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‘Queer’ Treatments: giving a voice to former patients who received treatments for their sexual ‘deviations’.

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ABSTRACT

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 United Kingdom (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 65-90 years at interview. All reported that the treatments had been unsuccessful in altering their sexual desires or behaviour. Most sought treatment due 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 health care services and ensure that they are nonjudgmental and accepting of their sexual orientation and current gender.

KEYWORDS

Nursing history, nursing ethics, gay, gay history, queer, marginalized, gender reassignment surgery.

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 paper reports on a study which aimed to examine the experiences of patients and meanings attached to treatments of sexual deviations, in the United Kingdom (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 century (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's 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, destabilising the critical interpretative categories – of youth, masculinity and nationhood – within which narratives of sexual difference and danger were framed. When established notions of Britishness seemed threatened from every direction, queer urban culture was viewed as ever more dangerous, assuming a central symbolic position in the post-war 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 since 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', 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 of 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 health care 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 of 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, 1959). A number of papers 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 paper seeks to begin to make good this omission by exploring the experiences of individuals 'diagnosed' as mentally ill due 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 & Thompson, 1998). Face-to-face oral history interviews were conducted with all participants; these were audio-taped and transcribed for historical interpretation.

Sample

Purposeful sampling was utilised when selecting participants for the study (Boschma, Scaia, Bonifacio & Roberts, 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 utilised, 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 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 to 90 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 the present 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 due 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 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 65-90 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 due to 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, 'Yeab, 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 due 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 torture scene by the Gestapo in Nazi Germany - 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 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 special 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 treatments of sexual deviations in the United Kingdom (1949 – 1992), examining 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 and 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 ten 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 (Smith & Bartlett, 1999). Moreover, McConaghy (1976) concluded 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.

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 healthcare delivered by these future nurses. Rondahl (2009) explored twenty-seven GLBT patients' perceptions of their nurses' attitudes towards their sexuality. The patients reported a sense of insecurity regarding 'coming out' to nursing staff due 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 due to 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 nonjudgmental, 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 above. 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 on them in some way. It could be argued that the treatments described above 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 due to sexual deviance and clinicians'

experiences and constructions 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 their interventions have a sound evidence base and that they constantly reflect on the influence and intersection of science, societal norms and contexts. 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: Tommy Dickinson

Study design: TD, CH, JP, MC

Data collection and analysis: TD, CH, JP, MC

Manuscript preparation: TD & CH

Conflict of interest:

No conflict of interest has been declared by the author.

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