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“Prison will not cure a sexual perversion”

Sexology, Forensic Psychiatry, and their Patients in
Twentieth-Century Britain

However much one feels that the men should be severely punished, the fact remains that prison will not cure a sexual perversion.

*Nesta Wells, Police Surgeon in Manchester
from 1927 to 1954¹*

In the mid-1960s, as he approached his 70th birthday, Russell George found himself in Strangeways prison in Manchester awaiting trial for indecent assault. A prison sentence seemed likely due to his previous convictions, but thanks to the efforts of his barrister the court agreed upon an alternative solution: he would be released from prison into the care of his family and a probation officer, on condition that he received treatment with a psychiatrist to address his undesirable sexual behaviour. George saw a psychiatrist almost every day for a year, and although the process of treatment “wasn’t easy by God; it wasn’t easy at all”, he persevered until he could be discharged, no longer a risk to the public. Reflecting on his sexual crimes and his encounter with psychiatry, George wished that others “like me” could know that “it’s something there’s treatment for, that it can be cured”.²

At the time of his first offences in the late 1920s, medical treatment to “cure” someone like George was all but unheard-of in Britain. Indeed, the medical profession had been reluctant to engage with the subject of “sexual deviance” at all, choosing for the most part to dismiss the new field of sexology that had emerged from continental European medicine.³ This chapter addresses the initial

1 Nesta H. Wells: Sexual Offences as Seen by a Woman Police Surgeon, in: British Medical Journal 2/5109 (1958), p. 1404–1408, p. 1407.

2 Russell George’s story is recorded in Tony Parker: The Twisting Lane. London 2013 [1969], p. 13–43. “Russell George” was the pseudonym provided by Parker.

3 The term “sexual deviance” refers throughout to behaviour that was understood as such by doctors in the early twentieth century. This included sexual crimes, such as rape, indecent assault, homosexual acts between men, and indecent exposure, as well as more ambiguous acts such as cross-dressing and certain displays of fetishism or sado-masochism. This framing of deviance, without enforcing contemporary labels that may not have been historically meaningful,

aversion within mainstream British medicine to sexology, and the role of criminology and forensic psychiatry in the eventual shift in the 1920s from an attitude of condemnation to one of acceptance and modest interest. Of interest are the ways in which medical thought and practice was shaped by this relationship with criminology, as well as practical considerations surrounding treatment. These influences led to the adoption of diagnostic criteria that were clearly defined in order to identify the treatable sexual deviant but also heavily reliant upon the subjective assessment of the doctor and the performance of his patient. The final section of this exploration suggests some of the experiences and reactions to medicine of the objects of sexological enquiry: the sexually deviant themselves, who, like Russell George, suddenly found themselves classed as patients as a result of their sexual behaviour.

1 Sexology in Britain

Although the first outpouring of Western medical interest in sexual behaviour is commonly attributed to the sexologists of the nineteenth century, British doctors were noticeably reluctant to discuss the subject. The founding fathers of modern sexology were viewed with some suspicion by the medical press, ostensibly due to the “loathsome” nature of their subject matter. Krafft-Ebing’s *Psychopathia sexualis* was featured with hostility in the *Journal of Mental Science*, amidst fears that the “medical profession is in danger of pandering to the morbid tastes of men, and women also”. Concerned by the “details” included within the case studies, “which seem unnecessary in a scientific aspect”, the reviewer concluded angrily that although doctors did have to address unsavoury matters from time to time, “this does not grant a licence to supply an unlimited quantity of coprophagic literature”.⁴ In the *British Medical Journal*, Krafft-Ebing’s opus was simply “the most repulsive of a group of books of which it is the type”. Havelock Ellis’s *Studies in the Psychology of Sex* fared slightly better but was still said to contain “disgusting and nauseous” facts unbecoming of a medical professional to mention.⁵

is influenced by Laura Doan’s encouragement to consider sexual identities and acts in the past on their own terms. Laura L. Doan: *Disturbing Practices. History, Sexuality, and Women’s Experience of Modern War*. Chicago 2013.

4 H. R.: Review of ‘Psychopathia Sexualis’, by Dr. R. von Krafft-Ebing, in: *Journal of Mental Science* 37/156 (1891), p. 152–154, p. 154.

5 *Sexual Psychology and Pathology*, in: *British Medical Journal* 1/2145 (1902), p. 339–341, p. 339–340.

When one of his volumes became embroiled in an obscenity trial in London in 1898, not one doctor would speak in its defence in court.⁶

Freudian theories proved equally unpopular for many years, benefitting more from the interest of well-educated laypeople than medical curiosity or awareness.⁷ In the early twentieth century, discussions of psychoanalysis within the correspondence pages of medical journals were heated. The renowned psychiatrist Charles Mercier condemned Freud's work as "the new pornography" which,

teaches that medical practitioners should question and cross-question for hours together, day after day, for weeks and months, clean-minded men and pure-minded women upon the very subjects that clean-minded men and pure-minded women put behind them and refuse to think about. Sex, sex, sex, in its grossest aspect, is dinned into their ears for hours every day and every failure to elicit a confession is met by the suggestion of some new form of beastliness.⁸

Historian of medicine Roy Porter has suggested that psychoanalysis was slow to infiltrate Britain "due perhaps to Anglo-Saxon phlegm and distrust of naval-gazing",⁹ and strict obscenity laws may also have been a vital consideration; Havelock Ellis was not the only doctor to face censure for publishing on the subject of sex. The line between educative material and obscenity remained a fine one for the profession to tread with care well into the twentieth century.¹⁰ However, such impassioned disapproval from Mercier suggests that there was more to his reluctance to

6 Phyllis Grosskurth: Havelock Ellis. London 1980, p. 196–199. Those such as Ellis who did endeavour to research and publish on the subject of sexual deviance were largely "outsiders", on the periphery of the profession. See Lesley Hall: *The English Have Hot-Water Bottles: The Morganatic Marriage Between Sexology and Medicine in Britain since William Acton*, in: Roy Porter, Mikulas C. Teich (eds.): *Sexual Knowledge, Sexual Science. The History of Attitudes to Sexuality*. Cambridge 1994, p. 350–366, p. 363; and Lesley Hall: *Disinterested Enthusiasm for Sexual Misconduct: The British Society for the Study of Sex Psychology, 1913–1947*, in: *Journal of Contemporary History* 30/4 (1995), p. 665–686.

7 See Edward Glover: *The Social and Legal Aspects of Sexual Abnormality*. Institute for the Scientific Treatment of Delinquency. London 1947, p. 2; Dean Rapp: *The Early Discovery of Freud by the British General Educated Public, 1912–1919*, in: *Social History of Medicine* 3/2 (1990), p. 217–243; and Lesley Hall: *Hidden Anxieties. Male Sexuality, 1900–1950*. Cambridge 1991, p. 26.

8 Charles Mercier: *Psycho-Analysis*, in: *British Medical Journal* 1/2768 (1914), p. 172–173, p. 173; and follow-up correspondence in subsequent volumes, including T. F. Keenan, T. Claye Shaw, Charles Mercier: *Psycho-Analysis*, in: *British Medical Journal* 1/2770 (1914), p. 275–276.

9 Roy Porter: *Madness. A Brief History*. Oxford, New York 2002, p. 197.

10 See Hall: *Hidden Anxieties* p. 55; and Harry G. Cocks: *Saucy Stories. Pornography, Sexology and the Marketing of Sexual Knowledge in Britain, c. 1918–1970*, in: *Social History* 29/4 (2004), p. 465–484. Historians have also suggested that ideals of masculinity effectively silenced any acknowledgements that British men engaged in sexually deviant acts. See Sean Brady: *Masculinity and Male Homosexuality in Britain, 1861–1913*. Basingstoke 2005.

engage with sexologists. In his complaints, Mercier implied that the very nature of psychoanalytic practice, in which the “clean-minded” were encouraged to dwell upon unsavoury topics, would provoke some of the “beastliness” he so abhorred. This concern is echoed elsewhere: discussions of Krafft-Ebing maintained that although a doctor did need to be proficient in the difficult subject of sexual deviance, as little as possible should be written and circulated about it. Excessive detail was “to be deprecated in view of the probability of the book falling into the hands of lay readers”, a claim which suggests particular anxiety around the readership of such works.¹¹ Fears of the spread of sexual knowledge beyond the medical profession imply both a proprietary inclination over such knowledge, and a belief that the very mention of deviance might lead to its enactment.

By the 1920s concerns about crime and mental disorder meant that previously “loathsome” subjects could more freely find a suitable outlet for expression. It is not new to suggest that doctors used criminology or forensic psychiatry as a respectable shield to conceal their potentially controversial professional interests; historian Ivan Crozier has argued that this is precisely what some doctors of the late nineteenth century did in order to study and comment upon homosexuality, as in, for example, A. S. Taylor’s extensive *Manual of Medical Jurisprudence*. However, such texts and commentary were restricted to the analysis of physical evidence of a small number of criminal acts and did not address diagnosis, aetiology or adjustments in sexual behaviour in the same innovative ways as sexological texts.¹² Medical study of sexual behaviour in all possible variety had to wait for the “psychological and psycho-pathological method of enquiry” into the offender, floated in 1907 as a new but necessary approach, to take hold. As the “psychological point of view” gradually became better established as one plausible method for dealing with crime, doctors began to suggest that some sexual crime could have a psychological explanation that medicine could illuminate.¹³ The first independent research into sexual deviance began to appear in 1924 in British medical journals, and focused on the prevalence and diagnosis of mental disorder amongst those in trouble with the law for their sexual behaviour.¹⁴

¹¹ H. R.: Review of *Psychopathia Sexualis*, p. 154.

¹² Ivan D. Crozier: *The Medical Construction of Homosexuality and its Relation to the Law in Nineteenth-Century England*, in: *Medical History* 45/1 (2001), p. 61–82.

¹³ J. F. Sutherland: *Recidivism regarded from the Environmental and Psychopathological Standpoints*, in: *Journal of Mental Science* 53/223 (1907), p. 568–590, p. 570; and J. P. Sturrock: *The Mentally Defective Criminal*, in: *Journal of Mental Science* 59/245 (1913), p. 314–325, p. 315.

¹⁴ William Norwood East: *Observations on Exhibitionism*, in: *The Lancet* 204/5269 (1924), p. 370–375; and M. Hamblin Smith: *The Mental Conditions Found in Certain Sexual Offenders*, in: *The Lancet* 203/5248 (1924), p. 643–646.

Slowly but surely, these articles were joined by a growing body of work produced by doctors in Britain, continuing to examine sexual misconduct in relation to mental illness and borrowing heavily from those sexological works that had been condemned so vigorously two decades earlier.¹⁵

In this, prison doctors and other early exponents of forensic psychiatry played a key role, and none less than Dr. William Norwood East. East had joined the prison service of England and Wales in 1899 as a newly-qualified doctor, and rose steadily through the ranks to become the Senior Medical Inspector and ultimately a Prison Commissioner, one of the few men running prisons on behalf of the Home Office. He was only the second doctor to hold this office. Still, his appointment reflects the growing recognition of the importance of medicine in matters of penology. He published prolifically in medical journals from the 1920s until the end of the 1940s, lectured on psychiatry at the prestigious Maudsley Hospital, frequently advised the government on the management of offenders and was credited with writing the first British textbook on forensic psychiatry.¹⁶ In the award of a knighthood for his services to the study of criminal psychology in 1947, the mainstream status of Sir William Norwood East MD and his specialism was confirmed.

Dr. East had drawn attention to the importance of medical advice for the courts, noting in 1930 that “the mental condition of an accused person may be as relevant to the charge as any other item of evidence” and with adequate medical intervention, “there is reason to hope that a certain number of criminal careers may be checked”.¹⁷ The impetus did not come exclusively from doctors, however. In 1919 the judiciary in Birmingham requested extra medical assistance to improve their assessment and management of potentially disordered offenders, and in 1920 the Prison Commissioners began to record the number of requests that they received for reports into the mental health of an accused person. This rose from 1,611 in 1920 to a peak in 1953 at 5,218, far outstripping any rise in prisoner

15 These include William Norwood East: *An Introduction to Forensic Psychiatry in the Criminal Courts*. J & A Churchill. London 1927; *The Interpretation of Some Sexual Offences*, in: *Journal of Mental Science* 71/294 (1925), p. 410–412; M. Hamblin Smith: *The Psychology of the Criminal*. Methuen & Co. London 1933; J. A. Hadfield: *Some Aspects of the Psychopathology of Sex Perversions*, in: *Proceedings of the Royal Society of Medicine* 29/8 (1933), p. 1022–1023; J. R. Rees: *Prognosis in the Sexual Neuroses*, in: *The Lancet* 225/5825 (1935), p. 948–949; William Norwood East: *Sexual Offenders*, in: L. Radzinowicz, J. W. C. Turner (eds): *Mental Abnormality and Crime. Introductory Essays*. London 1944, p. 177–207; and F. H. Taylor: *Homosexual Offences and their Relation to Psychotherapy*, in: *British Medical Journal* 2/4526 (1947), p. 525–529.

16 Sir Norwood East, M.D., F.R.C.P., in: *British Medical Journal* 2/4844 (1953), p. 1050–1051.

17 Report of the Commissioners of Prisons and the Directors of Convict Prisons for the year 1930. H. M. Stationery Office. London 1932, p. 44 and p. 45.

numbers, and was driven in the main by judges, magistrates and lawyers pressing for greater medical information in cases where there was “reason to suspect mental infirmity”.¹⁸

The sexual offender remained a frequent feature of these enquiries. London magistrate Claud Mullins recollected that his interest in psychology had been prompted by the consideration of sexual offenders brought before him, and various official enquiries into the problems of crime and punishment were instigated by and dwelt upon concerns surrounding mental abnormalities among certain types of criminals in particular, especially the sexual offender.¹⁹ In 1934, a programme of experimental psychotherapeutic treatment was introduced at Wormwood Scrubs prison under Dr. East’s management, and during its first four years of operation fully half of its subjects were categorised for diagnostic and therapeutic purposes as sexual offenders.²⁰

By the late 1930s, as the publication of the results of medical treatment at Wormwood Scrubs approached, concern over the details of sexual deviance becoming too easily available to the curious layperson was uttered by an unnamed civil servant but swiftly rebutted by Dr. East: “the chief value of the report would be lost if the chapter about sexual offences is omitted”, he stated. “Sexual offences are those which the general public frequently regard as symptoms of mental abnormality requiring psychotherapeutic treatment rather than punishment”, and should therefore be presented in depth.²¹ The medical profession, as represented by this senior government employee, could now appear confident that, given its important criminological bearings, sexual deviance was a matter that medicine must discuss.

18 On the “Birmingham experiment” see Report of the Commissioners of Prisons and the Directors of Convict Prisons, with Appendices, for the Year Ended 31st March, 1919. H. M. Stationery Office. London 1919, p. 16–17; and Psychological Treatment of Crime 1933–1939, HO 45/18736, File 438456/37, The National Archives (London). For Prison Commission statistics, see Report of the Commissioners of Prisons and the Directors of Convict Prisons, with Appendices, for the year ended 31st March, 1920. H. M. Stationery Office. London 1920; Report of the Commissioners of Prisons for the Year 1953. H. M. Stationery Office. London 1954, et al. The final quotation is from the Report of Prisons, 1920, p. 17.

19 Claud Mullins: Crime and Psychology. Methuen & Co. London 1943, p. 66; Report of the Committee on Sexual Offences Against Young Persons. H. M. Stationery Office. London 1925, p. 5; Report of the Departmental Committee on Persistent Offenders. H. M. Stationery Office. London 1932, chapter XI.

20 As reported in William Norwood East, William Henry de Bargaue Hubert: The Psychological Treatment of Crime. H. M. Stationery Office. London 1939.

21 Psychological Treatment of Crime 1933–1939, HO 45/18736, File 438456/37, The National Archives (London).

2 Sexology and forensic psychiatry

British medical interest in sexual deviance was, therefore, afforded some legitimacy and had grown in self-confidence thanks to its relevance to criminological interests, specifically forensic psychiatry. Within this context, sexual deviance was reframed as sexual offending, although it continued to include diagnoses such as fetishism that were not illegal in and of themselves but were punishable if the sexual motive was thought to have inspired criminality of any kind.²² However, difficulties in reconciling legal and medical concepts of deviance, disorder and responsibility, to say nothing of contrasting medical views, created significant limitations for medicine. Disagreements often played out in the courts and could damage the already-uncertain reputation of that new specialist in the witness box, the psychiatrist. A 1936 editorial in the *British Medical Journal* affirmed slightly anxiously that it “is greatly to be desired from every point of view that doctors, lawyers, and legislators may come to some agreement” regarding sexual offenders, but when agreement between doctors proved elusive in high-profile and controversial cases, the foundations of medical expertise regarding sexual offences and mental disorder came under scrutiny.²³

The peculiarities of the British legal system played no small part in creating this precarious situation for the medical expert. Unlike the procedure in many other jurisdictions, in which a medical witness was summoned by the judge, the adversarial legal system meant that prosecution and defence lawyers would each call upon the doctor whose evidence best suited their case. In the case of Neville Heath, convicted of murder in 1946 and described as a sexual sadist, two prison doctors testified for the prosecution that he was indeed sexually deviant, but quite sane and responsible for his actions. His defence argued that he should be found guilty but insane, and a third doctor gave evidence to the effect that his deviance was the symptom of disorder which rendered him incapable of exercising self-control and understanding that his actions were wrong.²⁴ Such contradictory opinions on the question of sexual deviance and mental instability were

²² See, for example, Dr. East’s discussion of “plait-cutters” in William Norwood East: *Medical Aspects of Crime*. London 1936, p. 345.

²³ Children’s Moral Welfare, in: *British Medical Journal* 1/3937 (1936), p. 1261–1262, p. 1262.

²⁴ Macdonald Critchley: Neville George Clevely Heath, in: James H. Hodge (ed.): *Famous Trials* 5. London 1955, p. 55–106; and Neville Heath, HO 144/22872, The National Archives (London). Press coverage included Ronald Camp: *Doctors Clash on Sanity of Heath*, in: *News Chronicle*, 26 September 1946, and his conviction and execution also led to questions in Parliament regarding the qualifications of the doctors involved.

reported in great detail in the national press, and portrayed a profession that lacked clarity and consistency in its own ideas.

In fact, Dr. East was one of the doctors who reviewed Heath’s mental state, and carefully stated that although Heath was “a psychopathic personality of the sexual pervert type”, he did not fall into any of the categories of mental disorder set down in law that might render him ineligible for the death penalty.²⁵ Throughout his senior career with the Prison Commission, Dr. East had been aware of the potential for tension between medicine and law, and frequently reminded his colleagues of the need for sensitivity towards the demands of the justice system and for a modest view of medicine’s powers that would not cause consternation with judge and jury. In 1920, writing in the *Journal of Mental Science*, he criticised a tendency amongst doctors to recommend practices that would be “definitely antagonistic to public opinion and liable to abuse”, and would delay the administration of justice “without adequate compensatory diagnostic advantage”.²⁶ Again in 1939 he reminded an audience of Prison Medical Officers at their annual conference to be modest in their claims to knowledge since “as specialists we cannot make any claim to omniscience” and emphasised the need not only for “unswerving adherence to scientific truth” but also for critically “sound judgment” in all dealings.²⁷ No matter what the ideal procedures might be for identifying mental disorder amongst offenders, or what new theories might be circulating as to causes and cures of sexual offending, medical practice needed to avoid any hyperbole that might cause incredulity and concern for the future management of offenders, and to focus upon that which would appear both credible and useful in court.

Perhaps some of the views against which Dr. East protested were those of his colleague, Dr. Maurice Hamblin Smith, who argued that “the frequency with which one meets with instances of [sexual deviance] in mental work is amazing” and that a “very strong case exists for the routine investigation of all persons charged with ‘sex’ offences. There is general agreement that the incidence of mental abnormality in offenders of this class is very high”.²⁸ Irrespective of whether or not the medical profession could produce sufficient evidence for this, resources simply would not permit such frequent medical investigations, nor would the Home Office or the judiciary tolerate it, nor indeed was it supported by

²⁵ Neville Heath, HO 144/22872, The National Archives (London).

²⁶ William Norwood East: Some Cases of Mental Disorder and Defect seen in the Criminal Courts, in: *Journal of Mental Science* 66/275 (1920), p. 422–438, p. 425.

²⁷ The Modern Psychiatric Approach to Crime, in: *Journal of Mental Science* 85/357 (1939), p. 649–666, p. 654.

²⁸ Hamblin Smith: *The Psychology of the Criminal*, p. 123 and p. 178.

wider criminological thought.²⁹ Although British criminology itself was inextricably linked to psychiatry and prison medicine, it has been described as less theoretical and less ambitious in its claims than its counterparts overseas, given the close relationship between its researchers and the day-to-day workings of prison and court.³⁰ Within this context, all practitioners had to remain realistic and interventions to study and treat sexual deviance had to remain limited in number and scope.³¹

Efforts in Britain to cure sexual offenders of their disordered acts were, therefore, modest. Private clinics began to conduct research into the treatment of sexually deviant patients with psychotherapy in the 1930s, but even when the first fruits of their research began to appear in British medical journals in the 1940s, the fact that they were largely run by volunteers meant that their patients were few in number. One, the Institute for the Scientific Treatment of Delinquency, saw around 166 patients per year in the late 1930s, of which between a quarter and a half were classed as sexual offenders.³² The first government-sanctioned programme of research and treatment, in Wormwood Scrubs prison, provided psychotherapy to around 50–100 individuals a year, a figure that increased very little into the 1940s.³³ The psychiatric treatment described by Russell George in the 1960s only became possible in law with the Criminal Justice Act of 1948, which permitted psychiatric treatment to form part of a criminal sentence. Earlier experiments took place here and there at the behest of more daring magistrates and

29 Criminological writings drew attention to the lack of knowledge or interest in psychology amongst judges and magistrates and the limited facilities for treatment, which made a greater use of medicine impossible. Another review bemoaned the “mass of ill-digested thought and partial observation” regarding criminals, including that “which regards him merely as a psychologically sick man. He is usually quite an ordinary person”. E. Roy Calvert, *Theodore Calvert: The Law-breaker. A Critical Study of the Modern Treatment of Crime*. London 1933; and *Criminal Science*, in: *The Magistrate*. November/December (1940), p. 333–334, p. 334.

30 David Garland: *British Criminology Before 1935*, in: *British Journal of Criminology* 28/2 (1988), p. 1–17, p. 2.

31 For some considerations of alternative approaches to treating sexual offenders in other countries, see Nikolaus Wachsmann: *Hitler's Prisons. Legal Terror in Nazi Germany*. New Haven, CT, London 2004, especially p. 140–151; Gunnar Broberg, Nils Roll-Hansen: *Eugenics and the Welfare State: Sterilization Policy in Denmark, Sweden, Norway, and Finland*. East Lansing, MI 1996; Philip Jenkins: *Moral Panic. Changing Concepts of the Child Molester in Modern America*. New Haven, CT, London 1998.

32 Edward Glover: *The Diagnosis and Treatment of Delinquency, Being a Clinical Report on the Work of the Institute during the Five Years 1937 to 1941*. Institute for the Scientific Treatment of Delinquency. London 1944, p. 7–11.

33 Report of the Commissioners of Prisons and the Directors of Convict Prisons for the Year 1937. H. M. Stationery Office. London 1938, p. 86; East, Hubert: *The Psychological Treatment of Crime*.

doctors from the 1930s, but the numbers treated were negligible.³⁴ In short, although the medical profession could now discuss sexual deviance in its relation to crime and mental disorder, there was very little in place for a proactive approach.

Although treatment options eventually became more varied from the 1940s and more widespread in the 1960s, given the limited solutions presented by early twentieth-century forensic psychiatry and its restricted resources, psychotherapy was the only viable option available to doctors as they began to investigate the psychological treatment of sexual offenders. Despite the influence of Freudian theories and interest in the practice of psychoanalysis, the demands upon doctors’ time and the frequency of short prison sentences amongst their patients precluded the use of lengthy psychoanalytical methods. Psychotherapy in its simple form was the most common approach and was not without success.³⁵ However, as soon as psychotherapy became an officially-recognised possibility for prisoners in 1934, examples of sexual offenders who were unsuitable for treatment emerged in an effort to explain failed attempts at treatment and to clarify which offenders would be more responsive to medical attention. *The Psychological Treatment of Crime*, the report on the first four years of treatment at Wormwood Scrubs prison, featured large numbers of case studies to illustrate “features making psychotherapeutic modification impossible”, or individuals “quite unsuitable for treatment”. Its conclusions emphasised that psychotherapy could only help to prevent future offending if “the cases to which the treatment is applied are carefully selected”.³⁶

Efforts to explain the failures of treatment emphasised the complexities of the doctor’s role in determining who might benefit most from the limited treatments on offer. There were frequent concerns that those who were unsuitable might infiltrate treatment programmes and in so doing, escape more appropriate, punitive, efforts for their rehabilitation. Dr. East cautioned that, for this reason, the “psychological treatment of crime is not to be recommended lightly”.³⁷ To illustrate his point, he discussed an individual imprisoned for a “homo-sexual offence” who had been considered for treatment, but it became clear that “he appreciated the practical benefits that might accrue to him if he was regarded as

³⁴ See Probation at Mental Hospital. A Legal Experiment, in: *British Medical Journal* 1/4021 (1938), p. 260; and *Psychological Treatment of Crime 1933–1939*, HO 45/18736, File 438456/37, The National Archives (London).

³⁵ East, Hubert: *The Psychological Treatment of Crime*, p. 152.

³⁶ East, Hubert: *The Psychological Treatment of Crime*, p. 153.

³⁷ Report of the Commissioners of Prisons and the Directors of Convict Prisons for the Year 1936. H. M. Stationery Office. London 1937, p. 62.

an interesting psychological problem rather than as a man who had made no effort to counteract his weakness by his own efforts". Although he "ingratiatingly and plausibly expressed contrition for his offences and his realisation of his mental abnormality", this was determined to be false and the apparently devious offender was quickly returned to the normal prison regime.³⁸ Doctors were therefore required to discern between fraudulent and genuine cases for psychotherapy, protecting access to limited medical programmes and upholding the punitive element of the dominant response to deviance.

This emphasis upon the doctor's informed selection of the most appropriate candidates to receive treatment, and the need to appear confident and knowledgeable to a sometimes doubtful judiciary, led to the introduction of specific selection criteria for the treatable deviant. It naturally behoved the relatively new specialism of forensic psychiatry to emphasise the expertise and experience that its work entailed, but the criteria themselves were shaped as much by the practical difficulties of psychotherapy for offenders, and subjective assessments of an offender's performance with their doctor, as by any medical theories of aetiology and cure. Limited access to psychotherapy, its uncertain status as neither punishment nor guaranteed cure, and the requirement for patients to engage proactively in the process of psychotherapy itself, were all important considerations in selecting patients for treatment. However, these selection criteria were not seen as purely practical and became confused with diagnostic guidelines. Judgements about suitability for treatment were entangled with diagnoses of disorder and deviance, and at times a failure to meet the selection criteria was read as a sign of the presence of a specific type of disorder: namely, constitutional and incurable perversion.

3 Diagnosing deviance

The criteria for a potentially suitable sexual offender for medical treatment were widely agreed upon in the 1930s and largely codified by 1949 (figure 1).³⁹ Alongside the practical considerations of length of sentence and the presence or

³⁸ Report of Prisons, 1936, p. 63.

³⁹ Figure 1 is from Report of the Commissioners of Prisons for the Year 1949. H. M. Stationery Office. London 1950, p. 73. The same criteria appear in W. Calder: *The Sexual Offender. A Prison Medical Officer's Viewpoint*, in: *British Journal of Delinquency* 6/26 (1955), p. 26–40; and John J. Landers, D. S. Macphail, R. Cedric Simpson: *Group Therapy in H. M. Prison, Wormwood Scrubs. The Application of Analytical Psychology*, in: *The British Journal of Psychiatry* 100/421 (1954), p. 953–960.

absence of insanity, mental defect or organic brain disease sat several measures designed to root out the undeserving and thereby to protect treatment programmes from accusations of providing a route for offenders to avoid punishment. Exclusionary criteria of a lack of zeal and co-operation or an attitude suggestive of “ulterior motives” in seeking treatment addressed this directly and demanded a persuasive performance from the offender. Only those who could convincingly demonstrate a desire to undergo treatment in the genuine hope of curing their disorder could be accepted for psychotherapy, and any semblance of deception to obtain access to medical specialists or a lack of enthusiasm or participation in the process would transform even the most promising case from hopeful to untreatable.

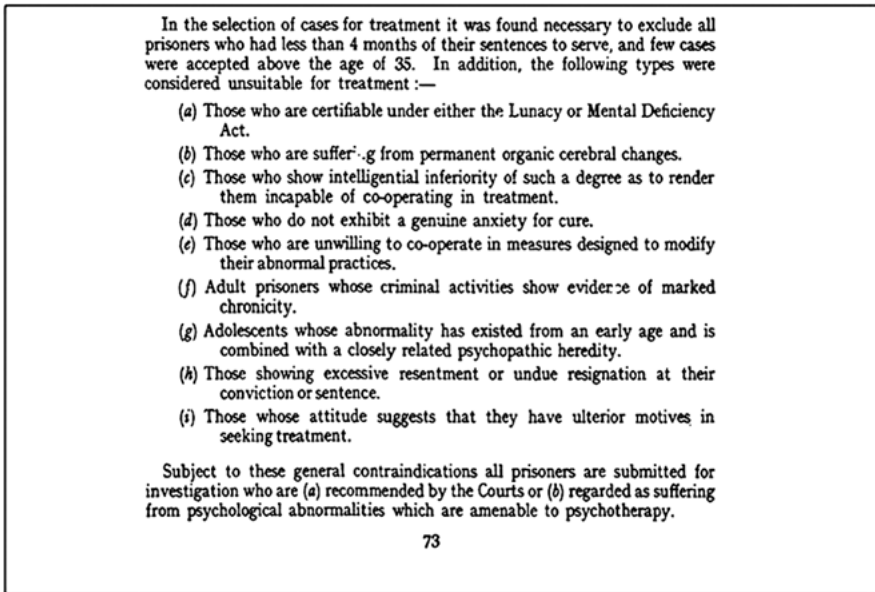


Fig. 1: Extract from the Report of the Commissioners of Prisons for the Year 1949.

However, from their origins as a method of apportioning limited rations of therapy, judgments from doctors regarding an honest desire for cure and a readiness to engage with medical processes involved determining the presence of treatable sexual disorders in the first place. The very fact of an offender displaying shame and disgust at their acts and earnestly requesting medical treatment were soon seen as a symptom of obsessional or circumstantial disorders that were thought to respond well to psychotherapy. In a collection of essays Dr. East asserted that “an obsessional patient usually admits and deplors his weakness”, and is prepared to

take steps to address it, “whereas a denial suggests shame for an act appreciated as disgraceful, and not regarded as pathologically excusable by the offender”. Implying that he would accept the offender’s judgement of whether or not his offence was pathological, he was confident that the obsessional patient, who could be identified by their desperation for cure, would indeed benefit from treatment.⁴⁰

In something of a vicious cycle, therefore, the offender’s performance of contrition, disgust and desire for treatment and cure had to be considered with a view to their suitability for psychotherapy in prison, but the performance also contributed to diagnosis, which in turn fed into beliefs about who could and could not be cured. This relationship played out in case studies from the 1930s and was re-enacted in the 1960s by Russell George. In the 1930s, sexual offenders who showed no desire to change were often categorised as “constitutional perverts” or “perverted personalities”, driven by something far more integral than an obsession or neurosis that could be eased by psychotherapy. Of one offender given as an example of the “sexually perverted personality”, it was said by his doctor that his “attitude was one of self-satisfaction” and “his co-operation would have been entirely negative if treatment had been seriously attempted”. It seemed that the very fact of his self-satisfaction contributed to his diagnosis as a “constitutional pervert”, and his possible lack of co-operation would have presented practical difficulties for psychotherapy.⁴¹ Similarly, another offender “considered that he was unjustly treated and was unable to appreciate the fact that his callous conduct was an affront to decency”, an observation that led his doctor to refer to an “abnormal sexual constitution” and a fixed “generalized moral abnormality” that defied current treatment options.⁴²

In the case of Russell George, although he initially felt that any medical interventions would be “pointless” and a “big waste of money”, his son persuaded him to support the suggestion from his lawyer that he should receive treatment instead of imprisonment. Devastated and suicidal following his brief experience of prison, George appeared far from self-satisfied or without remorse. He agreed to any and all of the conditions proposed and was prepared to pay for daily consultations with a psychiatrist, demonstrating his enthusiasm for cure through this considerable expenditure. Looking back after treatment, and possibly reflecting an understanding of deviance that he had acquired from his psychiatrist, he acknowledged that he had put “work, my job, my position, my family, my home” all “in the

40 East: *Medical Aspects of Crime*, p. 193. This is a reproduction of his 1924 essay on exhibitionism, reprinted in this collection with only one change: the addition of these comments. Apparently Dr. East’s diagnostic views had solidified in the intervening decade.

41 East, Hubert: *The Psychological Treatment of Crime*, p. 95.

42 East, Hubert: *The Psychological Treatment of Crime*, p. 118.

balance over and over again” in order to offend, as though his sexual deviance had been beyond his control. “Mad, I must have been mad”, he concluded.⁴³

Although the idea of sexual deviance as suggestive of mental disorder was alien to Russell George at first, an educated insight into the subject of sexual pathology was indicative of co-operation and a positive attitude towards change for doctors assessing potential patients in the 1930s and 1940s. One offender from the 1930s convicted of stealing women’s clothes to wear and classed as a sexual offender was said to be “concerned about his condition” and had “studied psychoanalytic literature in order to gain some insight”. Largely thanks to this, it was concluded that treatment “should prove of benefit to him in spite of his bad recidivist history”.⁴⁴ Another of “the sexually perverse constitutional type” had studied Jung and Adler, and was “co-operative in treatment and showed himself to be of good intelligence with the capability of obtaining a fair degree of psychological insight”. Despite his unpromising diagnosis, treatment was deemed as successful as it could possibly have been in the short time available.⁴⁵ This active interest, displayed through relevant reading and intelligent discussion with the doctor, was taken as a sign that offenders felt themselves to be the victims of illness, like Dr. East’s obsessional patient who detested his “weakness” and desperately hoped for change. Russell George did not mention any independent reading on the subject that he may have undertaken, but his level of general education and social status as an affluent retired engineer would not have caused his doctors to doubt his potential for gaining insight.

Intelligence as well as enthusiasm, therefore, was not simply a factor in assessing whether an individual would participate effectively in psychotherapy but could be read as an indicator of treatment’s success. It was, unsurprisingly, often conflated with education and class. An 18-year-old of limited schooling classed as a sexual sadist and said to have a “complete lack of experience in verbalizing his mental content” gave an unimpressive performance that led to a diagnosis of “mental subnormality” and rejection from the treatment programme.⁴⁶ In contrast, a freelance journalist who should have presented a challenging prospect, since he “showed strong evidence of a sexually perverted constitution”, turned out to be “extremely co-operative and developed considerable psychological insight in relation to his problems”. His prognosis was thought to be excellent.⁴⁷ Although the potential of group therapy for helping patients was

43 Parker: *The Twisting Lane*, p. 39–40 and p. 31.

44 East, Hubert: *The Psychological Treatment of Crime*, p. 124.

45 East, Hubert: *The Psychological Treatment of Crime*, p. 147.

46 East, Hubert: *The Psychological Treatment of Crime*, p. 121.

47 East, Hubert: *The Psychological Treatment of Crime*, p. 143.

recognised when it was introduced in the 1940s, since “many offenders who would be assessed as unsuitable for individual psychotherapy can be treated in a group”, the criteria for being transferred and accepted into the special unit at Wormwood Scrubs prison did not change.⁴⁸

In some cases a lack of co-operation contributed to diagnoses that ruled out treatment, while in other cases of offenders with a similar history, a display of education and insight could persuade the doctor that treatment would succeed. That these restrictions might favour the wealthy over the poor has not gone unremarked by historians who research the pathologisation of deviance.⁴⁹ The assessment of intelligence was one factor highlighted by Dr. Calder who observed that the “more intelligent, highly educated men who are most suitable for psychotherapy are apt to come from the higher income groups; the more dull and less literate men come as a rule from a less fortunate section of the community [...]. One law for the rich and one for the poor!”⁵⁰ An offender of good standing, free from any or many previous offences, stood at the opposite end of the medical and social scale to the hardened recidivist and was more likely to be recognised as medically treatable.

To explain sexual deviance amongst those of previously good character, doctors argued that an otherwise irreproachable individual could be driven to sexually perverted behaviour by a particular stressor. Such a case would be a good prospect for treatment, with no constitutional factors and an obvious potential for cure if the doctor could identify the particular cause. Dr. East described the case of a widower who had sent his daughter “on the streets so that he could view her relations with the men she took home”, but his explanation for such conduct was that the man had regressed to the “more primitive sexual aim” of “looking” after his wife’s death.⁵¹ This suggested a turn of events with its own logic and without a consciously unsavoury motive and positioned the case as one of recent, not chronic or constitutional, deviance. In another case study, Dr. East described “a man of middle age” who “was thrice found guilty of exposing himself”. Again, this was understood to have been precipitated by a particular event that removed the normal object of his sexual attention. Eighteen months before his offences his “wife after several years of happily-married life denied him

⁴⁸ Report of Prisons (1949), p. 80.

⁴⁹ For example, see Frank Mort: *Dangerous Sexualities. Medico-Moral Politics in England since 1830*. London 1987, especially the first section on the period 1830–1860; Joanna Bourke: *Rape. A History from 1860 to the Present Day*. London 2007.

⁵⁰ Calder: *The Sexual Offender*, p. 35.

⁵¹ East: *The Interpretation of Some Sexual Offences*, p. 421.

any further access”.⁵² Psychological disorder such as a sudden regression or neurosis could thus explain the normally respectable man’s offence without directly challenging his character or morals.

The best candidate for treatment was, therefore, identifiable through his intellect and attitude towards his offence. Practically speaking, doctors could not offer treatment to all sexual offenders, and nor did their early efforts suggest that this would prevent future crime in all cases, since so many offenders appeared “unsuitable” for treatment. Exclusionary criteria were founded upon the requirements of individual psychotherapy and the need to identify only the most promising prospects for treatment, but they were also blurred with diagnoses of untreatable “constitutional” disorder on the one hand, and obsessional or neurotic problems on the other. By the mid-1960s and Russell George’s sixth trial, his status as a wealthy and well-educated widower with no history of other criminality or perversion and his dedication to the prospect of treatment and cure would have assisted his case for psychiatry instead of prison and would have persuaded the medical profession of his suitability and diagnosis as well. Medicine may have attained some confidence in dealing with sexual deviance, but diagnosis had been shaped, if not distorted, by the demands of treatment within the criminal justice system and subjective assessments of patient personalities.

4 The patient

One aspect of this story is still to be uncovered: the experience of receiving medical treatment to change sexual behaviour. Interpreting this is not without problems, not least of which is the fact that articulate and often affluent men, especially writers, whose same-sex attraction constituted their offence and who encountered medical interventions from the 1950s onwards, are vastly over-represented in the existing sources. The opprobrium still connected to other forms of sexual deviance has silenced many. Added to this is the fact that any accounts of patient experiences do not offer unmediated access to its realities but are as carefully constructed and widely influenced as any other form of writing.⁵³ Nor can we untangle here the complex relationships between medical practices and diagnoses, and the views of patients about their own sexual behaviours and

⁵² The Interpretation of Some Sexual Offences, p. 421; An Introduction to Forensic Psychiatry in the Criminal Courts, p. 307–308.

⁵³ Angela Woods: Rethinking “Patient Testimony” in the Medical Humanities. The Case of Schizophrenia Bulletin’s First Person Accounts, in: *Journal of Literature and Science* 6/1 (2013), p. 38–54.

identities. As a result of these difficulties and many more, generalisations are impossible. However, some of the opinions, thoughts and reactions of a small number who encountered medicine as treatment for sexual deviance serve here as a reminder of the human side of sexological innovation.

From the 1930s, individuals received medical advice or treatment in relation to their sexual behaviour from a variety of sources, and reported an equally wide range of impressions of the medical profession. General practitioners, often the first point of contact for those who worried privately about their sexual behaviour, did not impress and often seemed to their patients “perplexed by their disclosure” and to have “little empathy for their patients’ situation”.⁵⁴ One reacted to his young patient’s concerns about same-sex attraction with an abrupt “Don’t be stupid”, dismissing him on the grounds that he would “grow out of it” and leaving him “utterly miserable”.⁵⁵ Some psychiatrists and nurses also provoked great distress in patients who were stunned by their lack of compassion, to the extent that they struggled to find the words to convey their shock, even decades later.⁵⁶ Others were more circumspect in their reactions. Wilfred Johnson, in prison for sexual assault, had signed up to see “the doctor from the Home Office” but was taken aback by the individual he met. Doubtful of his doctor’s professionalism, Wilfred pondered that you “wonder where they get some of them from, don’t you? To my mind he wasn’t like a doctor at all”.⁵⁷ Equally bemused on first meeting his psychiatrist was Russell George, who reflected that he “didn’t know at all what to make of him”. He explained that he had “never met one before” but concluded that his must have been typical: “I gather they’re all pretty much the same”.⁵⁸

Some medical professionals were remembered positively, such as the “young student nurse” who “was fantastic; we had such a laugh together [...] I used to do impressions of the Matron, and we would be rolling about laughing”.⁵⁹ Tellingly, the nurse was remembered for having offered an escape from treatment by assisting her patient in lying about its success. A pragmatic approach was also

54 Tommy Dickinson et al.: “Queer” Treatments. Giving a Voice to Former Patients Who Received Treatments for Their “Sexual Deviations”, in: *Journal of Clinical Nursing*, 21/9–10 (2012), p. 1345–1354, p. 1349. This view echoes the impression of GPs in Lesley Hall: “Somehow Very Distasteful”: Doctors, Men and Sexual Problems between the Wars, in: *Journal of Contemporary History* 20/4 (1985), p. 553–574.

55 Pete Price, Adrian Butler: Pete Price. NAMEDROPPER. Liverpool 2007, p. 33.

56 Dickinson et al.: “Queer” Treatments, p. 1350.

57 Parker: *The Twisting Lane*, p. 51.

58 Parker: *The Twisting Lane*, p. 32.

59 Tommy Dickinson: *Mental Nursing and ‘Sexual Deviation’. Exploring the Role of Nurses and the Experiences of Patients, 1935–1974*. dissertation, University of Manchester 2012, p. 248.

appreciated within Wormwood Scrubs, where Rupert Croft-Cooke, convicted of gross indecency, came to enjoy his conversations with an “intelligent-looking little man”, the visiting psychiatrist, who expressed sympathy for his position and debated the state of the law with him instead of proposing or even discussing any form of cure.⁶⁰

When it came to medical treatment in prisons, the most common critique was that the nation laboured under a sad delusion regarding its existence. Rupert Croft-Cooke took stock of the situation at Wormwood Scrubs and reported that “there were a few men in a psychiatric ward in the hospital, the only one among all the prisons in the country”. He reflected that when “judges promise treatment in prison to unlucky sex offenders given long sentences they do not perhaps realize that there is one psychiatrist to twenty-five thousand prisoners”.⁶¹ Similarly, the authors of *The Truth about Dartmoor* reflected upon the case of a fellow prisoner whose hobby, they said,

had been cutting the posteriors of small boys. Such peculiarities in England are considered as crimes, not diseases [...]. When judges blandly tell such men, ‘you will be treated in prison; you should be cured by the end of your sentence’, do they realise that the number of psychiatrists employed by the Prison Commissioners is – just one? And that one is permanently stationed at Wormwood Scrubs.⁶²

The anonymous author of *Prison and After: The Experience of a Former Homosexual* also agreed that at “no time during my imprisonment was there any reference to the psychological treatment promised by the Judge”, and that it was in fact “an illusion – one, I may add, that is still widely held in judicial circles”.⁶³ Journalist and former prisoner Peter Wildeblood similarly concluded that at “Wormwood Scrubs, which is so often pointed out as a centre for the psychological treatment of offenders, the facilities for such treatment were not so much inadequate, as virtually absent”. He reported meeting “many men who had been told by judges that they were being sent for three, or five, or seven years to a place where they would be properly looked after” but that “nothing whatever was being done for them. Out of 1,000 prisoners at the Scrubs, only 11 were receiving psychiatric treatment at the time I was there”.⁶⁴ The contradiction between the beliefs in public circulation and the realities of patient experiences in prison was

60 Rupert Croft-Cooke: *The Verdict of You All*. London 1955, p. 121–124.

61 Croft-Cooke: *The Verdict of You All*, p. 221–222.

62 George Dendickson, Frederick Thomas: *The Truth About Dartmoor*. London 1954, p. 167.

63 ‘J. D.’: *Prison and After*, in: *The Howard Journal of Criminal Justice* 9/2 (1955), p. 118–124, p. 121.

64 Peter Wildeblood: *Against the Law*. London 1959 [1955], p. 186–187.

felt to be stark and was no doubt a reflection of the limited means for treatment and the rigorous criteria for inclusion under which doctors largely operated.

A handful of male prisoners did receive treatment, but they were a minority. By the 1960s, Wilfred Johnson had embraced the belief that his indecent assaults may be symptoms of disorder, describing it as a “kind of illness almost that you’re suffering from, it descends on you, it’s like a malady come upon you”. However, when he asked to see the specialist doctor in prison, the reaction from the psychiatrist was to ask: “Why haven’t you tried to get treatment for yourself while you were out, instead of waiting till now?” He abruptly told Johnson that “there’s no treatment we can give you, so you’re wasting my time”, upsetting his potential patient greatly.⁶⁵ Perhaps Johnson was insufficiently convincing in his performance of contrition and desire for cure, perhaps the psychiatrist suspected a constitutional perversion, or perhaps resources were simply too limited for treatment to be attempted. This experience was echoed by Norman, who had a large number of convictions for assault and rape. Upon arriving in prison for the first time, he reported that he “asked for treatment or help of some kind, but I was told there wasn’t any, it was up to me to go and see a doctor myself when I got out”.⁶⁶

Some, including Russell George, ultimately accepted treatment only as an alternative to prison. “Nobody ever suggested to me I ought to try and do something about it, have treatment or something like that – but if they had, I wouldn’t have paid attention to them”, he admitted of his younger self. He remembered thinking of his sexual assaults as “just a little fault I had, nothing serious, not even worth talking about”.⁶⁷ Another man feared prison because “if the other inmates found out what I was in there for, well, I just thought they would kill me”. Of treatment he said that “I knew it was not going to make me straight, I didn’t want it to, but it seemed a better option than prison”.⁶⁸ Indeed, Russell George’s account is rather an exception given his description of treatment while on probation as being helpful. Trevor Thomas’s psychiatrist was “a Freudian, unfortunately for me. If he’d been Jungian he’d have probably said, go your way”. He struggled to convince himself that he was cured as it would “solve a lot of professional problems” and make others happy, but it proved so fruitless that his psychiatrist simply gave up.⁶⁹

⁶⁵ Parker: *The Twisting Lane*, p. 51–52.

⁶⁶ The Fryng-Pan. *A Prison and its Prisoners*. London 1970, p. 181–182.

⁶⁷ Parker: *The Twisting Lane*, p. 31 and p. 39.

⁶⁸ Dickinson et al.: “Queer” Treatments, p. 1349.

⁶⁹ Jeffrey Weeks, Kevin Porter: *Between the Acts. Lives of Homosexual Men 1885–1967*. London 1998, p. 85–86.

Others, in contrast, were concerned that the option of treatment while on probation was a neglected opportunity. Wilfred Johnson reflected regretfully that at the time of his first conviction, in 1945, “they didn’t seem to be even thinking of probation at all for my sort of case”.⁷⁰ Richmond Harvey bemoaned the case of someone he met in prison, a clergyman with convictions for “offences against boys”: “Despite Counsel’s plea that the accused was prepared to enter a home and undergo any form of treatment that medical science might prescribe”, he was “packed him off to a gaol for another four years, to live the life of an ordinary prisoner, and to return to the world with his impulses unchecked”.⁷¹ To fellow-prisoner Harvey he seemed to be in need of medical treatment, but whether medical advice or a judge’s opinion was the deciding factor in the final decision, he was not seen as a suitable candidate for anything other than traditional punishment.

Others were sufficiently disillusioned after volunteering for treatment that they resorted to lying to put an end to it. One recalled the “eureka moment” in which he realised that this would be possible. He wondered, “how do the doctors actually know what I’m thinking?”, and then “knew I would have to start lying about my feelings if I ever wanted to get out”.⁷² Another simply said that he had “lied, and told them that it had worked”, and was discharged shortly afterwards.⁷³ The fact that patients felt the need to deceive doctors and that they also felt able to do so suggest that, for some, the idea of medical expertise quickly became unconvincing and could easily be overcome. It seems possible that some patients within prisons performed equally convincing displays of cure, potentially distorting medical research and theories of types of disorder and their susceptibility to treatment.

While physical therapies provoked the strongest reactions, even psychotherapy could inspire unhappy memories. After release from prison following a conviction for “importuning”, Nat Burke was persuaded by the managers of his hostel to “go and try treatment as an out-patient at a psychiatric clinic”. Years before, he had been “given pills to subdue my sexual instincts” which led him to be doubtful that medicine had anything more to offer, but he decided to try and was sent to a “Jesuit psychologist, who ran a psychiatric clinic attached to a church in south London”. This therapist, Burke recalled, told him repeatedly that all he was “just a dirty little boy”. “Every time I saw him”, Nat reported, “he hammered away at this theme, telling me to repent and give up my ‘unnatural’

⁷⁰ Parker: *The Twisting Lane*, p. 55.

⁷¹ Richmond Harvey: *Prison from Within*. London 1937, p. 261.

⁷² Dickinson: *Mental Nursing and ‘Sexual Deviation’*, p. 250.

⁷³ Dickinson: *Mental Nursing and ‘Sexual Deviation’*, p. 248.

practices". Nat was so distressed by this experience that he "ran away, I literally ran away from his church one night after seeing him". Having lost his hostel place he lived on the streets and it was many years before he could seek treatment again, ultimately for alcoholism.⁷⁴ Others experienced psychoanalysis as unsatisfactory, although less traumatic. Thomas Worsley found it "on the whole a disappointing experience. I expected too much, no doubt; I certainly didn't find a solution, much less a cure".⁷⁵ Thomas Trevor concluded that it "didn't work of course. Fortunately".⁷⁶ One anonymous man found it a "long and painful experience" costing "considerable effort and expense", which in the end failed entirely.⁷⁷ For some, there may have been benefits, but medical treatments were primarily remembered negatively.

Whether or not those who were seen as sexually deviant believed that a cure was possible or even desirable, engaging with the medical profession was commonly a fraught experience. In some cases, treatment was physically painful and for others, emotionally wrought. Medical staff was described as unsympathetic and unhelpful, easily fooled, arrogant, hypocritical, cruel, confused and incapable, but also at times as gifted and compassionate, charming, clever, funny, tolerant and kind. Treatment was both actively sought and imposed in situations of limited choices or capacity for consent, lasting from a few days to years and incorporating most of psychiatry's arsenal. Some patients were grateful, others resentful, and some felt that they were still suffering the after-effects decades later.

The late adoption of the study of sexual deviance, its roots in criminology and its limited resources ensured that the theories and practices of doctors in Britain were restricted in scope, focused upon determining who in the criminal population could *not* be successfully treated, and prone to confusing practical and diagnostic considerations. For each patient like Russell George who happily announced their cure, many more were deemed ineligible for medical attention or dismissed as incurable. Of those few who were treated, the extent to which their performances of contrition, co-operation, intelligent insight and even cure shaped medical theories poses questions about the foundations of contemporary understandings of disorder and deviance. However, the very fact that medical treatments were offered, and that some wholeheartedly believed themselves to be ill because of their sexual behaviour, indicates the extent to which sexological theories had been able to take hold in Britain by the mid-twentieth century.

74 Parker: *The Twisting Lane*, p. 129–130.

75 T. C. Worsley: *Flannelled Fool. A Slice of Life in the Thirties*. London 1967, p. 211–212.

76 Weeks, Porter: *Between the Acts*, p. 65.

77 'J. D.': *Prison and After*, p. 122.

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