> Bayer, *Homosexuality and American Psychiatry*, p. 57.

<sup>73</sup> Drescher & Merlino, *American Psychiatry and Homosexuality: An Oral History* (New York, 2007), p. 43.

<sup>74</sup> Bayer, *Homosexuality and American Psychiatry*, pp. 103-105.

<sup>75</sup> Frank Kameny, 'Psychiatrists Re-evaluate: Aftermath of Gay Zapping', *Vector* 7 (1971), p. 21.

<sup>76</sup> Eisenbach, *Gay Power*, p. 233.

colleagues, as the APA officially barred homosexuals from careers in psychiatry.<sup>77</sup> Nevertheless, Gittings managed to find Dr. John Fryer. However, Fryer only agreed to do this on the condition that he would utilise the pseudonym Dr. H. Anonymous, and that he could wear a wig and mask and use a voice-distorting microphone.<sup>78</sup>

Dr. H. Anonymous was smuggled into the convention through back corridors into a packed lecture hall. During his address, he noted that there were more than 200 homosexual psychiatrists attending the convention:

As psychiatrists who are homosexual, we must know our place and what we must do to be successful. If our goal is high academic achievement, a level of earning capacity equal to our fellows, or admission to a psychoanalytical institute, we must make sure that we behave ourselves, and that no one in a position of power is aware of our sexual preference.<sup>79</sup>

When Dr. H. Anonymous finished, the audience honoured his brave presentation with a standing ovation. Frank Kameny noted that the Dallas convention was the first convention in which only positive views on homosexuality were voiced in the public forums.<sup>80</sup> Moreover, Eisenbach argues that whether or not the APA's new consideration for homosexuals resulted from education, sympathy or intimidation, it marked a turning point in the relationship between psychiatry and the gay community, and the intellectual tide seemed to be turning against the sickness model by 1972.<sup>81</sup> The APA's leadership was also changing during the early 1970s and a group of young psychiatrists formed the Committee for Concerned Psychiatry, which worked to get liberals elected to APA offices in order to alter the profession's positions on social

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<sup>77</sup> Drescher & Merlino, *American Psychiatry and Homosexuality*, p. xvii; Eisenbach argues, however, that gays were able to quietly enter the profession and flourish. Further, at the annual APA conventions, dozens of closeted homosexual psychiatrists gathered together in gay bars to convene what they jokingly referred to as the GAY-PA: Eisenbach, *Gay Power*, p. 233.

<sup>78</sup> Bayer, *Homosexuality and American Psychiatry*, pp. 57-58; Eisenbach, *Gay Power*, p. 233.

<sup>79</sup> Drescher & Merlino, *American Psychiatry and Homosexuality*, pp. 17-18.

<sup>80</sup> Alvarez, *Homosexuality*, p. 216; Eisenbach, *Gay Power*, p. 234.

<sup>81</sup> Eisenbach, *Gay Power*, pp. 234-345.

issues such as feminism and homosexuality. Furthermore, John Spiegel, a closeted homosexual, was elected president of the APA in 1973. Finally, Charles Silverstein from the Gay Activist Alliance (GAA) had also joined forces with the GLF against the sickness diagnosis.<sup>82</sup>

While the GLF in the USA appeared to be the most influential in tackling homophobic rhetoric in psychiatry, there were also protests to these treatments in the UK. The GLF in the UK had a subgroup entitled “The Anti-Psychiatry Group” who critically challenged the notion that homosexuality was a mental illness.<sup>83</sup> The Albany Trust<sup>84</sup> began using questionnaires to survey patients who had received “treatment” in psychiatric facilities to “cure” them of their sexual deviations. The results were fairly damning and the Trust started offering gay men counselling to come to terms with their sexuality.<sup>85</sup>

Furthermore, in an article entitled: “Aversion Therapy is Like a Visit to The Dentist” in *Gay News* in 1972; Peter Tatchell recalls his protest against two of Britain’s leading psychiatrists’ advocacy of aversion therapy as a “cure” for homosexuality. On 2<sup>nd</sup> of November 1972, the London Medical Group held a symposium on aversion therapy. Peter Tatchell, a member of the GLF, attended to challenge what he believed to be the psychiatric abuse of gay men by psychiatrists Prof. Hans Eysenck and Dr. Isaac Marks. When Dr. Marks, a Senior Lecturer and Consultant Psychiatrist at the Maudsley Hospital, tried to reassure his audience that the pain and discomfort experienced by the

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<sup>82</sup> Drescher & Merlino, *American Psychiatry and Homosexuality*, p. 121; Eisenbach, *Gay Power*, p. 235.

<sup>83</sup> The Anti-Psychiatry Group’s work is demonstrated in the letter at the beginning of this chapter. See, also HCA/EPHEMERA/1148 West London Gay Liberation Front interim statement ‘the Counter Psychiatry Group of the GLF’; Cook, *A Gay History of Britain*. p. 180.

<sup>84</sup> The Albany Trust was a UK registered charity founded in May 1958. The Trust worked in collaboration with the Homosexual Law Reform Society and eventually developed into an innovative counselling organisation for gay men, lesbians and sexual minorities: See, e.g. HCA/ALBANY TRUST/10.

<sup>85</sup> See, e.g. HCA/ALBANY TRUST/10/4 Malik Survey on psychosexual treatment. Completed questionnaires on psychiatric facilities for homosexuals in the London area; HCA/ALBANY TRUST/10/6 Eva Bene survey regarding use of medical and psychiatry treatment.

patient receiving aversion therapy was greatly exaggerated and, in fact ‘it is just like a visit to the dentist...It is no different from any other form of therapy’, Tatchell challenged his statement by citing patients who had undergone aversion therapy and were now chronically depressed. This led to a verbal altercation between Tatchell and the psychiatrists that resulted in Tatchell being ‘violently assaulted’ as ‘ten heavies [...] dragged’ him from the symposium.<sup>86</sup>

In 1973, the APA Committee on Nomenclature (the committee responsible for editing the DSM) held a meeting, and they invited GAA members Ron Gold and Charles Silverstein. Gold had a long history of undergoing torturous psychiatric treatment in a bid to cure him of his homosexuality, and he talked openly about the negative effects this had on him. There had been no plans to revise the DSM until 1978; however, Gold implored the committee to revise it immediately and thereby bring ‘to pass a more enlightened medical and social climate.’<sup>87</sup> Silverstein was a PhD student in psychology and knew that if he was going to convince the APA to revise the diagnosis of homosexuality; he needed to make an articulate argument that displayed an understanding of systems and classifications. He read the committee a long statement that surveyed the work of Kinsey and Hooker and quoted Freud’s sympathetic letter to an American mother regarding her son’s homosexuality.<sup>88</sup> Byer argues that while the committee were moved by Gold’s narrative, it was Silverstein’s calm and professional appeal that impressed them most. Therefore, they agreed to hold a debate at the APA convention in Hawaii later that year.<sup>89</sup>

The debate, entitled “Should Homosexuality Be in the APA Nomenclature?” found that the panel were broadly in favour that homosexuality should be included on the agenda

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<sup>86</sup> “Aversion Therapy Is Like A Visit To The Dentist”, *Gay News* No. 11, 1972.

<sup>87</sup> Bayer, *Homosexuality and American Psychiatry*, p. 119.

<sup>88</sup> See the introduction of this thesis for a copy of Freud’s letter; Eisenbach, *Gay Power*, p. 238.

<sup>89</sup> Bayer, *Homosexuality and American Psychiatry*, p. 120.



for discussion in the nomenclature. Indeed, the debate inspired Robert Spitzer, a Columbia University psychoanalyst, to join the fight against the sickness diagnosis.<sup>90</sup> Spitzer analysed the DSM to uncover something common to pathologies that did not apply to homosexuality. He found that people who suffered from most disorders listed in the DSM usually experienced serious distress or their conditions interfered with their overall functioning. He submitted a report to the Nomenclature Committee arguing that while homosexuality may not fall within the “normal” range of sexual behaviour, it did not impair social effectiveness. He argued that for behaviour to be listed as a psychiatric disorder, it had to be accompanied by subjective distress and/or ‘some generalized impairment in social effectiveness or functioning.’ He also made reference to Hooker’s study comparing functioning levels of homosexuals and heterosexuals and concluded that since general functioning was not necessarily impaired, homosexuals could not be diagnosed as having a disorder.<sup>91</sup>

Nevertheless, the Nomenclature Committee was divided on Spitzer’s report and the proposed revision of the DSM to remove homosexuality. To avoid further debate, the committee passed the issue over to the Council on Research and Development, who advised the APA on matters of policy. The Council approved Spitzer’s proposal, as its policy was to accept the advice of the experts on the sub-committees. However, Eisenbach argues that it is possible that the council failed to notice that Spitzer was not an “expert” on homosexuality.<sup>92</sup> The debate regarding removing homosexuality as a diagnosis was then moved to the Assembly of District Branches, and then to the Reference Committee, and finally it reached the APA board of trustees.

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<sup>90</sup> Eisenbach, *Gay Power*, p. 240.

<sup>91</sup> Clendinen & Nagourney, *Out for Good*, p. 217; Eisenbach, *Gay Power*, p. 241.

<sup>92</sup> Eisenbach, *Gay Power*, p. 242.

On December 15<sup>th</sup>, 1973, the APA board of trustees voted unanimously to remove homosexuality from the DSM, and the following year, the seventh printing of the DSM version II excluded homosexuality as a diagnosable illness.<sup>93</sup> Homosexuals were no longer considered mentally ill by the APA, and their DSM was widely utilised in the UK. Ron Gold summed up their decision, simply saying, ‘We’ve won!’<sup>94</sup> Furthermore, the media were keen to report this decision and ran front-page headlines such as the *New York Times*’ ‘Psychiatrists in a Shift. Declare Homosexuality no Mental Illness.’<sup>95</sup> Meanwhile, in mock relief, the *Gay Community News* announced, ‘It’s Official Now: We’re Not Sick.’<sup>96</sup>

Eisenbach argues that the removal of homosexuality from the DSM was based on science and politics. He argues that Spitzer wanted to help fight the social problem of homosexual discrimination by finding a scientific argument for the revision. However, his argument that a condition had to impair general functioning was flawed. Eisenbach posits that if, as Spitzer argued, a condition had to impair general functioning or cause great distress to be considered a disorder, then paedophilia, for example, would have not been considered a mental illness.<sup>97</sup> Nevertheless, Bayer argues that while the revision of the DSM did not ‘launch an unrestrained march toward social acceptance of homosexuality; it did move the power of “the experts” to the side of the gay rights movement.’<sup>98</sup>

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<sup>93</sup> American Psychiatric Association, *Seventh Printing Diagnostic Statistical Manual Version II* (Arlington, 1974).

<sup>94</sup> Eisenbach, *Gay Power*, p. 247.

<sup>95</sup> ‘Psychiatrists in a Shift. Declare Homosexuality no Mental Illness.’ *New York Times*, 16 December, 1973.

<sup>96</sup> ‘It’s Official Now: We’re Not Sick.’ *Gay Community News*, 16<sup>th</sup> December, 1973.

<sup>97</sup> Eisenbach, *Gay Power*, pp. 241-242.

<sup>98</sup> Bayer, *Homosexuality and American Psychiatry*, p. 157.

### Nurse therapists

Not only were there changes and developments in the ways that homosexuals were viewed by society, psychiatry and the law during this period: the profession of mental nursing was also experiencing changes and developments. Younger nurses entering nursing in the late 1960s and 1970s were exposed to the social changes discussed above, and Nolan argues that this prepared them to challenge the older nurses about their attitudes towards patients and staff.<sup>99</sup> In parallel with the wider society, nurses were beginning to question a culture which required them and patients to conform to institutional norms. Nevertheless, these nurses found that there was an enormous resistance to change and senior nurses were reluctant to disrupt the 'status quo' by backing younger staff against more experienced staff, even when cruelty to patients was an issue.<sup>100</sup> Indeed, Hopton argues that many of the asylum type practices were present in mental hospitals until well into the 1970s.<sup>101</sup> The tide was beginning to turn, however.

The 1960s witnessed the era of public enquiries into mental health care. Most of these enquiries were instigated by nurses writing letters to various prominent figures regarding patient care.<sup>102</sup> Of significant importance was one of these letters, which was published in *The Times* on 10<sup>th</sup> November 1963, signed by ten individuals:

We, the undersigned, have been shocked by the treatment of geriatric patients in certain mental hospitals, one of the evils being the practice of stripping them of their personal possessions. We have now sufficient evidence to suggest that this is widespread...We shall be grateful if those who have encountered malpractices in this sphere will supply us with detailed information, which would of course be treated as confidential.<sup>103</sup>

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<sup>99</sup> Nolan, *A History of Mental Health Nursing*, p. 133.

<sup>100</sup> Brand, *Look Back*, p. 190; Nolan, *A History of Mental Health Nursing*, p. 133.

<sup>101</sup> Hopton, 'Prestwich Hospital in the Twentieth Century', p. 355.

<sup>102</sup> Nolan, *A History of Mental Health Nursing*, p. 135.

<sup>103</sup> *The Times*, 10<sup>th</sup> November, 1963.

The contents of the letters received by ten signatories became the basis of a book entitled *Sans Everything, A Case to Answer*.<sup>104</sup> The book noted the degrading misery of the older adult in hospitals and demonstrated that with only minimal effort, their circumstances could be positively changed. Nolan argues that many claimed that the book was exaggerated. However, it was highly persuasive and prompted closer scrutiny of the treatment of other vulnerable groups in care, including the mentally ill.<sup>105</sup> It was also noted to break the tradition of secrecy in mental hospitals, as other nursing staff started to come forward condemning the treatment of patients in mental hospitals.

The 1969 Ely Hospital Enquiry report<sup>106</sup> was instigated by a letter sent to the *News of the World* from a nursing assistant, which was subsequently forwarded to the Health Minister.<sup>107</sup> The Ely Report delineated cruelty to patients, pilfering of food, and the unresponsiveness of senior nursing management, medical staff and the Physician Superintendent to reports of malpractice, at Ely Hospital, Cardiff.<sup>108</sup> More findings, some more severe, were also made during enquiries at other hospitals.<sup>109</sup> Moreover, many of the subsequent reports that were published from these enquires revealed that nurses in mental hospitals had an inability to either recognise or to act on gross deficiencies in the care of their patients.

In possible response to this escalating crisis, The Department of Health and Social Security published its paper entitled *Psychiatric Nursing Today and Tomorrow* in 1968. The paper posited that the patient is ‘an active participant and not a passive object for the exercise of medical skill’ and went on to advocate that ‘the nurse is the key therapeutic

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<sup>104</sup> Barbara Robb, *Sans Everything: A Case to Answer* (London, 1967). See, also Her Majesty’s Stationary Office, Command 3687: *Findings and Recommendations Following Inquiries into Allegations Concerning the Care of Elderly Patients in Certain Hospitals* (London, 1968).

<sup>105</sup> Nolan, *A History of Mental Health Nursing*, p. 135.

<sup>106</sup> Her Majesty’s Stationary Office, Command 3975: *Report of the Committee of Inquiry into Allegations of Ill-Treatment of Patients and other Irregularities at Ely Hospital Cardiff*, (London, 1969).

<sup>107</sup> Nolan, *A History of Mental Health Nursing*, p. 135.

<sup>108</sup> Command 3975: *Report of Ely Hospital Cardiff*.

<sup>109</sup> See, e.g. Beardshaw, *Conscientious Objectors*, pp. 84-88.

figure'.<sup>110</sup> Chatterton argues that this document instigated a cultural change within mental nursing, and the title of 'mental nurse' was replaced by the term 'psychiatric nurse'.<sup>111</sup>

During the 1970s, psychiatric nurses started to analyse their skills by undertaking their own studies into psychiatric nursing.<sup>112</sup> Key researchers during this period were Annie Altschul and David Towell, who proposed that nurses were not skilled in establishing and maintaining therapeutic interpersonal relationships with patients, and argued that they had no theoretical basis upon which to stand when caring for mental patients.<sup>113</sup> They suggested that the root cause of this was a problem with nurse education, which they found to still be institutionalised, with minimal opportunities for innovation. Moreover, according to Nolan, the work of these researchers stimulated wide-ranging discussions and closer examination of nursing practices.<sup>114</sup>

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<sup>110</sup> Department of Health and Social Security, *Psychiatric Nursing Today and Tomorrow* (London, 1968), pp. 45

<sup>111</sup> Chatterton "The weakest link in the chain of nursing?", p. 6.

<sup>112</sup> Nolan, *A History of Mental Health Nursing*, p. 137.

<sup>113</sup> Annie Altschul, *Patient-Nurse Interaction: A Study of Interactive Patterns in Acute Psychiatric Wards* (Edinburgh, 1972); David Towell, *Understanding Psychiatric Nursing* (London, 1975).

<sup>114</sup> Nolan, *A History of Mental Health Nursing*, p. 137.



**Figure 12. Psychiatric nurses in June 1975 on a long stay male ward once known as a “refactory ward” where some of the patients presented with challenging behaviours.**

**Source: Personal collection of Geoff Speight, Senior Lecturer in Mental Health Nursing at The University of Central Lancashire (pictured in the centre).**

A pioneering development during the 1970s was the introduction of the “nurse therapist”. These nurses autonomously practised adult behavioural psychotherapy for a range of clinical problems likely to respond to brief behavioural psychotherapy: one such problem was sexual deviation. Charlie Brooker argues that nurse-therapists were agents to effect lasting change in patients, and allowed psychiatrists to fulfil other roles for which they were trained, including being consultants, researchers and teachers.<sup>115</sup>

This dynamic new role was initiated for several reasons, including pressure of demand for services, which according to Geoff Russell had far outstripped supply. Russell went

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<sup>115</sup> Charlie Brooker, ‘Nurse Therapist Trainee Variability: The Implications for Selection and Training’, *Journal of Advanced Nursing* 8 (1983), p. 322.

on to argue that the bulk of psychiatric patients could no longer expect to have a psychiatrist as their main therapist.<sup>116</sup> There were also pressures to economize: medical training up to finals, according to *The Observer* on the 24<sup>th</sup> July, 1977, cost approximately £40,000, which was fifteen times the average national per capita income. Conversely, they argued that nurse training was noted to cost £4,400, which was less than twice the average national per capita income.<sup>117</sup> Coupled with salary differences on graduation, the Government was naturally interested in utilising non-medical staff to satisfy the demand for therapists. Finally, there was pressure from dissatisfied nurses, who felt that many traditional nursing roles had been taken over by social workers, occupational therapists and domestic supervisors.<sup>118</sup> Junior nurses often perceived their role as little more than issuing medicines and being vaguely supportive, while senior nurses, since the Salmon Report,<sup>119</sup> felt generally confined to administration or teaching and many felt as frustrated as their juniors.<sup>120</sup>

Selection for nurse therapy courses was rigorous. All potential trainees had to have as a minimum qualification the Registered Mental Nurse certificate. Applicants also had to attend an interview and had to demonstrate:

A desire to work in behavioural therapy, initiative, capability of working increasingly independently with adult neurotic patients and an ability to earn the respect of colleagues in other health care professions.<sup>121</sup>

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<sup>116</sup> Geoff F. M. Russell, *Policy for Action* (London, 1973), p. 56.

<sup>117</sup> "The True Cost of Training a Doctor", *The Observer*, 24<sup>th</sup> July, 1977.

<sup>118</sup> Royal College of Nursing, *New Horizons in Clinical Nursing* (London, 1976).

<sup>119</sup> The Salmon Report on Nursing Management in 1966 was welcomed as a policy for psychiatric nurses. The report created a new role of "Nursing Officer", which doubled the number of nurses in management roles. They played a key role in clinical supervision, management and personnel work. However, Nolan has posited that the role was never formally evaluated, and therefore, it is impossible to say what, if any, improvements were made to nursing practice with their introduction. They did, however, provide more opportunities for nurses to progress their careers and enter management positions: Nolan, *A history of mental health nursing*, p. 134.

<sup>120</sup> Julian Bird, Isaac Marks & Peter Lindley, 'Nurse Therapists in Psychiatry: Developments, Controversies and Implications', *British Journal of Psychiatry* 135 (1979), p. 321.

<sup>121</sup> Brooker, 'Nurse Therapist Trainee Variability', p. 322.

From the last requisite, ‘an ability to earn the respect of colleagues in other health care professions’, it could be argued that the people involved in developing the role foresaw that this new position might cause conflict with other health care professions. Indeed, they were right. The main opposition came from clinical psychologists, who preferred to restrict behavioural work to their own discipline. The nurse-therapist was unwelcome to them, as nurse-therapists were seen as medically orientated, academically naive and a block to progress towards clinical independence for clinical psychologists.<sup>122</sup>

Faith Ashley reflects on this strained working relationship:

We had to have a fairly thick skin at times, particularly in relation to psychologists’ attitude towards us. Many were not happy about our new role and some had a distinct lack of respect for us. I believe they did not perceive us to be “level” with themselves in relation to educational status. Nevertheless, without “bigging” ourselves up, we were a very intelligent, resilient and tenacious group of nurses. The selection and training we underwent was rigorous and I feel that the innovators of our role were aware of the challenges we were likely to face and selected and trained us with this in mind.<sup>123</sup>

The training course was eighteen months in duration, of which twelve months were given to intensive training at the training centre and six months to placement at a general practice, a health centre or another hospital. The teacher-trainee ratio was approximately 1:3. The syllabus included interview skills, with emphasis on the behavioural analysis of patients’ problems and subsequent negotiation of appropriate treatment goals. According to Brooker, the importance of clinical documentation was reiterated throughout the course, especially where communication with other professionals was necessary.<sup>124</sup> Again, this could be interpreted as a tacit apprehension the nurses had towards other members of the health care team. Trainees were also

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<sup>122</sup> Bird, Marks & Lindley, ‘Nurse Therapists in Psychiatry’, p. 328.

<sup>123</sup> Faith Ashley, interviewed 17<sup>th</sup> July 2010.

<sup>124</sup> Brooker, ‘Nurse Therapist Trainee Variability’, p. 322



taught how to apply a wide range of specific behavioural techniques and essentially to recognise the limits of their own competence. The training methods were wide-ranging and included the use of closed circuit television monitoring and feedback, clinical demonstrations, seminars, lectures and reviews.

The nurse therapists' worth was demonstrated in the treatment of sexually deviant patients. Peter Lindley discussed his practice as a nurse-therapist treating "sexual deviation in a young man" in the *Nursing Mirror* in 1975. In the paper he stated that he was responsible for prescribing and administering electrical aversion therapy for a young man with homosexual desires. Lindley summarised that the patient had improved, as his 'homosexual desires had diminished'.<sup>125</sup> In 1977, Isaac Marks, Julian Bird and Peter Lindley found that for the ten patients who completed treatment for their sexual deviation with a nurse therapist, the frequency of the patients' sexually deviant behaviour diminished, and they concluded that nurse therapists thus produced useful improvement in patients with sexual disorders. The paper, however, fails to comment on the small sample size and the self-report nature of the findings: as we witnessed in the previous chapter, many patients were able to subvert their health care professionals by feigning heterosexuality or repulsion with their transvestism. Furthermore, there are no follow-up findings on these patients.<sup>126</sup> Moreover, Neil McConaghy, a psychiatrist, concluded in 1976 in the *British Journal of Psychiatry* that aversion therapies would appear not to have altered the patients' pre-existing sexual orientation and the practitioners involved did not consider the considerable damage wrought by these treatments.<sup>127</sup> Ironically, the nurse therapists were claiming to be successful in an already discredited area of care.

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<sup>125</sup> Lindley, 'Sexual Deviation in a Young Man', p. 63.

<sup>126</sup> Marks, Bird & Lindley, 'Behavioral Nurse Therapists', p. 27

<sup>127</sup> Neil McConaghy, 'Is Homosexual Orientation Irreversible?', *British Journal of Psychiatry* 129 (1976), pp. 356-563.

The nurse therapists, who worked in the latter part of the study period, considered themselves autonomous practitioners, ‘[...] we had a lot of autonomy and could make decisions about and prescribe treatment of our own accord’.<sup>128</sup> Furthermore, it appears that these nurses were also following the “nursing process”<sup>129</sup> and were responsible for assessing, planning, implementing and evaluating the treatment for patients in their care. This can be demonstrated in a number of primary manuscript sources available in a book published in 1977, by the Royal College of Nursing. The book, entitled *Nursing in Behavioural Psychotherapy: An Advanced Clinical Role for Nurses*, traces the development of this advanced practice role.<sup>130</sup> Within the book, there is an assessment tool entitled *The Guide to Sexual History*, which the nurse therapists utilised to assess their patients’ sexual history.<sup>131</sup> In a *Treatment Plan and Progress Summary* the nurse-therapist has developed a care plan with treatment formulations and aims for a patient with a diagnosis of ‘homosexuality’.<sup>132</sup> Finally, it also appears that the nurses evaluated the efficacy of the treatment they were implementing. In the *Nurse-Therapist’s Letter to the General Practitioner at One Month Follow Up*, the nurse states:

Throughout the course of the treatment he [the patient] was able to report a lessening in intensity and frequency of urges to indulge in homosexual activity, until he was no longer troubled by these thoughts or desires. [...] When seen recently at a one-month follow-up interview his progress had been maintained.<sup>133</sup>

I would argue that the training the nurse therapists received equipped them with a theoretical basis upon which to stand when treating their patients, which was in broad

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<sup>128</sup> Faith Ashley, interviewed 17<sup>th</sup> July 2010.

<sup>129</sup> Nursing practise was first described as a four-stage (assess, plan, implement and evaluate) nursing process: by Ida Jean Orlando in 1958.

<sup>130</sup> Issac, M. Marks, ‘Nursing in Behavioural Psychotherapy: An Advanced Clinical Role for Nurses’, *Royal College of Nursing* (London, 1977).

<sup>131</sup> Marks, ‘Nursing in Behavioural Psychotherapy’, Appendix A7.

<sup>132</sup> Marks, ‘Nursing in Behavioural Psychotherapy’, p. 135.

<sup>133</sup> Marks, ‘Nursing in Behavioural Psychotherapy’, p. 134.

contrast to other nurses in this study, especially the SENs. I would also propose that nurse therapists identified the importance of developing a therapeutic relationship with patients in their care. Indeed, nurse therapist Peter Lindley considered:

[...] it essential to establish a very good working relationship with “John”. Our first three sessions were spent chatting about his problem in order to arrive at a clear picture of his situation.<sup>134</sup>

Once again this is in contrast to other nurses in this study, as Edward Lyons, who nursed patients receiving chemical aversion therapy in the early 1960s, remarked: ‘We didn’t have to talk to ‘em [sic]. If he was emotionally distressed it still went on.’<sup>135</sup> However, despite this newfound education, the evidence base for aversion therapy to treat sexual deviation was still very limited. Therefore, the nurse therapists were still doing something quite spurious, as the efficacy of the treatments they were implementing still relied on self-report from the patient and had already been discredited by a psychiatrist in the *British Journal of Psychiatry*.<sup>136</sup>

It is impossible to measure whether the nurse therapists treated patients with any more humanity than psychiatrists had done. One psychiatrist from Michael King’s study gave an interesting reflection regarding nurse therapists’ attitudes towards electrical aversion therapy:

It was the nurses who actually gave the aversion therapy. [...] The nurse would sit in another room when the treatment was taking place. I can’t remember now whether they had a one-way mirror or something like that. I was surprised that the nursing staff didn’t feel more strongly because one hears of nursing staff having conscientious objections to termination of pregnancy or even sometimes giving ECT. It surprises me that they didn’t

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<sup>134</sup> Lindley, ‘Sexual Deviation in a Young Man’, p. 64

<sup>135</sup> Edward Lyons, interviewed 10<sup>th</sup> February 2010.

<sup>136</sup> McConaghy, ‘Is Homosexual Orientation Irreversible?’, pp. 356-563.

say: “I don’t want to do this treatment”. There was some sort of physical barrier between the nurse and the patient.<sup>137</sup>

Interestingly, I would argue that this psychiatrist is directing the responsibility for administering aversion therapy onto the nurses, as they were the ones ‘who actually gave’ it.<sup>138</sup> Furthermore, I would argue that she perceived herself as working within a higher moralistic framework than the nurses, which is ironic given that she did not appear to voice any objections to these treatments at the time either. Moreover, Greta Gold gives an interesting reflection of a nurse therapist’s attitude towards her when the nurse administered electrical aversion therapy to her: ‘Tears began running down my face and the nurse said: “What are you crying for? We have only just started!”...[Chokes]...I was speechless’.<sup>139</sup> Therefore, some of these nurses may have been equally as antipathetic to their patients as the doctors. However, Faith Ashley remarked, ‘The nurse therapists role was to provide support and reassurance. We would talk to them about their homosexuality and not just shock them as people often think.’<sup>140</sup>

During this period, community care had returned to the political agenda, and in 1975, the report entitled *Better Services for the Mentally Ill* was published.<sup>141</sup> The report evaluated the current state of psychiatric services and outlined a plan for future services. These included reducing overcrowding in hospitals by increasing the number of patients being treated in the community. Nevertheless, the report also noted that staffing levels and community facilities at present were inadequate to properly support patients in the

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<sup>137</sup> Female psychiatrist interviewed as part of a study by Michael King, ‘*Doubts about the treatments*’ available at: <http://www.treatmentshomosexuality.org.uk/index.php/en/narratives-en> [last accessed 29 December 2011].

<sup>138</sup> Michael King, ‘*Doubts about the treatments*’

<sup>139</sup> Greta Gold, interviewed 24<sup>th</sup> March 2010.

<sup>140</sup> Faith Ashley, interviewed 17<sup>th</sup> July 2010.

<sup>141</sup> Department of Health and Social Security, *Better Services for the Mentally Ill*, Cmnd.6233 (London, 1975).

community. As it became increasingly apparent that community services were the way forward for mental health care, it was evident that nurses needed education to support them in making the transition from hospital to the community. This led to the development of the first course for Community Psychiatry Nurses (CPNs) at Chiswick College in the early 1970s and, analogous to the nurse therapists, CPNs were soon to begin gaining recognition as autonomous practitioners. Moreover, by the 1970s nurses were acquiring specialist skills dealing with specialist groups, which was very much in contrast to their generalist work in mental hospitals.<sup>142</sup>

It is important to note that the majority of the papers discussing the work of nurse therapists with “sexually deviant” patients were published in the mid to late 1970s. Interestingly, this was also after the APA removed “homosexuality” as a diagnosis in 1974. There are a number of explanations for this. Many of the patients discussed in these papers had a paedophilic or cross-dressing element to their sexual desires.<sup>143</sup> Due to the obvious risk paedophiles may pose, such sexual desires remain classifiable as a mental disorder, and albeit not with aversion therapy, treatments are still administered for these individuals.<sup>144</sup> Additionally, despite education and liberalism regarding transvestism and transsexuals,<sup>145</sup> transvestism remains classifiable as a mental disorder.<sup>146</sup> Furthermore, before an individual can undergo gender reassignment surgery, he/she has

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<sup>142</sup> Nolan, *A History of Mental Health Nursing*, p. 137.

<sup>143</sup> See, e.g. Lindley, ‘Sexual Deviation in a Young Man’, pp. 63-64; Marks, ‘Nursing in Behavioural Psychotherapy’, p. 133.

<sup>144</sup> See, e.g. Ray Blanchard, ‘The DSM Diagnostic Criteria for Paedophilia’, *Archives of Sexual Behaviour*, 16 (2009), pp. 1-11

<sup>145</sup> The Beaumont Society was formed in 1966. This is a support group based in the UK for transgendered people, and then as now it is important in terms of alternative configurations of support and non-medical models of explanations; see also HCA/EPHEMERA/568 Transsexual Action Organisation (TAO) ‘Transsexual Information’, two leaflets and one pamphlet by the TAO.

<sup>146</sup> The current versions of the Diagnostic Statistical Manual and the International Classification of Diseases both classify transvestism as a mental disorder: ‘Transvestic Fetishism’ (DSM: 302.3) American Psychiatric Association, *Diagnostic Statistical Manual Version IV* (Washington, 1994) & ‘Transvestism’ (ICD: F64.1) World Health Organisation, *The International Classification of Diseases version 10 Classification of Mental and Behavioural Disorders* (Geneva, 1992).

to be diagnosed with the psychiatric diagnosis of Gender Identity Disorder.<sup>147</sup> This could offer a context to explain why treatments for transvestism continued.

It is difficult to quantify the impact that the APA's decision to remove homosexuality from its DSM had on homosexual men and nurses in the UK. King argues that the APA's decision to remove homosexuality from its DSM had some impact in the UK. However, he argues that the treatments appeared to peter out in parallel with the growing profile of gay liberation.<sup>148</sup> Furthermore, ironically, just as the media appears to have had a positive impact in promoting these treatments, it also appears to have supported their curtailment. In 1970, former nurse Claire Rayner wrote an article in the *Daily Mail* entitled: "Should Shame be the Cure?" In the article she argued that doctors were unjust in their use of chemical aversion therapy as, it stripped patients of their dignity and inflicted pain and shame on them.<sup>149</sup> The *Sunday Times* followed suit in 1971 with an article entitled: "Fears Over Aversion Therapy Grow: Using Shock Tactics to Bend the Mind".<sup>150</sup>

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<sup>147</sup> NHS Choices available at:

<http://www.nhs.uk/Conditions/Genderdysphoria/Pages/Introduction.aspx>[last accessed 15 May 2012].

<sup>148</sup> Michael King, 'Dropping the Diagnosis of Homosexuality: Did it Change the Lot of Gays and Lesbians in Britain?', *Australian and New Zealand Journal of Psychiatry* 37 (6) (2003), pp. 684-688.

<sup>149</sup> "Should Shame Be The Cure?", *Daily Mail*, 10<sup>th</sup> September, 1970.

<sup>150</sup> "Fears Over Aversion Therapy Grow: Using Shock Tactics to Bend the Mind", *Sunday Times*, 9<sup>th</sup> May, 1971.



Figure 13. "Fears Over Aversion Therapy Grow: Using Shock Tactics to Bend the Mind", *Sunday Times*, 9th May, 1971.

Source: Reprinted with permission from the Gay and Lesbian News Media Archives, London

Meanwhile the *Glasgow Daily Record* ran an article entitled: "Doctors are the 'problem' men".<sup>151</sup> The article argued that homosexuals are more at risk from medicine than from the law. Susan Traherne recalls the influence the press had on her perceptions of the treatments she had administered for sexual deviations:

I remember in the 1970s that the press started to change direction in regard to their views on these treatments. Historically they had promoted them now they were condemning them. I had already started to feel guilty about the treatments I had given in the 1960s, but reading these articles in

<sup>151</sup> "Doctors are the 'problem' men", *Glasgow Daily Record*, 28th November, 1974.

the media really confirmed to me that the treatments were wrong.<sup>152</sup>

Meanwhile, Faith Ashley remarks on her perceptions of the influence that gay liberation had on these treatments:

On reflection, I think the greater acceptance and understanding that gay liberation created, in the end, had a lot more impact in decreasing the number of referrals I received. [...] Nurses, myself included, were beginning to see homosexuals as no different from any other individual.<sup>153</sup>

The above testimonies suggest that the newfound radicalism of gay liberation was a lot more influential in curtailing these treatments than was the APA's decision. Furthermore, I would argue that along with the gay liberation movement, the media eventually influenced nurses to view using aversion therapy to cure homosexuality as inappropriate. Nevertheless, despite liberalism and education regarding transvestites and transsexuals which allowed these individuals to be more broadly accepted by society, they did not appear to have the same medical liberalism as homosexuals, as these individuals still remain open to psychiatric diagnosis and evaluation.

In spite of the APA's decision to drop the term "homosexuality" as a diagnosis, it is important to note that The World Health Organisation (WHO) did not follow suit until 1990. The term was eventually removed from their diagnostic manual in 1992 with the introduction of the *International Classification of Diseases edition 10 Classification of Mental and Behavioural Disorders* (ICD-10).<sup>154</sup> Nevertheless, none of the participants in this study stated that they received treatments after 1974. There is a dearth of literature describing

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<sup>152</sup> Susan Traherne, interviewed 30<sup>th</sup> December 2009.

<sup>153</sup> Faith Ashley, interviewed 17<sup>th</sup> July 2010.

<sup>154</sup>World Health Organisation, *The International Classification of Diseases version 10 Classification of Mental and Behavioural Disorders* (Geneva, 1992).



these treatments for purely homosexual desires after 1974, and the treatments appeared to stop in the mid to late 1970s.<sup>155</sup>

### **Conclusion**

This chapter has explored the assertive journey to gay liberation. While the new 1967 Act essentially legalised homosexual sex between consenting men, the many restrictions within the new legislation meant that many homosexual men were still open to social exclusion, legal proceedings and medical treatments. For the men who did not express their sexuality through coupledness and domesticity, prosecution continued. This in turn led these men to be offered the option of imprisonment or remand provided they were willing to undergo psychological treatment, and as this thesis has demonstrated, many chose the latter.

During this period wider society was also beginning to change. In the western world, individuals were beginning to question the definitions of “difference”. In parallel to these changes, gay men and women were starting to unite and promote sexual and subcultural difference as positive and life enhancing as gay liberation emerged – individuals were actively and vocally refuting the sickness label and the treatment that had come to accompany it. The media were also starting to become more accepting of sexual difference during this period and ran headlines questioning the efficacy of medical treatments for homosexuality. This newfound gay assertion and change in direction from the media appeared to have a positive effect on some of the nurses in this study, as they began to view the treatments they administered as inappropriate as ideas of deviance shifted.

During this period, nurses working in psychogeriatric care began to question practices, which led to a number of public investigations. These public investigations were also

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<sup>155</sup> Smith, King & Bartlett, ‘Treatments of homosexuality in Britain since the 1950s’, p. 2.

noted to spread to the rest of mental health care as the plight of the mentally ill and their conditions of treatment and care became a public issue. Community care was noted to be back in the political mainstream and new roles were created, including advanced practice roles such as the CPN and nurse therapist. Moreover, in contrast to the nurses who cared for patients receiving treatments for sexual deviations in the earlier part of the study, these advanced practice nurses appeared to have a theoretical basis upon which to stand when treating their patients. Nevertheless, in spite of the emphasis amongst nurse therapists believing they had a scientific foundation for their work, these nurses were still administering a spurious intervention, as the treatment's efficacy still relied on self-report from the patient. Furthermore, ironically, these nurses were claiming success in an area of care that had already been discredited.

The chapter also explored the journey to the APA's decision to remove homosexuality from its DSM. While this decision had some influence in decreasing the use of aversion therapy to cure homosexuality, it appears to be the impact of gay liberation and shifts and changes on the part of the media that essentially led to the curtailment of these treatments.

## CHAPTER VII

### CONCLUSION

It is fairly clear that the nurses in this study did not deliberately set out to inflict pain and distress on homosexuals and transvestites in their care. A variety of circumstantial factors provided momentum for the development and implementation of medical “treatments” to “cure” these individuals. This thesis has demonstrated that the medicalisation of sexual deviation can be traced back to the late nineteenth century. However, the Second World War appears to have been a critical point in the medicalisation of sexual behaviour. In spite of the War exposing the British to different and more liberal sexual attitudes, this was also the period when the idea of homosexuality as a pathology was more universally adopted by psychiatrists in both Britain and the USA.

#### **From criminalisation to medicalization**

There appeared to be a cultural shift in the immediate post-war years urging the nation to return to pre-war values. This was marked by a growing emphasis on domesticity, “traditional” family life and social order, with which it was believed that homosexual men were at odds. There was never any dedicated campaign by the police to target these individuals during the 1950s; however, arrests did increase.<sup>1</sup> This left homosexual men and transvestites living through this period fearful, hyper-vigilant and cautious of the police.<sup>2</sup>

A crucial event during this period seems to have been the Montagu trial in 1954. This appeared to mark the nadir of the persecution of gay men in Britain and largely

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<sup>1</sup> Houlbrook, *Queer London*, pp. 19-43.

<sup>2</sup> Dickinson, Cook, Playle & Hallett, “‘Queer Treatments’, p. 1349.

persuaded the liberal intelligentsia that something had to be done regarding the perceived ‘problem’ of homosexuality.<sup>3</sup> This led to the formation of the Wolfenden Committee in 1954. The committee reported in 1957 and recommended that homosexuality between consenting adults over the age of 21 should be decriminalised. A further recommendation was that medical treatments should be made available to homosexuals to cure them of their disorder – reinforcing the notion that homosexuality was the result of an ingrained condition, which could nevertheless be cured. Following Wolfenden there was a distinct altering of notions regarding homosexuality from a criminal perspective to understandings of the subject as pathology. This was coupled with what Chris Waters describes as the ‘therapeutic state’, based on the belief that experts, with their ‘modern knowledge’, could assist in the eradication of any number of social maladies.<sup>4</sup> Psychiatrists began optimistically promoting their worth in being able to cure sexual deviation by reporting successful outcomes.<sup>5</sup> Indeed, for many men, discovering that there was a “cure” for their disorder gave them a sense of hope and legitimacy.

By the late 1950s, homosexuality was being expressed in media, literary, medical, sociological and legal discourses. These played a role in shaping public knowledge about who the sexual deviant was and what he represented. However, these were all portraying mixed messages regarding sexual deviation, leaving the recipients very confused.<sup>6</sup> Moreover, I argue that along with the courts, these public, somewhat prejudicial discourses created a favourable social and political context for the treatments. They helped to shape unsympathetic family, police and social attitudes, which in turn

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<sup>3</sup> Weeks, *Coming Out*, p. 164; Jivani, *It's Not Unusual*, p. 111.

<sup>4</sup> Waters, ‘Disorders of the Mind’, p. 151.

<sup>5</sup> See, e.g. James, ‘Case of homosexuality treated by aversion therapy’; ‘How doctor cured a homosexual’. *The Observer*, 18<sup>th</sup> March, 1962.

<sup>6</sup> See, e.g. Rees and Usill, *They Stand Apart: A Critical Survey of the Problem of Homosexuality*; Westwood, *Society and the Homosexual*; ‘Evil Men’, *Sunday Pictorial*, 25<sup>th</sup> May, 1952.

tacitly coerced men into receiving treatment. This thesis has suggested that these factors created an affront to the patient's autonomy because they reduced the degree of voluntariness on the part of the patient.

### **Mental nursing: culture of control**

These mixed public discourses of sexual deviation also created uncertainty for the nurses in this study. The nurses were also exposed to a number of contextual factors in their clinical practice, which may have influenced their decision to administer aversion therapy to cure sexual deviations. The introduction of the Mental Treatment Act 1930 brought with it a therapeutic optimism, due to the possibility of curative treatment for mental patients. This led to the introduction of new somatic treatments, which were rather brutal and distressing for the patients receiving them.<sup>7</sup> Indeed, some nurses in this study also administered or witnessed these invasive somatic treatments, which were discussed in Chapter III, alongside psychiatrists' elementary justifications for them.

With the introduction of such treatments, some nurses took on more advanced roles. However, the vast majority had no theoretical underpinning for the interventions they were implementing. Essentially, nurses were unaware that what passed for treatment in their workplace might represent no more than the penchant of their particular Medical Superintendent, based on no firm evidence at all. Moreover, the exposure of nurses to these somatic treatments may have normalised the implementation of "therapeutic" interventions, which caused distress to the patients receiving them. This could offer a context to explain some nurses' acceptance that such disturbing interventions as aversion therapy were a normal, and morally acceptable, part of a larger venture that promised positive outcomes. In essence, the ends could justify the means.

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<sup>7</sup> See, e.g. Crossley, 'The Introduction of Leucotomy'; James, 'Insulin Treatment in Psychiatry'; Kragh, 'Shock Therapy'; Berrios, 'The Scientific Origins of Electroconvulsive Therapy: A Conceptual History'.

The education the nurses received regarding sexual deviation pressed the notion that homosexuals and transvestites were deviants in need of psychiatric evaluation.<sup>8</sup> However, their education appears to have given little, if any, attention to equipping nursing students with the skills required to nurse these individuals. The nurses in this study reported that they felt unprepared to care for these patients when they were admitted onto their wards. This was compounded by the wider debate regarding how to view the sexual deviant that was being pressed by the media and literary works, which were discussed in Chapter II. In essence, nurses did not receive an education that was based on a coherent and robust knowledge regarding these individuals.

With the inauguration of the 1959 Mental Health Act, the emergence of rhetoric regarding community care, the introduction of new health and social care practitioners, and the reduction in patient numbers, many nurses and psychiatrists felt their profession was under threat. Moreover, in combination with the rhetoric discussed in Chapter II regarding the lack of consensus on the optimal way to deal with the problem of sexual deviants, I argued that some psychiatrists – and nurses – may have developed and implemented treatments for these individuals as a tacit way of bringing “new” patients into the mental hospital. This could have been in a pragmatic and perhaps not even acknowledged attempt to protect their jobs and enhance their profile. It further marked out a specialism and a specialist discourse.

Although some nurses in this study sensed that there was something wrong in administering aversion therapy, their participation in this aspect of their clinical practice appears to have been encouraged and reinforced by specific informal, possibly deleterious, features of mental hospital life. The stresses of institutional life may have destabilised the individual initiative of mental nurses: insensitive staff discipline, fears of

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<sup>8</sup> See, e.g. Ackner, *Handbook for Psychiatric Nurses*, pp. 108-116; Bachelor, *Henderson and Gillespie's Textbook of Psychiatry*, pp. 197-209.

victimisation and the betrayal and abuse of colleagues and senior staff may have threatened the performance of even the most conscientious nurse. However, the most noteworthy feature within such institutions appears to have been the passive obedience of nurses to higher authority.

### **Subordination or subversion?**

The nurses within this study are presented as if they were polar opposites. The reality was much more complex and it may be too simplistic to present these nurses as either “subordinate” or “subversive”. It is unlikely that there was any malevolence underpinning the motivations of the nurses in this study to administer aversion therapy, and I would argue that the subordinate nurses in this study who administered this treatment fall into three categories (insofar as it is possible to categorise), each having their own motivation or rationale for administering the treatment.

Some subordinate nurses appeared to have behaved in an unenquiring and unquestioning manner. These nurses accepted that their role was to carry out, uncritically and without question, whatever medical staff or their nursing superiors had prescribed. Nurses may have obeyed their superiors’ orders to avoid being publicly humiliated in front of colleagues and patients. This was compounded by the fact that the nurses, especially the SENs, did not always possess the medical knowledge that they perceived the doctors to have, so they believed that it was pertinent for the well-being of a patient that nurses obey orders.

Nevertheless, I would argue that the knowledge of the medical staff in relation to aversion therapy for sexual deviations was also poor. These treatments had a very limited evidence base, they were extremely experimental and they lacked regulation. Furthermore, with no general protocol or ethical guidelines, the treatment of choice in

aversion therapy was often the unilateral decision of the consultant psychiatrist.<sup>9</sup> This highlights the power that the medical profession appeared to hold at the time. These nurses seem to have been swamped by this medical power and the influential culture of the institution, which dictated that nursing was learnt ‘by watching the example of others, based on “common sense” assumptions and concern with neatness rather than on research-based theory’.<sup>10</sup>

Other subordinate nurses sensed that there was something wrong in what they were doing. However, these nurses appeared to overcome any reservations they may have had regarding administering aversion therapy by limiting their culpability. I argued that they did this by ensuring that they were not responsible for individual patients and by focussing on specific tasks, while others used humour. Furthermore, nurses were encouraged not build up strong relationships with their patients receiving aversion therapy and they avoided relating to their patients by dehumanising and objectifying those patients through language and a focus on administrative tasks.

While I noted the different historical context and that none of the nurses in this study knowingly murdered patients, as nurses under Nazi rule did, I identified that there was an issue here of a replaying, in a minor key, of some of the dynamics between Nazi nurses and their role in the euthanasia projects, and the nurses in this study and their role in aversion therapy, as similar strategies were used by Nazi nurses to limit their accountability in relation to the unethical acts they implemented.<sup>11</sup> Meanwhile, Peter Mellor, whose testimony we explored in Chapter III, sensed that there was something wrong in administering aversion therapy; however, he believed objecting to the

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<sup>9</sup> Dickinson, Cook, Playle & Hallett, “‘Queer Treatments’, p. 1350.

<sup>10</sup> Hopton, *Prestwich Hospital in the Twentieth Century*, p. 360.

<sup>11</sup> See, e.g. Biley, ‘Psychiatric Nursing: Living with the Legacy of the Holocaust’, p. 366; Berghs, Dierckx de Casterle & Gastmans, ‘Practices of Responsibility’, p. 850.



treatments or refusal to assist with them may have brought his own sexuality into question and this motivated him to participate in this clinical practice.

Finally, there were the subordinate nurses who genuinely believed that they were acting beneficently. These nurses appeared to believe, at the time, that aversion therapy was the most effective intervention to cure sexual deviants. However, I suggested that reliance on the principle of beneficence led the nurses to become 'beneficently paternalistic'. Essentially, the patients were being told what was good for them without regard for their own needs or interests.<sup>12</sup> Furthermore, I argued that by acting based on their notions of beneficence, these nurses were not upholding the principle of non-maleficence, as the treatments were very traumatic and painful for the patients receiving them.<sup>13</sup> In addition, no former patients in this study reported any efficacy of the treatments and all stated that these treatments had a negative long-term impact on them. Moreover, there are parallels with some nurses in this study and with Nurse Rivers' participation in the Tuskegee study.<sup>14</sup> Indeed, Rivers was a black woman believing she was helping other black people, and some nurses in this study administered treatments for homosexuality, but were themselves homosexual.

The predominant theme among the nurses in this study was that they appeared to be engulfed by the culture of the institution and some developed a passive obedience to higher authority. Other nurses, however, albeit a small minority, were able to engage with this culture in clever ways and covertly undermine their superiors by engaging in some fascinating subversive behaviours. Essentially, these nurses were doing the opposite of some of the subordinate nurses: they were questioning the orders they had been given by higher authority. In parallel with some of the subordinate nurses, they

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<sup>12</sup> Gillon, *Philosophical Medical Ethics*, p. 87.

<sup>13</sup> See Chapter II for reflections regarding the treatments of the patients in this study; see also, Smith, King & Bartlett, 'Treatments of homosexuality in Britain since the 1950s – an oral history: the experience of patients', pp. 1-4; Dickinson, Cook, Playle, & Hallett, "'Queer' Treatments', p. 1349.

<sup>14</sup> Reverby, 'Rethinking the Tuskegee Syphilis Study'.

also argued that their behaviours were based on the notion of beneficence. Nevertheless, in contrast to the subordinate nurses, the subversive nurses were upholding the principle of non-maleficence when they chose to engage in resistive practices. Indeed, I argued that these “subversive nurses” were empathic and their resistive behaviours had a positive long-term impact on their patients’ sense of self-esteem.

This thesis has highlighted that within mental nurses’ clinical practice there was an immense gulf between the prescriptions of theory, the intentions of policy and the realities of practice. For example, one article published at the time urged nurses not to merely accept doctors’ orders, but to make the decision to partake in aversion therapy only after they had reflected on their own values regarding it.<sup>15</sup> However, only Elizabeth Granger recalled reading this article and along with her university-based nurse education, I argued that this might have encouraged her to act on her conscientious objections to the treatments.

### **Cultural shift: clinical stagnation**

The later part of this thesis witnessed a new stress on individual freedoms that was, in part, inspired by the civil rights movement in the USA and other general “counter-cultural” shifts. This period also witnessed a sympathetic shift in the media representations of sexually deviant individuals and the APA’s decision to remove the term “homosexuality” from its DSM. Furthermore, this period witnessed the inception of nurse therapists.

In contrast to the nurses who cared for patients receiving treatments for sexual deviations in the earlier part of the study, these advanced practice nurses appeared to have a theoretical basis upon which to base their practice. However, the testimony of a

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<sup>15</sup> Seager, ‘Aversion Therapy in Psychiatry’, p. 424.

former patient who was treated by a nurse therapist indicated that this particular nurse was equally as antipathetic as the doctors. Moreover, in spite of the emphasis amongst nurse therapists believing they had a scientific foundation for their work, these nurses were still administering a spurious intervention, as the treatment's efficacy still relied on self-report from the patient. Furthermore, ironically, these nurses were claiming success in an area of care that had already been discredited. In essence, in their quest for professionalization, nurse therapists were taking on the mantle of the controlling clinical practitioners.

### **Contribution of the thesis**

The participants in this admittedly small-scale study may not be representative of all the people who underwent or administered treatment for sexual deviations, as some individuals may have been reluctant to take part, or may have died or emigrated. In respect to the former patients who participated in the study, it may have only been those most perturbed by the treatments they received who wanted to participate. Furthermore, it is, perhaps, too simplistic to label the nurses involved in caring for individuals receiving aversion therapy as either "subordinate" or "subversive". There may also have been nurses who steadfastly refused to participate in this aspect of clinical practice. Meanwhile some nurses may have had sinister motivations underpinning their participation in this area of clinical practice. Therefore, this study cannot address the full reality of the meanings that all nurses attached to these treatments.

All the former patients who participated in this study reported that the treatments they received had been ineffective in altering their sexual desires, as they either remained homosexual or eventually underwent gender reassignment surgery. It is, however, important to bear in mind that if these treatments had been effective for some individuals in so far as they were now heterosexual, these people might have been

reluctant to come forward to tell their story. Therefore, this study cannot address the full reality of the issues raised by these treatments.

Nevertheless, in spite of the above being perceived, by some, as shortcomings to a research study, I would argue that this thesis indicates the value of an in depth study such as this. It shows how issues might resonate with wider histories without actually representing them. Moreover, it illustrates how experience is necessarily fragmentary and contradictory and broad sweeps of histories can sometimes miss too much – especially when the focus of the study is on how people felt and thought.<sup>16</sup> In essence, I would argue that this thesis makes a case for the inclusion of local and micro history in this kind of work.

This thesis enhances our understanding of sexuality in relation to nursing as a profession by discovering a hitherto neglected history of gay life in mental hospitals, and sits at the nexus of memory studies, histories of subjectivities, and histories of post-war Britain. In doing so, it offers a fresh understanding of the draw of mental nursing to gay men and supplements previous work regarding gay life at sea and within the military during World War II.<sup>17</sup> By identifying this previously hidden and multifaceted homosexual male sub-culture within the mental hospitals and discovering that different types of gay male nurses had their own implicit rules and behaviours, which included status distinctions between the lower ranking SENs and the nursing officers in the higher ranks, it relates to Matt Houlbrook's seminal work regarding camp 'queans' and the 'respectable middle class queer' men.<sup>18</sup> Therefore, it adds to this debate and contributes to our understanding in relation to status, class and sexual identity among gay men.

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<sup>16</sup> Ginzburg, Tedeschi & Tedeschi, 'Microhistory', pp. 10-35; Cook, 'Gay Times': Brixton squats in 1970s London', pp. 1-26

<sup>17</sup> See, e.g. Baker & Stanley, *Hello Sailor!; A Gay History of Britain*. p. 187.

<sup>18</sup> For a more detailed exploration of class within homosexual urban culture see, e.g. Houlbrook, *Queer London*, pp. 167-195.

This thesis offers a new insight into the role of mental nurses caring for patients receiving aversion therapy for sexual deviation. As the first focussed study exploring the nurses' role in caring for sexually deviant patients, it provides a basis for further historical analysis of this subject and related issues. I envision that this study can offer insights into the way nurses may behave when a particular set of social, political and contextual factors are at play. Overall, this thesis displays how histories of discourse do not map straightforwardly onto histories of everyday life. It exposes the tensions in relations between the two, and the equivocal way in which nurses read and listened to influential cultural outputs and acted in accordance with these.

Firstly, the culture of many mental hospitals – and their nurses – was custodial, impersonal and ritualized. The work of nurses was also largely constrained by the asylum-type conditions in which they worked, and the character and quality of patient care was largely influenced by the medical staff, who appeared to have overriding control of both the institution and the nurses working within it. In addition, due to their limited knowledge base, some nurses believed that it was pertinent for the well-being of a patient that nurses obey orders. They took on the status offered to them of obedient followers of orders.

Furthermore, nurses were exposed to prejudicial attitudes towards homosexuals and transvestites, which were being expressed by the media and by literary, medical, sociological and legal discourses. Indeed, Herbert Kelman and Lee Hamilton argue that all obedience depends upon the existence of a favourable social and political context, in which individuals deem the commands that have been issued not to be a gross transgression of their intrinsic values and their central morality.<sup>19</sup> Moreover, I would argue that the rhetoric regarding sexual deviants during the 1950s and 1960s created a

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<sup>19</sup> Kelman & Hamilton, *Crimes of Obedience*, 78.

favourable social and political context for these treatments. Without judgement, this resulted in a set of actions that, on reflection, were ethically unjustified, brutal and harmful to the patients receiving them. I would argue that what was lacking at the time was a culture in which nurses possessed the knowledge base and self-esteem to voice their concerns and question those in higher authority.

This thesis is timely as reports of disturbing allegations of nurses' involvement in electrocutions, whippings; operations without anaesthetics and other brutal treatment of patients in Syrian Military Hospitals are published.<sup>20</sup> Furthermore, in May 2012, history was made when Ms Lesley Pilkington, a psychotherapist, was found guilty of malpractice after trying to "cure" a homosexual patient in her care. Ms. Pilkington a 60-year-old Christian tried to cure an undercover homosexual news reporter from *The Independent*. This involved her suggesting that the reporter was sexually abused as a child, and praying to God to bring his repressed memories to the surface. She also suggested that God heals HIV, and informed him that homosexuality was a mental illness. Britain's largest professional body for therapists, the British Association for Counselling and Psychotherapy (BACP), found her guilty of 'professional malpractice' in 2011 but she appealed. However, on the 22 May 2012 she lost her appeal when the BACP upheld its verdict.<sup>21</sup>

Finally, it is envisaged that this study might act to reiterate the need for nurses to ensure that their interventions have a sound evidence base, and that they constantly reflect on the moral and value base of their practice and the influence that science, societal norms and contexts can have on changing views of what is regarded as "acceptable practice".

We can learn much from studying aspects of our profession's past in which our actions,

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<sup>20</sup> "Video allegedly shows shackled patients in a Syrian hospital", *Los Angeles Times*, 6<sup>th</sup> March, 2012; "Tortured by the very doctors and nurses who should be saving their lives", *The Daily Mail*, 5<sup>th</sup> March, 2012.

<sup>21</sup> "Therapist who could "cure" gay men loses malpractice appeal", *The Independent*, 24<sup>th</sup> May, 2012.

even if countenanced by the context in which they were situated, did not serve patients and society well.

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## EPILOGUE

I outlined in Chapter VI that the APA's 1974 decision to remove homosexuality from its DSM, along with social protests and a newly emerged gay liberation movement, eventually led to the curtailment of medical treatments to cure homosexuality. A conservative turn in the 1980s, however, provided the cultural and social foundations to reclassify homosexuality as a contagious pathology, and could offer a context to explain why the WHO took a further eighteen years before it mirrored the APA's decision to remove homosexuality from its diagnostic manual.

In 1981, the Centre of Disease Control in the USA reported that five young men had died from a rare form of pneumonia in Los Angeles. A year later, on 4<sup>th</sup> July 1982, 37-year-old Terry Higgins became the first known person in Britain to die of an AIDS-related disease at St Thomas' Hospital, London.<sup>1</sup> This virulent and completely unpredictable pathogen endangered homosexual men and threatened to undo the social advances that had been made for homosexuals in the previous two decades.

The social reaction to AIDS during the first few years of the epidemic was permanently marked by the unique social distribution of the disease. With more than ninety percent of reported cases coming from intravenous drug users, gay and bisexual men, the community expressed not only its fears about contagion but also its moral judgement. Before the term "AIDS" was first coined in 1982, it had been labelled 'Gay Cancer' or 'GRIND' (Gay-related immune deficiency), and there was a strong sense that the condition was associated with sexual identity rather than sexual practice.<sup>2</sup>

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<sup>1</sup> Jones, *Tales from Out in the City*, p. 27; Cook, *A Gay History of Britain*, p. 195.

<sup>2</sup> Weeks, *Coming Out*, p. 232; Cook, *A Gay History of Britain*, p. 196.



Just under a decade since homosexuality had been demedicalised, the power of the medical profession was being brought into intimate contact with the gay community, and once again medicine was compelling homosexual men to examine their behaviour.<sup>3</sup> The media were shaping a lot of public perception regarding the epidemic, and headlines such “Gay Plague” characterised gay men as plague bearers who were highly contagious.<sup>4</sup> Press coverage such as this created a backlash against homosexuals in the 1980s and served to confirm all the lingering prejudices, which had lain dormant during the 1970s. There was rhetoric regarding compulsory testing for all gay men and even of quarantine.<sup>5</sup>

In 1983, work began on revising the WHO ICD-9 (the predecessor to the ICD-10, which still classified homosexuality as a psychiatric disorder).<sup>6</sup> It is interesting to note that this was just as the AIDS epidemic was coming to the fore along with its strong association with homosexual men. Indeed, in Britain, by March 1983, there were six reported cases of AIDS, and by July that year, this figure had more than doubled. By October 1985, the number of cases had risen to 241 and, while it was difficult to measure the exact number of individuals infected in Britain, the most widely held assumption at the time was that it was at least 20,000.<sup>7</sup> By 1986, the catastrophic worldwide implications of the AIDS epidemic were becoming ever more apparent. In June of that year, the USA Public Health Service predicted that by 1991 there would be 270,000 cases of AIDS in the USA alone.<sup>8</sup> This could offer a context to explain why the WHO delayed its decision to remove homosexuality from its diagnostic manual.

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<sup>3</sup> Drescher & Merlino, *American Psychiatry and Homosexuality*, p. 127; Bayer, *Homosexuality and American Psychiatry*, p. 204.

<sup>4</sup> Cant, *Footsteps and Witnesses*, p. 57; Jivani, *It's not Unusual*, p. 189.

<sup>5</sup> Jones, *Tales from Out in the City*, p. 57; Jivani, *It's not Unusual*, p. 197.

<sup>6</sup> Drescher & Merlino, *American Psychiatry and Homosexuality*, p. 121.

<sup>7</sup> Weeks, *Coming Out*, p. 244; Jivani, *It's not Unusual*, p. 186.

<sup>8</sup> Bayer, *Homosexuality and American Psychiatry*, p. 204.

Nevertheless, the AIDS crisis reunited gay men in a way that had not happened since the 1970s and new protests groups, like “Act Up” and “Outrage”, emerged employing similar tactics to the GLF.<sup>9</sup> Gay men were also gaining a higher profile in the arts and media by the late 1980s, including Sir Ian McKellen sensationally ‘coming out’ during a radio debate.<sup>10</sup> These all played a role in dissipating the initial panic around HIV and AIDS.

On the 17<sup>th</sup> May 1990, the General Assembly of the WHO decided to remove homosexuality from their list of mental disorders.<sup>11</sup> The International Lesbian, Gay, Bisexual, Trans and Intersex Association argue that this action served to end more than a century of medical homophobia and constitutes a historic date and a powerful symbol for members of the GLBT community. Therefore, on the 17<sup>th</sup> of May every year, this decision is remembered when “The International Day Against Homophobia and Transphobia” is celebrated.<sup>12</sup>

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<sup>9</sup> Cant, *Footsteps and Witnesses*, p. 60; Jivani, *It's not Unusual*, pp. 198-199.

<sup>10</sup> Cook, *A Gay History of Britain*, p. 208.

<sup>11</sup> It was eventually removed from their diagnostic manual with the introduction of the *International Classification of Diseases edition 10 Classification of Mental and Behavioural Disorders* (ICD-10), published in 1992: Eisenbach, *Gay Power*, p. 232.

<sup>12</sup> International Lesbian, Gay, Bisexual, Trans and Intersex Association, *May 17th is the International Day Against Homophobia*. Available at: <http://ilga.org/ilga/en/article/546> [last accessed 21 May 2012].

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*Conducted by author*

<i>Date of interview</i>	<i>Pseudonym applied to interviewee</i>
29/12/2009	Unna Drinkwater
30/12/2009	Susan Traherne
04/01/2010	Julian Glover
07/01/2010	Emily Whitbread
27/01/2010	Albert Holliday
02/02/2010	Gregory Gregson
10/02/2010	Edward Lyons
12/02/2010	Jackie Fletcher
20/03/2010	Elliot Whitman
24/03/2010	Greta Gold
25/03/2010	Adam Carter
28/04/2010	Delroy Health
29/04/2010	William Newman

03/05/2010	Elizabeth Granger
21/06/2010	Oscar Mangle
23/06/2010	Luke Vanston
14/07/2010	Pat Mullins
17/07/2010	Faith Ashley
08/08/2010	Peter Mellor
10/08/2010	Terry Orchard
05/12/2010	Charles Dance
31/12/2010	Molly Millbury

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## **APPENDIX A**

### **Referencing guidelines**

## STYLE SHEET

### Layout of Text

In order for your work to be easily legible, and so that tutors can write comments on it, there are rules about how the work must be presented. Here is a simple checklist for you to work through:

- All work must be double line spaced.
- Leave a blank line before each new paragraph.
- Longer quotes and citations (more than two lines) need to be single line spaced and indented. Indented quotes do not have 'quotation marks'.
- Pages should be numbered in the top right-hand corner.
- You should use Times New Roman font, size 12, for the main part of your essay and bibliography.
- Leave a large margin (about one inch, or 2.5 cm) around all work.

Many of these settings will be automatic on university computers, but some formatting will have to be done by you. For anything which you are unsure of, click on 'Help' in Microsoft Word, and follow the instructions there.

### Bibliographies & Footnotes

Bibliographies and footnotes are prepared in a similar way. There are, however, slight differences between the two. This guide should be referred to as you get used to all the different rules and regulations.

#### Bibliographies

The bibliography needs to be prepared according to the following rules. There are variations to these rules which different historians may apply, but the key thing is for you to be consistent throughout your work. Pay attention to your colons, commas, full stops, brackets and use of italics.

In terms of secondary sources, you will use three major types in your work: books, essays in books, and articles in journals.

#### *Books*

Surname, Forename. *Full Title of Book in Italics: Including Subtitles and Dates After a Colon with Each Important Word Written with a Capital* (Place of Publication Nearest to You, Date of Publication).

E.g.:

Haine, Scott. *The World of the Paris Café: Sociability among the French Working Class, 1789-1914* (London, 1996).

Poovey, Mary. *Making a Social Body: British Cultural Formation, 1830-1864* (Chicago, 1995).

#### *Essays in Books*

Surname, Forename. 'Full Title of Essay in Single Inverted Commas but not Italics: "Double Inverted Commas are for Quotes Within the Title"', in Firstname Surname (ed. [or eds. if there is more than one editor]), *Full Title of Book in Italics* (Place of Publication Nearest to You, Date of Publication), pp. 123-456 [the page numbers of the essay in the book must be included].

E.g.:

Frisby, David. 'The Metropolis as Text: Otto Wagner and Vienna's "Second Renaissance"', in Neil Leach (ed.), *The Hieroglyphics of Space* (London, 2002), pp. 15-30.

Jelavich, Peter. 'Performing High and Low: Jews in Modern Theater, Cabaret, Revue and Film', in Emily Bilski (ed.), *Berlin Metropolis: Jews and the New Culture, 1890-1918* (London, 1999), pp. 208-235.

#### *Articles in Journals*

Surname, Forename. 'Full Title of the Article in Single Inverted Commas but not Italics: "Double Inverted Commas are for Quotes Within the Title"', *Full Title of Journal in Italics* 4 [Number of journal in year or in series] (Year in Brackets), pp. 123-456 [the page numbers of the article in the journal must be included].

E.g.:

Garside, Paul. "Unhealthy Areas": Town Planning, Eugenics and the Slums. 1890-1945', *Planning Perspectives* 3 (1988), pp. 24-46.

Gilloch, Graeme. 'The Heroic Pedestrian or the Pedestrian Hero? Walter Benjamin and the Flâneur', *Telos* 91 (1992), pp. 108-117.

#### Footnotes

Footnotes are prepared according to similar rules to bibliographic references, but with three important differences:

- In footnotes, we list the forename before the surname: 'Mary Smith', not 'Smith, Mary'.
- An entry only appears once in a bibliography, but you may have to refer to the same work several times in footnotes. When you mention the same book, article or essay more than once in your footnotes, you use the full citation the first time, but thereafter you use what is called 'short form citation.' We no longer use *ibid.* or *op. cit.* or other devices.
- In footnotes, we always need to indicate the specific page or pages we have taken our information from. This means that we end each footnote by specifying the exact page (signified by p.) or pages (signified by pp.) on which we found that specific piece of information or argument.

#### *Books - First citation:*

Mary Poovey, *Making a Social Body: British Cultural Formation, 1830-1864* (Chicago, 1995), pp.18-22.

#### *Books - Second and subsequent citations:*

Poovey, *Making a Social Body*, p. 38.

#### *Essays in Books - First citation:*

David Frisby, 'The Metropolis as Text: Otto Wagner and Vienna's "Second Renaissance"', in Neil Leach (ed.), *The Hieroglyphics of Space* (London, 2002), pp. 22-24. [The pages on which the information can be found.]

#### *Essays in Books - Second and subsequent citations:*

Frisby, 'The Metropolis as Text', p. 28.

#### *Articles in Journals - First citation:*

Graeme Gilloch, 'The Heroic Pedestrian or the Pedestrian Hero? Walter Benjamin and the Flâneur', *Telos* 91 (1992), p. 116. [The page on which the information can be found.]

#### *Articles in Journals - Second and subsequent citations:*

Gilloch, 'The Heroic Pedestrian or the Pedestrian Hero?', p. 117.

## **APPENDIX B**

**Biographies of the twenty-two interviewees whose testimonies have been referred to**

## PARTICIPANTS

The twenty-two participants who were interviewed for this study are described below. All names have been changed, as discussed within Chapter I. Some of the participants did not want to give a great deal of biographical information, as they wished to remain unrecognizable for their own security today.

### Nurses

*Edward Lyons interviewed 10<sup>th</sup> February 2010*

Born 1912. Trained as a mental nurse and qualified in 1936. Worked as a staff nurse in various mental health settings before retiring in the 1960s. Sadly, Edward passed away in August 2010, aged 98.

*Elliot Whitman interviewed 20<sup>th</sup> March 2010*

Born 1935. Commenced work as a nursing assistant in 1953 aged 18. In 1964 he commenced as a pupil nurse and was in the first cohort of SENs in mental nursing to qualify. Worked as an enrolled nurse in various mental health settings before retiring in the 1990s. He now lives in London with his partner, Alan.

*Elizabeth Granger interviewed 3<sup>rd</sup> May 2010*

Born 1944. Undertook a university-based SRN nurse education at Edinburgh University in the early 1960s. She worked as a staff nurse in a cottage hospital for six months once she qualified. However, she always wanted to pursue a career in mental nursing. Therefore, she commenced a conversion course at her local psychiatric hospital and qualified as a mental nurse in 1967. She soon became a ward Sister and eventually became the Director of Nursing for a large private group of nursing homes before she retired in the 1990s. Sadly, Elizabeth passed away in January 2012, aged 68.



*Unna Drinkwater interviewed 29<sup>th</sup> December 2009*

Born 1911 in Galway in the Republic of Ireland. Due to very poor job prospects in Ireland, she moved to Lancashire, England in 1929 to live with her cousin. Almost immediately she found a job at the local county asylum as a nursing student and qualified in 1933. She worked as a staff nurse there for her whole career before retiring in 1963. Sadly, Unna passed away in December 2010, aged 98.

*Jackie Fletcher interviewed 12<sup>th</sup> February 2010*

Born 1937. Trained as a mental nurse and qualified in 1960. Worked as a staff nurse in various mental health settings before retiring in 2005. She now lives in Cork in the Republic of Ireland.

*Peter Mellor interviewed 8<sup>th</sup> August 2010*

Born 1930. Trained as a mental nurse and qualified in 1951. He eventually became a Nursing Officer before he retired in 1985. He now lives in Inverness with his partner, Michael.

*Terry Orchard interviewed 10<sup>th</sup> August 2010*

Born 1946. Commenced as a pupil nurse in 1965, qualifying in 1967. He worked as a State Enrolled Nurse in various psychiatric hospitals around the UK before retiring in 2001. He now lives in Belfast with his partner, Bernard.

*Faith Ashley interviewed 17<sup>th</sup> July 2010*

Born 1940 in Blackpool, Lancashire. She trained as a mental nurse, qualifying in 1961. She went on to train as a nurse therapist and went on to become the Sister of a specialist Behaviour Therapy Research and Treatment Unit. She is now retired and lives in Cardiff with her husband.

*Charles Dance interviewed 5<sup>th</sup> December 2010*

Born 1947 in Huddersfield. Unsure about what direction he wanted his career to go in after leaving school; his mum suggested that he consider mental nursing. He went along to his local mental hospital and was initially accepted as a cadet nurse for six months before commencing his nurse training at in 1965, aged 18 years. Once qualified he commenced a shortened general nursing programme and qualified as a general nurse, as at the time he believed this would increase his chances of promotion later in his career. Charles returned to mental nursing and became a community psychiatric nurse. He eventually became a professor of mental health nursing. He has now retired and lives in Manchester with his wife.

*Julian Glover interviewed 4<sup>th</sup> January 2010*

Born 1921. Within weeks of the outbreak of WW2 Julian was called up for military service, and he took part in many Campaigns during the war. Feeling his life was lacking direction once the war was over; he saw an advert in the local paper about the mental hospital in his village, which was recruiting staff. He went along and was offered a place as a student nurse, and qualified as a mental nurse in 1950. He worked as a staff nurse for the rest of his career. Now retired, he lives in Bournemouth with his wife, Mary.

*Emily Whitbread interviewed 7<sup>th</sup> January 2010*

Born 1939. Bored with her job as a secretary, she responded to an advert for mental nursing which showed a nurse assisting with “brain surgery”. She was successful in her application and commenced her nurse training in 1957 qualifying in 1960. Emily eventually became a Clinical Nurse Manager of an Older Adults Mental Health Service. She retired in 1994 and now lives in Cornwall with her partner, Walter.

*Susan Traherne interviewed 30<sup>th</sup> December 2009*

Born in 1933 in Calais, France. She responded to an advertisement in a French newspaper in 1951, advertising for staff for a Mental Hospital in Berkshire, England. She was successful at the interview and moved over the same year and qualified as a staff nurse in 1955. Here she met her future husband, also a nurse, and decided to stay in the UK. She eventually became a nurse tutor until her retirement in 1988. She returned to France with her husband upon their retirement and currently lives in Dijon, France.

*Luke Vanston interviewed 23<sup>rd</sup> June 2010*

Born in 1942 in the West of Ireland. Luke spent eight years in a monastery studying theology, bible scriptures and teaching. However, he felt that there wasn't a great deal to do after this. Therefore, he moved to London in the early 1960s and commenced work in a pharmacy. However, he took an instant dislike to this. He was a keen runner, and during a meeting his running club held at the Maudsley Hospital in London one weekend, he realised that many of the hospital staff had great sporting opportunities, and that there were a lot of other people from Ireland there. This prompted him to commence his nurse training in 1963, qualifying in 1966. Luke worked in mental health nursing for the remainder of his career and eventually became a professor of mental health nursing. He currently lives in Staffordshire with his wife.

*Pat Mullins interviewed 14<sup>th</sup> July 2010*

Born 1947. Commenced as a pupil nurse in 1966, qualifying in 1968. She worked as a State Enrolled Nurse in various psychiatric hospitals around Scotland before retiring in 1987. She now lives in Edinburgh with her husband.

*Adam Carter interviewed 25<sup>th</sup> March 2010*

Born 1940. Commenced his pupil nurse training in 1966, qualifying in 1968. He worked as a State Enrolled Nurse in Jersey until he retired in 2002. He still lives in Jersey with his partner, John.

## **Patients**

*Oscar Mangle interviewed 21<sup>st</sup> June 2010*

Born 1929. Grew up in a small rural farming village in Lancashire. Moved to London in 1947. Worked in retail for his whole life before he retired in the 1980s. Now lives on the Isle of Man.

*Albert Holliday interviewed 27<sup>th</sup> January 2010*

Born 1928 in Sheffield, and then moved to London to attend art school in 1946, aged 18. Worked as a painter his whole career. Now retired and lives in Cornwall, but still loves to paint.

*Greta Gold interviewed 24<sup>th</sup> March 2010*

Born 1935, in a fishing village in Cornwall. Worked as a bus driver for many years. Underwent gender reassignment surgery in 1982 and went on to train as a social worker. She is now retired and lives in London with her partner, Thomas.

*Delroy Heath interviewed 28<sup>th</sup> April 2010*

Born 1940 in Kingston, Jamaica. He emigrated to the UK with his parents and brother in 1951, aged 11. He went on to attend St. Andrews University where he read history. He went on to teach history in a secondary school and eventually became the head teacher. He retired in 2005, and lives in Devon with his partner, Darren.

*Molly Millbury interviewed 31<sup>st</sup> December 2010*

Born 1945, Kensington, Liverpool. She initially worked on the docks with her father. Molly underwent gender reassignment surgery in 2000 and now owns a successful hat designing business. She lives in Manchester with her partner, Robert.

*William Newman interviewed 29<sup>th</sup> April 2010*

Born 1930. Born in London and lived there all his life. He trained as a butcher in the family's butchers shop and eventually inherited the business from his father. Sadly, William passed away in January 2012.

*Gregory Gregson interviewed 2<sup>nd</sup> January 2010*

Born 1920 in Salisbury, Wiltshire. He served in the RAF during the war. Gregory was captured by the Japanese during the fall of Singapore and interned in a POW camp in Osaka Japan. He completed his studies at Oxford University after the war. Worked as a university lecturer in English literature until his retirement in 1980. Sadly, Gregory passed away in July 2010.

## APPENDIX C

*Mental Health Practice* article used for  
recruitment purposes

# Nursing history: aversion therapy

Tommy Dickinson is looking for nurses who were involved in the 'treatment' of homosexuality and transvestism from the 1930s to the 1980s

## Summary

Aversion therapy was used in the mid-20th century to treat people with a number of disorders and addictions. This article describes aspects of this now-discredited treatment and seeks information from nurses who were involved in its delivery.

## Keywords

Behaviour modification, aversion therapy

ALBERT IS anxious. He has been given a choice: go to prison or hospital to be 'cured', and he has chosen the latter. He is being held in a darkened room.

A nurse enters with an injection of an emetic dose of apomorphine and a glass of brandy. The nurse leaves him alone and goes to sit behind a one-way mirror; she does not speak to him throughout the treatment because she thinks it will compromise its efficacy.

He vomits within minutes and the nurse turns on a strong light that shines on a piece of card pasted on the wall: this has several photographs of nude or near-nude men. The nurse asks Albert to select one he finds attractive. A recording is played to reinforce the assumed repulsiveness of his homosexuality, which is what brought him to hospital. The recording contains words such as 'sickening' and 'nauseating', followed by the noise of someone vomiting, which accentuates the emetic effect of the apomorphine.

This sequence of 'therapeutic' interventions is repeated every two hours; Albert is allowed no food or drinks, other than the prescribed alcohol. When he wakes in the morning, feeling dreadful, frightened and wishing he had chosen the prison option, he finds a card placed in his room, depicting a young, sexually attractive female. Eventually, he is allowed out of his room and given an injection of testosterone propionate and told to retire to his room when he feels any sexual excitement. When he does this, a recording of a 'sexy' female vocalist is played to him.

No, this did not take place under a totalitarian regime, but is based on an article describing the

treatment of a patient in an NHS hospital (James, 1962). Similar treatments were handed out in other NHS and military hospitals throughout the UK from the 1950s to the 1980s. Albert, according to a follow-up article (James and Earley 1963), was 'cured'. This is aversion therapy. Male homosexuality remained illegal until 1967 and entrapment by undercover policemen was routine in the 1960s. It was also considered an antisocial mental illness that could be cured with aversion therapy, which could also include giving patients electric shocks. It remained classifiable as a mental illness until 1990.

Nurses frequently administered aversion treatments and some wrote articles discussing the merits of chemical and electrical therapies (Seager 1965). King *et al* (2004) investigated this practice and interviewed one nurse, who said: 'We had to become electrifying geniuses.' There is little information about this now-discredited mental health nursing practice.

I am researching this part of our profession's past for my doctorate, titled 'The historical intersection of sexual deviation and psychiatry', at Manchester University. I aim to interview nurses who helped to administer these treatments to understand their perceptions, motivations and experiences. I will also explore the professional, personal, social and cultural context in which aversion therapy developed.

I would like to hear from nurses who may have helped administer the treatments. Participants' names and personal details will remain confidential. Increasing our knowledge of this aspect of mental health nursing's history will be a timely reminder of the importance of ensuring that our nursing interventions are underpinned by an evidence base.

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Tommy Dickinson is a senior lecturer in mental health at the University of Central Lancashire and doctoral student at the University of Manchester. He can be contacted on 01772 896531 or by email at TDickinson@uclan.ac.uk

## **APPENDIX D**

### **Interview Questions**



### Guided Interview Schedule (Former patients)

Biographical section:

(Aim of this section is to settle the interviewee, and ease him/her into recollection of the period under study)

Establish:

Date and place of birth

What were the society's attitudes to homosexuality/transvestism during the period under investigation?

What were their family's attitudes to homosexuality/transvestism during the period under investigation?

Focusing on the patient's experience of receiving treatments to change sexual deviation:

Provide prompts to explore through anecdote and case histories the areas relating to:

How they came to be referred for these treatments?

What were their thoughts and feelings about these treatments?

How were their physiological and psychological needs met by the nurses caring for them?

What treatments did they receive and how did they happen?

Where did they happen?

What were their thoughts about the nursing care they received?

What were their thoughts about the environment where the treatments took place?

What were their perceptions of the roles and boundaries between medical, psychological and nursing staff?

How long did the treatments last?

What aftercare did they receive?

How did the treatments affect them at the time?

What impact do they feel the treatments had on their life in general?

### Guided Interview Schedule (Former nurses)

#### Biographical section:

(Aim of this section is to settle the interviewee, and ease him/her into recollection of the period under study)

Establish:

Date and place of birth

Motivation to enter nursing

When training started

Where training took place – which hospital, how training was organized (theory/practice split)

Places where the participant worked, especially hospitals, and specialisms within hospitals

#### Nursing in general:

(Aim of this section is to enable memories of the general work of nursing during the period, to explore its discipline and routines and conditions of work)

Explore memories of training

Memories of ward work

What was good and what was not so good?

Explore particular routines for the day

How duties were allocated

How work was recorded

Explore memories of procedures e.g., re: cleaning – daily, weekly, monthly, yearly

Explore working relationships with medical staff and clinical psychologists, ward rounds etc

Explore relationships with other hospital staff, e.g. cleaners, porters etc.

Explore relationships with patients and visitors

*Focusing on nursing patients receiving treatments to change sexual deviation:*

(The aim of this section and the next is to move towards the specific focus of the study – that of nursing patients receiving treatments to change their sexually deviant behaviour. NB specific topics may be added to this and the following section in the light of further reading of documents from the period)

Explore procedures e.g. aversion therapy (e.g. how did this fit into the daily routine, what preparation did they do for the procedures, how did they prepare the patient, curtaining/side rooms/sterilisation of equipment), how did they monitor the patient?

What were their motivations to nurse this patient group?

Patient hygiene, toileting

Ward management – bed spaces, visitor numbers and movement of patients

Cleaning, disinfection and sterilisation of equipment

Explore particular pre- and post-therapy nursing procedures.

How did they assess and manage any risks involved in these treatments?

What communication and interpersonal skills did they utilise when nursing these patients?

How did they manage distressed/agitated/aggressive patients?

How much autonomy did they have nursing these patients?

What meanings did they attach to these treatments?

What were the referral pathways of these patients?

What aftercare was available? Were nurses involved in providing such care?

**APPENDIX E**

**Research Ethics Committee  
Approval Letter**

Our Ref: HS/MH

Mr T Dickinson  
PhD Student  
School of Nursing, Midwifery & Social Work  
Jean McFarlane Building  
University of Manchester  
Oxford Road  
Manchester  
M13 9PL

21 December 2009

*By email and internal post.*

Re: The Historical Intersection of Psychiatry and 'Sexual Deviation' between 1949-1992: exploring the role of nurses and the experience of former patients.

Proposal Number: 09/1031/NMSW

Dear Mr Dickinson,

Thank you for the clarifications and amendments to the above study as requested by the Research Ethics Committee.

I am of the opinion that no major concerns or objections are evident of an ethical nature. Therefore on behalf of the Committee and taking Chair's Action, I am happy to grant full ethical approval.

During the progress of the study please inform the Committee of any changes or amendments that may be necessary.

On completion of the study would you please provide the Committee with a "Completion of Study Report".

Direct Contact: Jean McFarlane Building, University Place

## **APPENDIX F**

**Letter of invitation sent to potential  
Participants**



PhD in Nursing research topic:

**Mental Nursing and “Sexual Deviation”, 1935 – 1974: exploring the role of nurses and the experience of patients.**

**Researcher:** Tommy Dickinson

**Date:** XXXXX

**Dear:**

Thank-you very much for your interest in my research, I am a Senior Lecturer in Mental Health Nursing, and I am conducting this study for a Doctorate of Philosophy in Nursing at the University of Manchester. The study seeks to collect the memories of former patients who received treatments for homosexuality and cross-dressing, and also explore nurses’ memories about their work nursing these patients. Therefore, through this letter, I now invite you to participate in this study.

Attached to this letter you will find a Participant Information Sheet and a Consent form. If you are interested in this study, I would kindly request that you read the Participant Information Sheet and ensure you fully understand the information. Should you require any further information, please do not hesitate to contact me. My details are at the bottom of this letter and on the information sheet. Once you understand the information and are sure you would like to participate, I would ask that you sign one of the consent forms and mail it back to me in the stamped addressed envelope provided. You may ask a friend or family member to witness this form. The other form is for you to keep. I appreciate your time and interest in this study, and if you are willing to participate, I would be

grateful if you would return the consent form to me by **XXXX**. Once I have received your consent, I will contact you about arrangements for the meeting.

With gratitude for your interest,

Yours sincerely

Tommy Dickinson

Senior Lecturer in Mental Health

The University of Central Lancashire

Department of Nursing

Preston

Lancashire

PR1 2HE

Tel: 01772 895531

Email: [TDickinson@uclan.ac.uk](mailto:TDickinson@uclan.ac.uk)

## **APPENDIX G**

### **Participant Information Sheet**

## Participant Information Sheet

**Study Title:**

**Mental Nursing and 'Sexual Deviation', 1935 – 1974:  
exploring the role of nurses and the experience of patients.**

I would like to invite you to take part in my study. Before you decide I would like you to understand why the research is being done and what it would involve for you. **I will go through the information sheet with you and answer any questions you have.** I suggest that this should take about 10 minutes.

Talk to others about the study if you wish.

(Part 1 tells you the purpose of this study and what will happen to you if you take part. Part 2 gives you more detailed information about the conduct of the study).

Please do not hesitate to ask me if there is anything that is not clear.

## **PART 1**

### **What is the purpose of the study?**

The purpose of the study is to collect memories of former patients and nurses, particularly their memories of how they received or helped administer treatments to change people's sexual preferences. The study considers the time when homosexuality and other sexual desires or preferences were classifiable as a mental illness. I am particularly interested in speaking with former patients who received aversion therapy to treat this behaviour, and also nurses who may have been involved in nursing patients receiving this therapy. There may be insights from your experience which the present generation of nurses, gay, lesbian and transgendered people in the UK would find of interest.

### **Why have I been invited?**

You have contacted me in response to publicity asking for help. I want to meet former nurses who nursed patients receiving treatments to change their sexual desires and the former patients who received these. I hope to be able to interview 30 former patients and nurses in total.

### **Do I have to take part?**

It is up to you to decide to join the study. I will describe the study and go through this information sheet. If you agree to take

part, I will then ask you to sign a consent form. You are free to withdraw at any time, without giving a reason.

### **What will happen to me if I take part?**

Should you agree to take part I will first of all ensure you fully understand what is involved by going through this participant information sheet and answering any questions you may have. Should you still want to participate, I will then ask you to complete and sign a consent form.

Should you agree, you will be required to be interviewed by me. During the interview I will give you an opportunity to talk about your past experiences of either a) receiving treatments to change your sexual desires or b) your experience of nursing patients receiving treatments to change their sexual desires. The interview will be arranged for a time and place acceptable to you. This would normally be where you live. However, if this is not suitable for you, you can identify a local public place (e.g. library) where the interview could be conducted. You can have a relative or friend present during the interview if you would like this. Following the making of arrangements, you will be contacted two days before the interview to check that it is still convenient for the interview to take place.

There is no time limit for the interview. This will depend on you. You might want to stop the interview for a rest, or ask for the interview to continue on another occasion. It is absolutely fine for you to state your wishes to the interviewer and this will be

respected. You can withdraw your consent for the interview at any time.

Once the interview has been conducted I will transcribe what has been discussed and send you a copy which you can check for accuracy. If you feel that there are any changes that need to be made, these can be made. Once you are happy with the transcribed interview, I will send you a copy to keep.

### **Is there a payment for taking part?**

I do not have money to pay you for your time and involvement with the study. However, return standard fare travel will be paid to the local place of your choice should you not want to be interviewed in your own home.

### **Can I have someone with me during the interview?**

You can have a relative or friend present during the interview if you like.

### **How long will the interview last?**

As a guide, it is anticipated the interview will last between 1 and 1.5 hours; however, there is no time limit for the interview. This is in your control. You might want to stop the interview for a rest, or ask for the interview to continue on another occasion. It is absolutely fine for you to state your wishes to the interviewer and this will be respected.

**Will the interview be recorded?**

I would like to record the interview using a digital audio recorder. If you wish it, I will prepare a copy of the recording for you to keep. The interview could proceed without being recorded, though this would make it more difficult for the interviewer to record what you say.

**Will the interview be confidential?**

Any recording of the interview will only be listened to by those directly involved in the study, and anyone else you authorise. Parts of the interview, in written form, may be reproduced anonymously as part of the research thesis and subsequent publications. Unless you wish it, your name will not be associated with any audio or written transcript. The transcript will be shredded when the study is complete.

**Can I use photographs and other memorabilia?**

If you have any photographs or other memorabilia which you think might be of interest to the project, we would be very grateful for the opportunity to view these. The interviewer will be pleased to discuss these with you during or after the interview.

**Who will be the interviewer?**

The interviewer will be myself - Tommy Dickinson. I am a Registered Nurse who graduated in 2001, and have held various posts in mental health settings in the UK and Australia. I am now



a Senior Lecturer in mental health nursing with the University of Central Lancashire's School of Nursing and Caring Sciences. I am undertaking a Doctor of Philosophy degree with the University of Manchester's School of Nursing, Midwifery and Social Work. The interview will form part of the work towards that qualification. I can be contacted on 01772 895531, or email: [TDickinson@uclan.ac.uk](mailto:TDickinson@uclan.ac.uk) or by post at Tommy Dickinson, Senior Lecturer in Mental Health, The University of Central Lancashire, Preston, Lancashire, PR1 2HE.

### **Who is overseeing the project?**

The senior supervisor of the project is Prof. Christine Hallett, School of Nursing, Midwifery and Social Work, University Place, University of Manchester, Oxford Road, Manchester M13 9PL; tel: 0161 275 2000; email: [Christine.Hallett@manchester.ac.uk](mailto:Christine.Hallett@manchester.ac.uk)

### **What are the possible disadvantages and risks of taking part?**

I realise that recalling these past experiences may be difficult for you and there is a possibility that you may become upset or distressed.

### **What are the possible benefits of taking part?**

I cannot promise the study will help you but the information I get from the study will help the wider audience to realise the historical treatment of gay, lesbian and transgendered people and for the

younger population to remember what it would have been like to live as one of these people in the past.

Further, for the nursing profession it will hopefully be a timely reminder of the importance of ensuring that our nursing interventions are underpinned by an evidence base and the risks of ignoring the association between science and society.

**What do I do if there is a problem?**

Any complaint about the way you have been dealt with during the study or any possible harm you might suffer will be addressed. The detailed information on this is given in Part 2.

**Will my taking part in the study be kept confidential?**

Yes. I will follow ethical and legal practice and all information about you will be handled in confidence. The details are included in Part 2.

This completes part 1.

If the information in Part 1 has interested you and you are considering participation, please read the additional information in Part 2 before making any decision.

## **PART 2**

### **What will happen if I don't want to carry on with the study?**

You can withdraw your consent to be involved at any time. If I have already collected information from you I will ask whether you want this destroyed, returned to you or if I could keep it for possible use in the study.

### **What if there is a problem?**

#### **Complaints**

If you have any concern about any aspect of this study, you should speak to me in the first instance and I will try and resolve any problems. However, if you wish to make a more formal complaint you can do this by contacting Prof. Christine Hallett, School of Nursing, Midwifery and Social Work, University Place, University of Manchester, Oxford Road, Manchester M13 9PL; tel: 0161 275 2000; email: [Christine.Hallett@manchester.ac.uk](mailto:Christine.Hallett@manchester.ac.uk)

### **What will happen to the results of the research study?**

I plan to submit the research findings in a PhD thesis to the University of Manchester. I also plan to submit the research in publication format to be considered for a book and in nursing journals. Furthermore, I plan to send abstracts of various parts of the research to present at conferences. I will send you a summary of the research findings if you wish.

**Who is organising the study and funding the research?**

The study has been approved by the University of Manchester. Some of the money towards the research costs has been provided by the Mona Grey Prize; the Wellcome Trust; the Royal College of Nursing; and the Royal Historical Society.

**Who has reviewed the study?**

The study has been reviewed and approved by the University of Manchester's Committee on the Ethics of Research on Human Beings. This is an independent group of people from the University of Manchester and exists to protect your safety, rights, wellbeing and dignity.

**Further information and contact details**

For general and specific information about the project, or advice about participation, contact Tommy Dickinson. Tommy can be contacted on 01772 895531, or email: [TDickinson@uclan.ac.uk](mailto:TDickinson@uclan.ac.uk) or by post at Tommy Dickinson, Senior Lecturer in Mental Health, The University of Central Lancashire, Preston, Lancashire, PR1 2HE.

If you are unhappy about any aspect of the project, contact the senior supervisor of the project Prof. Christine Hallett, School of Nursing, Midwifery and Social Work, University Place, University of Manchester, Oxford Road, Manchester M13 9PL; tel: 0161 275 2000; email: [Christine.Hallett@manchester.ac.uk](mailto:Christine.Hallett@manchester.ac.uk)

## **APPENDIX H**

### **Consent Form**

## CONSENT FORM

Title of project:

**Mental Nursing and 'Sexual Deviation', 1935 – 1974: exploring the role of nurses and the experience of patients.**

Name of Researcher: **Tommy Dickinson**

1. I confirm that I have read and understand the Participant Information Sheet for the above study. I have had the opportunity to consider the information and ask questions and have had these answered satisfactorily. **Please initial.....**
2. I understand that my participation is voluntary and that I am free to withdraw at any time without giving any reason. **Please initial.....**
3. I understand that I can be accompanied during the interview by a person of my choosing. **Please initial.....**
4. I confirm that I received treatments for my sexual preferences or nursed patients receiving these treatments between the periods 1949 - 1992. **Please initial.....**
5. I understand that relevant direct quotes may be used in publications or presentations. **Please initial....**
  - i. I agree to my name being used in direct quotes.  
**Please initial....**
  - ii. I do not agree to my name being used in direct quotes.  
**Please initial....**

6. I agree to take part in the above study. **Please initial.....**

Signed.....

Date.....

NAME

(BLOCK  
LETTERS).....

Address for correspondence.....

.....

Full Telephone number (including STD code):.....

Witnessed.....

Date.....

NAME (BLOCK  
LETTERS).....

Please return one copy of your completed form to:

Tommy Dickinson  
Senior Lecturer in Mental Health  
The University of Central Lancashire  
Preston  
Lancashire  
PR1 2HE

I confirm that I have fully explained the purpose and nature of the study and any risks involved.

Signed.....Date.....

Name of person talking consent

.....



## APPENDIX I

### Publications from the Study

**Dickinson, Tommy, Cook, Matt, Hallett, Christine & Playle, John.** “Queer” Treatments: giving a voice to former patients who received treatments for their “sexual deviations”. *Journal of Clinical Nursing*, 21 (9) (2012), pp. 1345–1354.

PATIENTS PERSPECTIVES

## ‘Queer’ treatments: giving a voice to former patients who received treatments for their ‘sexual deviations’

Tommy Dickinson, Matt Cook, John Playle and Christine Hallett

**Aims and objectives.** The study aimed to examine the experiences of patients and meanings attached to ‘treatments’ of sexual deviations, which included homosexuality and transvestism, in the UK (1949–1992), exploring reasons for such treatments, experiences and how individual lives were affected.

**Background.** Male homosexuality remained illegal in England until 1967 and, along with transvestism, was considered an antisocial sexual deviation that could be cured. Homosexuality remained classifiable as a mental illness until 1992. Nurses were involved in administering treatments to cure these individuals; however, there is a paucity of information about this now-discredited mental health nursing practice.

**Design.** A nationwide study based on oral history interviews.

**Methods.** Purposeful and snowball sampling was utilised when selecting participants for the study. Participants were recruited via adverts in gay establishments/media. All participants gave signed informed consent. Face-to-face oral history interviews were conducted and transcribed for historical interpretation.

**Results.** Seven former male patients made contact, aged 65–97 years at interview. All reported that the treatments had been unsuccessful in altering their sexual desires or behaviour. Most sought treatment owing to unsupportive and negative attitudes from friends, family and wider society. Others selected treatments instead of imprisonment. Most eventually found happiness in same-sex relationships. However, all were left feeling emotionally troubled by the treatments they received.

**Conclusion.** Defining homosexuality and transvestism as mental illnesses and implementing what could be argued to be inefficient treatments to eradicate them appears to have had a lasting negative impact on the patients who received them.

**Relevance to clinical practice.** Nurses who care for older gay, lesbian, bisexual and transgender patients need to be mindful of their potential past treatment by healthcare services and ensure that they are non-judgmental and accepting of their sexual orientation and current gender.

**Key words:** gay, gay history, marginalised, nursing ethics, nursing history, queer

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*Christine Hallett*, PhD, Professor of Nursing History and Director of the UK Centre for the History of Nursing and Midwifery, The School of Nursing, Midwifery and Social Work, The University of Manchester, Manchester, UK.

**Correspondence:** Tommy Dickinson, Senior Lecturer, Mental Health, School of Health, The University of Central Lancashire, Preston, Lancashire PR1 2HE, UK. Telephone: +44 01772 895531. E-mail: TDickinson@uclan.ac.uk

## Introduction

In 1949, the sixth edition of the World Health Organisation's *International Statistical Classification of Diseases, Injuries and Causes of Death* (WHO 1949) was published. For the first time, this included a section on mental disorder, within which homosexuality and transvestism were classified as mental disorders. This paved the way for the medical, nursing and psychological professions to provide 'treatment', which included aversion therapies based on Pavlovian conditioning, for individuals diagnosed with these disorders (King & Bartlett 1999). Male homosexuality was also illegal in England and Wales until 1967 (Dickinson 2010). It took until 1992, however, for the World Health Organisation to finally drop the term 'homosexuality' as a diagnosis with the publication of the *International Classification of Diseases Edition 10 Classification of Mental and Behavioural Disorders* (WHO 1992). Nurses were involved in administering these aversion therapies (James 1962, Seager 1965, Anon 1968). However, there is a paucity of information about this now-discredited mental health nursing practice. Therefore, this article reports on a study which aimed to examine the experiences of patients and meanings attached to treatments for sexual deviations, in the UK (1949–1992), exploring reasons for such treatments, experiences and how individual lives were affected.

## Background

The medicalisation of sexual behaviour can be traced back to 1892 with Krafft-Ebing's *Psychopathia Sexualis*, which delineated for the first time an exhaustive list of sexual deviations. In 1897, sexologists Havelock Ellis and John Addington Symonds extended the terminology to include homosexuality, paedophilia and transvestism in their masterwork *Sexual Inversion* – one of the many terms developed by sexologists to refer to same-sex desire. *Sexual Inversion* was the first British attempt to synthesise biological, anthropological and psychological knowledge on the subject. Sexology was the study and classification of sexual behaviours, identities and relations and was used as the focus of much of the therapeutic work regarding sexual deviations in the later 19th and early 20th centuries (Cook 2007).

By the 1920s, the mapping of homosexual identities in terms of sexual inversion was being challenged by the advent of new, psychoanalytical understandings of sexual development (Doan & Waters 1998). Pioneering this psychoanalytical approach was Sigmund Freud. By studying the psychic mechanisms that determined sexual object choice, he opposed the work of those sexologists who believed that homosexuals needed to be studied as a special category of

person. For Freud, homosexual and heterosexual object choices were simply two outcomes of each person's unique development, a process that began in a shared, polymorphous, infant bisexuality (Bland & Doan 1998). Freud believed that every male had to pass through a phase of homosexuality as a way of delivering himself from the Oedipus complex (Freud 1923).

Psychoanalytical discourses of homosexuality in Britain had made considerable headway by the 1930s, and for many students of the subject, Havelock Ellis' work already seemed discredited (Waters 1998). Indeed, Freud (1935, p. 147) stated that:

homosexuality is nothing to be ashamed of, no vice, no degradation; it cannot be classified as an illness; we consider it to be a variation of the sexual function, produced by certain arrest of sexual development

With the outbreak of the Second World War in 1939, the British medical profession had more pressing matters at hand and homosexuality was given little consideration during the war. Indeed, Jivani (1997) argues that gay men and lesbians had what could be called a 'good' war and the experiences of gay men and the exposure of the general public to these individuals during the war played an influential part in shaping future beliefs and attitudes towards gay people.

This liberation was short-lived, however, and during the 1950s, sexual deviations, particularly homosexuality, came under a panoptical gaze. After the Second World War, fears surrounding homosexuality acquired a particularly electric resonance and narratives of sexual danger as corruption predominated in public discourse (Houlbrook 2005). For many observers, the rapid social changes unleashed by the war seemed to have rendered Britain's stability problematic. Houlbrook (2005) suggests that these societal changes destabilised the critical interpretative categories – masculinity and nationhood – within which narratives of sexual difference and danger were framed. Established notions of 'Britishness' seemed threatened from every direction, therefore, homosexual urban culture was viewed as ever more dangerous, assuming a central symbolic position as a key threat to the establishment in the postwar politics of sexuality.

In addition, during this period, there was the very public arrest, trial and conviction of three influential individuals in 1954 – Lord Montagu, a peer of the realm, Peter Wildeblood, the diplomatic correspondent of the *Daily Mail* and Michael Pitt-Rivers, a wealthy landowner and cousin of Montagu's. The trio were convicted of conspiring to incite two RAF men – Edward McNally and John Reynolds – to 'commit unnatural offences'. Jivani (1997) argues that the press were agog and

reports made much of the precedent that had been set: this was the first time that a peer of the realm had been convicted in a criminal court as the right of peers to be trialled by their fellow peers, in the House of Lords, was abolished in 1948. The case made legal history, but it was also a milestone in the history of Britain's attitude towards gay men (Cook 2007). Not only did it mark the nadir of the persecution of gay men in the country, in retrospect it was hugely influential in persuading the liberal intelligentsia that something must be done regarding the 'problem' of homosexuality.

Therefore, the Departmental Committee on Homosexual Offences and Prostitution, chaired by John Wolfenden, was set up on 4 August 1954 to appraise the law affecting homosexuality from the point of view of liberating it (Jivani 1997). The fullest and most compelling evidence to the Wolfenden Committee in favour of reform came from medical witnesses. Drs Inch and Boyd from the Scottish Prisons and Borstal Services aired serious doubts as to the value of imprisonment in reforming sexual offenders and favoured the decriminalisation of homosexual behaviour for consenting adults over 21. They advocated that courts should have routine psychiatric reports on all homosexual offenders prior to sentencing, supplied by a properly staffed University or Regional Hospital Board Clinic and for the homosexual recidivist or 'homosexual psychopath', and there should be a separate psychopathic institute. Finally, treatment regimes had to be more effectively monitored and sustained by means of improved staff resources for after-care and social work. Underlying their evidence was a belief that a less punitive policy would in fact produce a more liberal and sympathetic attitude to homosexuality in British society (Davidson 2009).

On 4 September 1957, the Committee published its report, where it recommended that homosexual sex in private between consenting adults over 21 should be decriminalised; that buggery should be reclassified from a felony to a misdemeanour (reducing the potential length of sentences); and that sentences more than 12 months old should not be prosecuted, except in the case of indecent assault. The report also advocated further research into causes and treatment for homosexuality and suggested that treatments should be offered to individuals to cure them. It took until 1967 for the government to decriminalise homosexuality in England and Wales, 1980 in Scotland and 1982 in Northern Ireland. However, all the governments supported the use of treatments in a bid to cure individuals of their homosexuality. Never before had there been such a refocusing of public debate surrounding sexual deviations onto issues of aetiology rather than punishment: the stage had been set for the healthcare professions to provide treatment for individuals diagnosed with these disorders.

By the 1950s, popular reportage was suspicious of the claims of psychoanalysis. Many urged the greater use of therapeutic techniques in the treatment for sexual deviations and psychological interventions to alter sexuality increased sharply (King & Bartlett 1999). The emerging discipline of clinical psychology was influenced by seminal work that suggested that neurotic disorders (which included homosexuality and cross-dressing) were acquired through faulty learning and might respond to behaviour modification, particularly aversion therapy (Wolpe 1958). A number of studies reported on these pioneering treatments for patients suffering from sexual deviations (Max 1935, Raymond 1956, Freund 1960, James 1962).

Anecdotal evidence of medical attitudes towards this patient group is scattered in the written and recorded testimonies of gay, lesbian, bisexual and transgendered (GLBT) people (Ashley 1982, Jivani 1997, Price 2007). With the notable exception of Smith *et al.* (2004), there is a paucity of literature exploring the experiences of the individuals who were subjected to these treatments. Moreover, this is an aspect of nursing history that has not hitherto been studied. Therefore, this article seeks to begin to make good this omission by exploring the experiences of individuals 'diagnosed' as mentally ill owing to sexual deviance, thus enhancing the body of knowledge relating to the history of mental health nursing.

## Methods

### Method

The main research method used in the study was oral history; this can be defined as 'a systematic collection, arrangement, preservation and publication...of recorded verbatim accounts and opinions of people who were witnesses to or participants in events' (Moss 1974, p. 7, Perks & Thomson 1998). Face-to-face oral history interviews were conducted with all participants; these were audiotaped and transcribed for historical interpretation.

### Sample

Purposeful sampling was utilised when selecting participants for the study (Boschma *et al.* 2007). This included individuals on the basis of personal knowledge of the event or phenomenon, as well as the ability and willingness to communicate this experience to others (Sandelowski 1999). Snowball sampling was also used, where subjects put the researcher in contact with others who may have had similar stories to tell (Kirby 1997). However, these treatments did not become mainstream in UK mental health services, and it is estimated

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that only about 1000 patients received them (Smith *et al.* 2004). Therefore, obtaining participants proved difficult.

Seven former male patients were recruited, aged from 65–97 years at interview. Five of the participants were treated for homosexuality. The remaining two were treated for transvestism; however, they subsequently underwent gender reassignment surgery and are now living as females. Two participants were recruited from flyers posted on notice boards of various gay bars: one was recruited from an advert in a national gay magazine; one participant was recruited following an interview with the chief investigator (CI) regarding the study on a local radio station; and one was recruited following a talk regarding the study by the CI at a social group for older GLBT people. The remaining participant was recruited by means of snowball sampling. Sedgwick (1990) has posited that sampling in queer historical research can rely on small numbers, as depth rather than breadth in data collection is sought.

### Historical interpretation

Oral history is not given from a theoretical perspective, meaning that it does not actively seek to convey a specific ideological value (Perks & Thomson 1998). The interpretation of such histories in respect of theories is left to the historians and so can provide material for the support or rebuttal of any number of philosophies (Moss 1974). However, they will often challenge ‘...official documents and other works written from the perspective of white, male, dominant members of society’, thus challenging history as it was traditionally determined (Babbie & Benaquisto 2009, p. 27). It would be wrong, however, to state that the historian holds interpretative authority over the material. Indeed, the act of remembering can be very empowering and in some cases therapeutic, especially for gay people who may have had to analyse their past fairly comprehensively (Plummer 1995). Many of the therapeutic dimensions listed by Church and Johnson (1995) were apparent in the participants in this study – the sharing of feelings, the expression of satisfaction or of anger at unresolved issues, changes in affect and a desire to contribute usefully.

Borland (1998) has posited that owing to the participants having interpreted their past over a number of years, it is important that historians open up the exchange of ideas so that they do not simply gather data on others to fit their paradigms. Borland suggests that the researcher must always be concerned about the potential emotional effect that alternative readings and interpretations of personal testimonies may have on the living subject. To work around this and to ensure rigour in the interpretation phase, Borland has suggested that it is important to work in alliance with the

participant throughout not only the data collection phase, but also the interpretation phase. In the light of this, the CI involved the participants in the interpretative process; this included returning transcripts to participants for checking and comment. However, this was not possible with one participant, as he sadly passed away in the time between data collection and interpretation.

### Ethical considerations

Ethical approval was obtained through the University of Manchester Research Ethics Committee. Further, the Ethical Guidelines for the Nurse Historian and Standards of Professional Conduct for Historical Inquiry in Nursing (Brown 1993) were adhered to. The main ethical issues of the study were confidentiality and anonymity of the participants and ensuring that they had given informed consent. All participants were given a participant information sheet and had the study fully explained to them. They were given the opportunity to ask any questions, and if they still wanted to participate, they signed a consent form.

Parahoo (1997) argues that another pertinent aspect of all research is respect for non-maleficence. Parahoo believes that it is often more difficult to tease out the potential for psychological harm in research studies. This is particularly so when interviews are used for data collection, where the sensitivity of the researcher in conducting the interview has as much, if not more, potential for causing psychological harm as the actual topic being researched. This was a pertinent issue for the study, as the participants were often recalling a very fraught chapter in their lives. Therefore, the guidance posited by Kirby (1997) was followed, which states that the interviewer must be supportive when needed and be ready to offer to switch off the tape recorder and let the interviewee recover his or her composure whenever necessary. Furthermore, one of the conditions of ethical approval was that the CI had to have the number of a counsellor available to give to the participants should they become distressed during the interview; however, all participants declined this when it was offered to them.

### Results

Seven former patients were recruited, aged 65–97 years at interview.

#### Reasons or motivations for treatment

Many of the participants reflected on the negative impact the media had had on their lives, and in some cases, it provided the catalyst for them to seek treatment:

...all I had to do was open the daily paper and it was rubbed in my face how evil and perverse I was. It made me feel like ending it all. I knew I had to do something; it was either kill myself or cure myself. (Female 1)

This was often exacerbated by unsupportive attitudes from their friends, family and the police:

I started dressing [wearing women's clothes] at 16. What I used to do was go for a walk in the early hours of the morning, dressed in a skirt and coat. Probably not a good idea for a young person to be out at that time in the morning, which was why the police stopped me. My instant reaction was to run away and to try to hide and avoid the police. The police caught me and took me to the police station. It was a blues and twos event. Lots of people came in and saw me – it was like I was in a 'freak show'. I got quite a rough ride off the police. They seemed to think I was connected with rapes and sexual assaults and all sorts and I was quizzed and questioned about that for about three or four hours. My family came to collect me and marched me to my GP the next day and I was referred to a psychiatrist. (Female 2)

One participant sought treatment because of the turmoil he found himself in when he realised he was attracted to members of the same sex:

This was terrifying really because I was thrown into confusion and it made me very poorly because I had three children, little ones and a wife and we all loved each other, we had been happy building our lives, you know. I was very fond of my wife as well and everything was going okay and then all this began to happen and threw me into awful confusion and made me very, very poorly and so I thought I had to go to the doctor. So I did. (Male 2)

Six of the men approached their general practitioner (GP) about their problems and were referred to National Health Service (NHS) professionals who specialised in this area. All reported that their GPs appeared perplexed by their disclosure and appeared to show little empathy for their patients' situation. One participant, however, was coerced into receiving treatment when he was entrapped and arrested by an undercover police officer in a public place for importuning:

Well when I was given the option, prison or hospital, well I just thought if I go to prison...if the other inmates found out what I was in there for, well, I just thought they would kill me! I mean, I was fairly accepting of my sexuality, but in society and particularly within a prison, it was viewed in the same light as a paedophile. No, I'm not going to prison, that is all I could think. So I just said, 'Yeah, I'll go to hospital for the aversion therapy.' It knew it was not going to make me straight, I didn't want it to, but it seemed a better option than prison' (Male 3)

## Treatments

The treatments the participants described were all carried out in NHS hospitals throughout the UK. The most common treatment was chemical aversion therapy, which involved inducing vomiting by utilising a powerful emetic, Apomorphine (four participants). Electrical aversion therapy was also used. In the case of transvestism, the man stood on an electric grid dressed in women's clothes, while at the same time receiving electric shocks through the feet (two participants). In the case of homosexuality, pictures of nude men as the erotic stimulus were used as the subject to be averted (one participant). The electric shocks were usually administered in response to increases in penile erection, measured by a plethysmograph (Bancroft 1969). The age at which the participants received treatment ranged from 16–41 years, and most were in their early 20s. The participants who received chemical aversion therapy were treated as inpatients on psychiatric wards owing to the intensive nature of their therapy and the side effects of nausea and dehydration. Those receiving electrical aversion therapy were treated as outpatients for weeks or, in case of two participants, for over a year.

All participants described the treatments as very arbitrary and primitive. Most reflected on un-empathetic interactions with the nursing staff administering their treatments:

I remember sitting in the room on a wooden chair 'dressed' [wearing women's clothes], but I had to be barefoot as my feet had to touch the metal electric grid. My penis was also wired up to something to measure if I got an erection – I felt totally violated...I remember the excruciating pain of the initial shock; nothing could have prepared me for it. Tears began running down my face and the nurse said: 'What are you crying for? We have only just started!'... [Chokes]... I was speechless. (Female 1)

I can still taste the vile taste of stale sick in my mouth. All I wanted was to wash my mouth out with fresh water, but I wasn't even allowed that. I remember trying to sneak out of my 'prison cell' one night to get some water, but the nurses caught me and literally threw me back in. I was not allowed out for three days. I went to the toilet in the bed; I had no basin, no toilet facilities – nothing. I had to lie in my own faeces, urine and vomit. I thought I must be dreaming at one point, it was like a barbaric torture scene by the Gestapo in Nazi Germany trying to extract information from me – I thought I was going to die...' (Male 4)

Many participants became disenchanted by the treatments. One recalled being discharged by his consultant:

He was very demeaning of homosexuality, he said, 'just go out and do it.' Those were almost his last words. 'You have to deal

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with it yourself: we have done all we can for you' he said. It was just like that and I was wanting to say, I wanted to tell him how I couldn't go on with life if that was the case but, when they began to take that attitude, then I began to think I must be out of here because ...You know, he was very dismissive. I mean, it's like...well, I was shocked, I was shocked, I was speechless, I couldn't ... I couldn't articulate. I couldn't react. I just said 'thank you' and went out the door. (Male 5)

Three days later, the participant was back in the same hospital on constant observations, having attempted to take his own life. Only four of the participants were followed up by their consultant psychiatrist; this follow-up varied from one to six months.

#### Aftermath of the treatments

The treatments appeared to have petered out with the decriminalisation of homosexuality in England and Wales in 1967 and the influence of the Gay Liberation Front in the early 1970s. This gave the participants space to explore their sexuality. At the time of their interviews, five participants considered themselves to be homosexual. The remaining two participants had both undergone gender reassignment surgery and were living happily as females. There were, however, varying degrees of acceptance by the participants of their current situation. Three were in same-sex long-term relationships. One was single, but he actively embraced his sexuality and enjoyed being a part of a social group set up for older gay people. One participant stated that he has never come to terms with his sexuality and deals with this by remaining celibate. Moreover, all participants reported still being disturbed by the treatments they received:

I am gay, but I have never come to terms with it. I desperately wanted the treatments to work, but they didn't. If there was a pill I could take to turn me straight, I would have taken it; I still would to this day. The only way I can deal with it is to not have any sexual relationships with anyone. I have lived on my own since I came out of hospital. Luckily my children accepted me and I still see them and they are very supportive. But I can still have terrible flashbacks of my time in hospital and the barbaric treatments I received. (Male 5)

I am an openly gay man: although my life partner died in 2004, I still attend a local gay group for older gay men and women and still very much identify myself as gay – I'm very happy and at ease with it. However, I am still slightly troubled by the treatment I received in hospital, I just don't know how something so tortuous could have been concealed under the term 'health care'. (Male 1)

#### Discussion

The current study sought to explore the experiences of patients and meanings attached to the treatments for sexual deviations in the UK (1949–1992), examining the reasons for such treatments, experiences and how individual lives were affected. Some participants wanted to change the way they were feeling and were willing to try anything to protect them from the shame that was placed on them by society, their families, the media and the police. Others, however, appeared to have accepted their sexuality, did not want to change it, despite the substantial social and legal risks involved and had no confidence in the reliability of the treatments they opted for. This concurs with Bancroft (1969) and Smith *et al.* (2004), who found that many men sought treatment because of public humiliation, a court order or pressure from their families.

All the participants in the study are male or were male at the time they received the treatment; no individuals who were women at the time of treatment came forward as research participants. That is not to say that women were not subjected to these treatments: they were. However, of all reported cases in the literature, only one published study included women (McCulloch & Feldman 1967). While female sexual deviation – particularly prostitution – was inscribed within forms of surveillance that echoed the regulation of male sexualities, lesbianism remained invisible in law. Moreover, when we consider that one of the main reasons why men were referred for these treatments was through a court order, this could provide some interpretation for the limited response from females to the study and their limited presence in the literature.

Although no participants in the present study received them, oestrogen treatment to reduce libido and psychoanalysis were also utilised as treatments for sexual deviations (Westwood 1953). The participants in the study had received either electrical or chemical aversion therapy, with the latter being more popular. In contrast, Smith *et al.* (2004) found that electrical aversion therapy was received by the majority of the participants in their study. However, this could be attributed to the fact that the treatments lacked regulation and a sound evidence base. Moreover, the treatments were experimental in nature, and the treatment of choice rested largely on the autoschediastic decision of the consultant psychiatrist.

None of the participants in the present study suggested that the treatment had been effective and all were still troubled in some way by their experiences of receiving such treatment. This concurs with the findings of Smith *et al.* (2004), who found that no participants suggested that treatment had had

any direct benefit, and for many, it had reinforced the emotional isolation and shame that had been a feature of their childhood and adolescence. All participants in the present study appeared to have accepted their current sexuality except one, who has never come to terms with it and remains celibate. Despite this dichotomy between the participants' levels of acceptance of their sexuality, the treatments appeared to prove unsuccessful, as all men were still homosexual and two eventually underwent gender reassignment surgery. Woodward (1958) discussed the prognosis of 113 homosexual offenders who were treated between 1952–1953. She concluded that:

A better prognosis was significantly associated where the heterosexual interest was more dominant; a worse prognosis was significantly associated when the homosexual interest was more dominant (p. 58)

The treatments, therefore, largely relied on the individual's initial dominant sexual desire. However, it could be argued that this goes without saying that surely the treatments are going to be more effective for people who already have heterosexual feelings than for those who do not.

It appears from the literature that negative effects from the treatment were fairly common. In a feasibility study of 10 men treated by Bancroft (1969), one developed phobic anxiety to attractive men and attempted suicide; one became aggressive, attempted suicide and was anorgasmic in homosexual relationships; one developed serious depression after rejection by women; one became psychotically depressed and wandered into the streets removing his clothes, and one became disillusioned by the homosexual world and could no longer sustain emotionally rewarding relationships. Further, deaths occurred from the inhalation of vomit during aversive conditioning with apomorphine (West 1968, Smith *et al.* 2004). Nevertheless, Bancroft (1974) did not seem unduly concerned by what appears to be the considerable negative consequences of these treatments. Long-term outcomes were not encouraging, despite practices to boost follow-up rates. A few patients believed that they had become heterosexual, but there was no confirmation of this claim beyond penile volume measurements in response to erotic stimuli (King & Bartlett, 1999). Moreover, McConaghty (1976) concluded that aversion therapies would appear not to have altered the patients' preexisting sexual orientation, and the practitioners involved did not consider the considerable damage wrought by these treatments.

Nursing continues to struggle with the sexuality of patients; indeed, Douglas *et al.* (1985) concluded that homophobia was high in nurses in their study. Dinkel *et al.* (2007) argues that nursing students and faculty in their study

had ambivalent or heterosexist attitudes towards GLBT people, which may impact the health care delivered by these future nurses. Rondahl (2009) explored 27 GLBT patients' perceptions of their nurses' attitudes towards their sexuality. The patients reported a sense of insecurity regarding 'coming out' to nursing staff owing to not knowing how they would react, while others related that nursing staff judged homosexuality as something abnormal.

The discrimination by health service providers and practitioners to GLBT patients has contemporary resonance for practising registered nurses. The Committee on Human Sexuality (2000) has stated that many older GLBT people are reluctant and fearful to seek mental health care services because of their historical poor treatment by such services. It has also been argued that health care provision is heteronormative and assumes that people are heterosexual unless otherwise asserted (Kean 2006). Moreover, older GLBT people may not be comfortable or assertive 'coming out' to health professionals, which can result in services failing to meet the needs of this patient group (Dorfman 1995). However, it has been posited that this issue can be alleviated when health care practitioners are non-judgmental, accepting of their patients' sexual orientation and able to assess and implement quality care for this patient group (Price 2009).

### Limitations of the study

The participants in the study reported here may not be representative of all the people who underwent treatment, as people may have been reluctant to take part or may have passed away or emigrated. It may have only been those most perturbed by the treatments they received who wanted to participate in the study. Finally, it is important to highlight that, while all participants in the present study either remained homosexual or eventually underwent gender reassignment surgery, if these treatments had been effective for some individuals in so far as they were now heterosexual, it could be argued that these people would be very reluctant to come forward to tell their story. Therefore, this study cannot address the full reality of the issues raised by these treatments.

### Conclusion

Conclusions at this stage are tentative because of the limitations discussed previously. These testimonies show, however, that the courts and unsympathetic family, police and social attitudes incited people to seek treatment. No participant reported any treatment efficacy and all reported that the treatments they received had had a detrimental effect



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on them in some way. It could be argued that the treatments described previously had a very limited evidence base, were extremely experimental and lacked regulation. Furthermore, nurses appeared to have played a central role in administering these ethically dubious treatments. This is a pertinent finding, and to explore nurses' perceptions, motivations and experiences of administering these treatments, the CI is currently undertaking further research in this area. Moreover, the study displays the negative consequences of defining homosexuality and transvestism as mental illnesses and attempting to 'cure' individuals suffering from these 'illnesses' through medical and nursing interventions.

### Relevance to clinical practice

It is hoped that this study will make an important contribution to the documented history of experiences of individuals 'diagnosed' as mentally ill owing to sexual deviance and clinicians' experiences and perceptions of the 'management' of individuals belonging to stigmatised groups. It is envisaged that this study might also act as a reminder of the need for nurses to ensure that their interventions have a sound evidence base and that they constantly reflect on their morals, values and the influence that science, societal norms and contexts can have on changing views of what is regarded as 'acceptable practice'. Nurses have a unique opportunity to serve as true patient advocates when working with disparate aggregates of individuals. Those who care for older GLBT patients need to be mindful of their potential past treatment

by health care services, ensuring that they are non-judgmental and accepting of their sexual orientation and current gender. It is anticipated that the study enables the nurse not only to review his or her own experience of nursing this client group, but also to envision alternative possibilities for constructive and caring intervention for these patients in their care. Nurses need to embrace the diversity of their patients and ensure that the dignity, uniqueness and inherent worth of every individual are respected, promoted and protected.

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### Contributions

Study design: TD, CH, JP, MC; data collection and analysis: TD and manuscript preparation: TD, CH.

### Conflict of interest

The author declared that there is no conflict of interest.

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