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### **Hidden from history? A brief modern history of the psychiatric ‘treatment’ of lesbian and bisexual women in England**

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It is well documented that homosexuality was classified as a mental illness in the DSM until 1973, when it was replaced with the diagnosis of ‘sexual orientation disturbance’. While it is widely known that homosexual men were criminalized and risked a spell in prison or aversion therapy in a psychiatric hospital (Dickenson 2013), the class dimension is probably lesser known. According to the Queer historian, Chris Waters (2017), it was the more privileged middle class men who were offered aversion therapy, as a ‘softer’ option than jail (Alan Turing being the most prominent example). In contrast, the majority of mostly working class men who were discovered engaging in same sex relations were more likely to end up in prison, without the offer of ‘treatment’ as an alternative. However, there are aspects of this history we know even less about. Because it is well-documented, gay men’s experiences of psychiatric treatment for same-sex attraction has become a dominant historical discourse. But what happened to same sex attracted women in England (1950’s-1970’s) who were not subject to direct court referral routes into psychiatric treatment like their male counterparts? Although female homosexuality was not criminalized in England, it was still, like male homosexuality, officially classified as a mental disorder (‘sexual deviation’).

As part of a cohort of studies around the theme of Sexualities and Health funded by the Wellcome Trust, we conducted a ‘bottom up’ archival study of women’s and lesbian, gay, bisexual and transgender (LGB&T) archives in England to investigate this question. Documentation proved to be sparse and fragmented and what little material we found presented us with numerous challenges to interpretation. A small number of psychiatrists and psychologists had various, often competing, theories *about* homosexuality and published papers promoting examples of experimental or purportedly successful ‘treatments’ which they often used to test out their theories. However, it is not clear how much they actually influenced practice (Oram and Turnbull 2001).

Our archive research suggests that same-sex attracted women’s experience of treatment in England was probably even more complex than men. As there was no psychiatric consensus about whether female homosexuality could, or indeed should, be treated, professional attitudes and practices ‘varied enormously’ (Jennings 2008 p.892). It seems likely that women were more likely to receive psychiatric interventions for accompanying mental health problems, and only for their homosexuality very rarely. Echoing Waters’ accounts of gay men, Jennings suggests lesbian encounters with the medical profession resulted in a ‘range of responses and treatment options, shaped by the class and educational

background of the patient and variations in clinical practice between regions, the public and private sectors, and individual practitioners' (Jennings 2008 p.898).

In practice, various mental health-related disciplines in England were involved with the treatment of same-sex attracted women, whether to change, or accept and adjust to their sexual orientation. This included psychiatrists, psychologists and psychotherapists. Whilst some women in the armed services were referred to psychiatry because their sexuality was discovered, it appears that women were rarely coerced into treatments. Indeed some women actively sought help from the medical and psychiatric establishment. It seems that women from more educated backgrounds may have been more likely to seek help, perhaps because they had more faith in professional expertise. Most women who voluntarily sought help received some kind of psychotherapy from a range of practitioners, including psychiatrists. Some wanted an explanation of their sexual desires, others wanted help to be 'normal' and 'overcome homosexual tendencies' because of feelings of guilt and shame. These women presented to services in distress and despair because of struggles with their sexual orientation, isolation and social ostracism.

The emerging picture is ambiguous as the archives yielded both positive and negative accounts of psychiatric practice. Unfortunately some mental health professionals colluded with the view that lesbian sexual desire could and should be 'treated'. For example, the London based psychiatrist Clifford Allen argued in 1965 that female homosexuality 'is a sexual neurosis and is just as treatable as any other neurosis' and claimed to have 'cured' a number of female patients through psychotherapy. We found unpublished data from the Maudsley hospital in South London in the mid 1970's that suggested that small numbers of women were treated for 'sexual deviation' as their 'primary diagnosis'. Whilst we do not know whether any of these women received aversion therapy, we do know that the Maudsley Hospital administered this treatment to gay and bisexual men and, because of this, was the target of Gay Liberation Front (GLF) activism in 1972.

There are a small number of documented instances of aversion therapy using electric shock or chemical emetics being given to same-sex attracted women. For example, four cases of 'anticipatory avoidance therapy' were recorded at Crumpsall Hospital in North Manchester between 1962 and 1967 (MacCulloch and Feldman 1967; Feldman and MacCulloch). This was a variant of aversion therapy, involving mild electric shocks, pioneered by psychologists in the hospital's department of psychiatry, with the full support of the medical director. We found at least five other examples of women receiving aversion therapy elsewhere in the 1960's. Whilst these were often reported as 'successful' in the literature, women reported that it made them feel 'terrible' for months, and that although it resulted in them not being able to act on their attraction to women, at least for a period of time, it did not make them more attracted to men. We also found an unverified account of a woman dying by suicide following aversion therapy in a hospital in the North East of England. Unusually, we identified three examples of women treated with lysergic acid (LSD) in the 1950's and 1960's to 'overcome their sexuality'. These were administered as experimental treatments in Newcastle, London and Leicester based hospitals. We also found isolated

examples of a woman receiving Deep Insulin Coma Treatment to treat her sexuality in the 1950's; a woman who was threatened with psychosurgery in the 1950s; and another who was threatened with electro-convulsive therapy. A number of accounts describe women being treated punitively to induce shame because of their sexuality when they were psychiatric in-patients, including being segregated from other female patients.

However, we also discovered positive examples of mental health professionals supporting women to accept their sexual orientation, rather than to try and change it. For example, one woman was treated by a female psychiatrist at the Tavistock Hospital in London following a suicide attempt and vividly remembered her saying: "You must remember it is natural for you...People who are left-handed and who are forced to write with their right hand usually develop a stutter...and you are sexually left handed". In addition, there were examples of women being encouraged to form relationships with other women and to attend venues and groups where they might meet other women. The lesbian organisation, the Minorities Research Group (MRG) reported having had patient referrals from psychiatrists and even saw psychiatry and other mental health professionals like psychiatric social workers as potential allies in supporting the idea that lesbians were psychologically 'normal'. There are also reports of sympathetic and supportive psychiatrists published in MRG's *Arena 3* magazine, such as Dr. Stanley Jones who was quoted as saying 'attempted "treatment" can only be described as a moral outrage'.

Despite the examples in the archives, it is largely impossible to find out how many women were subjected to treatment for homosexuality. The cases we have identified may be rare and it appears that the majority of same sex attracted women did not seek or receive treatments for their sexuality. Despite this, there are likely to be more examples of other women who did. We were unable to access any hospital records from Crumpsall Hospital, which we know administered aversion therapy to many men and at least a few women and are only able to report on what we found recorded in LGB&T and women's archives. These archives are unlikely to include those who stayed in the system or who never 'came out'. The woman who received Insulin Coma Treatment was recorded as saying 'I wish there were a way of knowing how often this went on', and continued, 'the most dreadful thought that will stay with me is that many young lesbians who were given cures for their lesbianism never left these institutions.'

Historical research can be a way to honour these women's experiences. The effects of these treatments were often long-term, with many lesbian, gay and bisexual people understandably cautious and even fearful about using mental health services. These communities still live with the legacies of these experiences, whether or not they directly experienced them. Therefore, it is important to surface, understand and hopefully reconcile ourselves to this history in all its ambiguity -the negative treatments and the more positive experiences. Attention to such historical accuracy can help us avoid what Diana Rose (2016) has referred to as either a 'Whig history' (of psychiatric progress) or a 'reverse Whig history' (of psychiatric oppression). The relationship between

psychiatry, gender and sexuality is inevitably more complex than either type of history would suggest.

Despite treatment of female homosexuality being relatively uncommon, this history is still important, both to the individuals concerned, and to the history of both psychiatry and LGB communities. Practices like aversion therapy were not a standard psychiatric 'treatment' for same sex attracted women in England. However, leading psychiatric organisations did not officially challenge these practices either. Indeed professionals who 'pioneered' these treatments remained in prominent positions around the world for many years (King and Bartlett 1999). Moreover, the 'anticipatory avoidance' aversion treatment that was carried out on both men and women was exported and adopted elsewhere, especially in the United States (Sansweet 1975). Furthermore, it was only last year that the Royal College of Psychiatry issued an official apology for their part in these treatments. However, it is important to appreciate how individual practitioners were able to resist prevailing societal prejudices and act ethically and compassionately to support individuals, and indirectly, communities. It is worth pausing to consider how practitioners might be able to do this now, in our current context.

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