2022

Aversion therapy for homosexuality in scientific historical context

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Introduction

This is a brief survey of the use of aversion therapy to “treat” homosexual behavior. It focuses particularly upon the period 1970–1980, which corresponds to President Dallin H. Oaks' tenure as president of Brigham Young University (BYU).

What is "aversion therapy"?

Aversion therapy is a group of techniques intended to help control unwanted behavior, a type of “behavioral therapy”. The basic idea is that an undesired behavior is paired with something unpleasant. Due to conditioning, the animal or person receiving the therapy comes to associate the unwanted behavior with the unpleasant experience, and thereafter avoids the unwanted behavior.

A simple example would be of a cat that jumps onto a kitchen counter. Many pet owners will spray the cat in the face with a squirt bottle. The cat is not harmed by the water, but does not like it—and so eventually learns not to jump on the counter. (Many pet owners can report that the cat soon avoids the counter—at least when its owner is around to apply the squirt bottle!)

What were the origins of aversion therapy?

One recent history says:

> Aversion therapy was a post-war subdivision within a set of psychological and psychiatric treatment methods grouped under the term ‘behaviour therapy’. Behaviour therapy was an elaboration of classical reflex conditioning developed by the Russian physiologist Ivan Pavlov in the early decades of the 20th century and further investigated by his American contemporary, John B. Watson.[1]

Why did behavior therapy and aversion therapy arise?

Psychiatric practice drew heavily on Freudian theory prior to World War II. Freud saw mental illness and some other behavioral difficulties as evidence of delayed psychosexual development.

[1] Kate Davison, "Cold War Pavlov: Homosexual aversion therapy in the 1960s," *History of the Human Sciences* 34/1 (2021): 92.

Freudian psychoanalysis and other "psychodynamic" talking cures were lengthy, expensive, labor-intensive, and not terribly helpful for many issues. There was also a growing recognition that Freud's claims were unscientific, or difficult to assess with scientific tools.

Researchers were seeking better methods to help patients that would be quicker, more effective, and more easily studied scientifically.

Behaviorism was appealing because, unlike Freudian theory, one did not need theories about what went on "inside the mind."[2] (One early theorist, John B. Watson, "denied completely the existence of the mind or consciousness"![3])

Even for those who did not go so far, there was little worry about the subconscious, or the Oedipus complex, and so on.[4] One could simply study a stimulus (the aversion) and the resulting behavior. Both of these were external, and thus open to scientific observation.

Sexual orientation: changing vocabulary and concepts

How did Freudian theory impact behavioral therapies?

Many psychoanalysts believed that

> that sexual habits, orientation, and psychosexual structure were not rigid. They believed that 'a variety of methods could allow *some* patients to have heterosexual desire … or significantly reduce or practically eliminate the appeal of the same sex for at least some time'.[5]

[2] For a summary of the Freudian position, see Charles W. Socarides, "Scientific Politics and Scientific Logic: The Issue of Homosexuality," *Journal of Psychiatry* 19/3 (Winter 1992): 318–320.

[3] Matt Jarvis, *Theoretical Approaches in Psychology* (Routledge: London and Philadelphia, 2000), 14. Perhaps unsurprisingly, Watson eventually left research and went into advertising.

[4] Joel Fischer and Harvey L. Gochros, *Handbook of Behavior Therapy with Sexual Problems*, 2 volumes (Pergamon Press, 1977), 1:xliv." [B.F.] Skinner believed that we do have such a thing as a mind, but that it is simply more productive to study observable behaviour rather than internal mental events" (Jarvis, 17).

[5] Davison, "Cold War Pavlov," 96, italics in original.

As the previous citation demonstrates, our ideas and even vocabulary about sexual orientation has changed considerably since World War II. It is important to understand how words were used at the time they were used, so we do not misunderstand what scientists were saying.

In 2022, most people believe that each individual has a "sexual orientation"—a fixed, life-long pattern of sexual attraction that is largely resistant to change.

We lose sight of how recent an idea and terminology this is.

What did "sexual orientation" mean during the 1970s?

There was considerable flux in terms at this period. As late as 1984, researchers complained that different scientists used the terms "homosexual" and "sexual orientation" in different ways.[6] Some used it to refer only to behavior. Other used it to refer to inner desires. Others used it to describe the origin of feelings and desires, and so on.

In the mid-1970s, one gay rights group preferred that people refer to "sexual orientation," because they said it reflected what people *did*, not simply what their desires were:

> 1. The term "affectional or sexual preference" is defined…as "having or manifesting an emotional or physical attachment to another consenting person or persons of either gender, or having a preference for such attachment." This is vague and appears incomprehensible. …"Sexual orientation" defined in some existing legislation as "choice of sexual partner according to gender") is at least quickly comprehensible, and *more clearly encompasses homosexual behavior*.
>
> 2. It diverts attention from the real source of homosexual oppression—the fact that we engage in sexual acts that are forbidden and criminal in our society. Neither *homosexuality* per se nor *homosexual lifestyles* are illegal in any state in the United States; it is certain kinds of acts that are illegal. …
>
> 4. It tends to obscure the reality…that *human sexual behavior* falls on a continuum between those who are exclusively heterosexual and those who are exclusively homosexual. …
>
> This language both trivializes and obscures the struggle that gay liberationists are involved in: to argue and insure [sic] that *sexual acts* committed between consenting partners should not be punished.

[6] Michael G. Shivley, Christopher Jones, John P. De Cecco, "Research on Sexual Orientation: Definitions and Methods," *Journal of Homosexuality* 9/2–3 (1984): 132–134.

> 6. It represents a concession to the prevailing heterosexual view that sex is good and justifiable only when it is complemented by "love." Equal rights must be extended to homosexuals regardless of whether or not they are emotionally or physically attached to another person.[7]

As one author noted:

> For this advocacy group, "homosexual orientation" "more clearly encompasses homosexual behavior." Using their preferred term focuses on "sexual acts that are forbidden," rather than focusing on "homosexuality per se" "nor [even] homosexual lifestyles." Instead, it highlights that "certain kinds of acts are forbidden," and since "human sexual *behavior* falls on a continuum," they wish "that sexual acts … not be punished." The term further avoids "a concession … to the view that [the] sex [act] is good … only when … complimented by 'love'."
>
> [Thus] in 1975–1977 … a pro-gay group saw "homosexual orientation" and "sexual preference" as quite different things. The former was primarily concerned with behavior, not desire.[8]

The "Kinsey scale" had been published in 1948, and did not see "sexual orientation" in the same sense that we use the term today.[9]

> In 1980 [one] author argued that Kinsey's work demonstrated that "sexual orientation fluctuates, surely over a lifetime and, for some people, as often as the weather." As evidence, he cited Kinsey's claim that "Some males may be involved in both heterosexual and homosexual activities within the same period of time. … even in the same day. … Males do not represent two discrete populations, heterosexual and homosexual."[10]

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[7] David Thorstad (editor), "Sexual Preference vs. Sexual Orientation," *Gay Activist* 6/1 (New York, NY; March 1977): 3, italics added, underlining in the original. Though published in 1977, the official statement was "adopted … in early 1975" (3); cited and footnote reproduced with permission from Gregory L. Smith, "Feet of Clay—Queer Theory and the Church of Jesus Christ," *Interpreter: A Journal of Latter-day Saint Faith and Scholarship* 43 (2021): 204, https://journal.interpreterfoundation.org/feet-of-clay-queer-theory-and-the-church-of-jesus-christ/.

[8] Smith, "Feet of Clay," 204.

[9] Kinsey, WB Pomeroy, CE Martin, *Sexual Behavior in the Human Male* (Saunders: Philadelphia, 1948).

[10] Smith, "Feet of Clay," 205, citing John P. De Cecco, "Definition and Meaning of Sexual Orientation," *Journal of Homosexuality* 6/4 (Summer 1981): 57 who in turn is citing Kinsey (1948), 29, 61, 63–64, italics in original, underlining added.

> This author went on to argue that "homosexual orientation" is actually a cluster of traits including "physical sexual activity," "interpersonal affection," and target of "erotic fantasy." Choice of label was more frequently based upon "physical sexual activity, either as behavior or desire."[11] Significantly, he concluded, "Sexual orientation is one of the few areas of human behavior in which biology is *not* destiny." This is the furthest thing from today's "sexual orientation," which most see as innate and unchanging, and unrelated to acts.

It is thus not surprising to see early behaviorists remark that "The Kinsey rating has the merit that it conceives of homosexuality as a graded form of behaviour and not as something which is present in an all or none manner."

Was aversion therapy intended to "change sexual orientation"?

Because of the varied vocabulary and meanings given to it, this is not as easy a question to answer as we might think. If researchers were not working with the idea that a fixed, life-long orientation existed—and many were not—then they can hardly have been trying to change it, even if that is what the long-term success of their experiments would have amounted to. As one historian of the period said, with the behaviorists

> a further innovation was to separate orientation from behaviour, suggesting it might be possible to condition patients' sexual behaviour in a heterosexual direction irrespective of whether their inner emotional and erotic orientation changed.[12]

Aversion therapy, then, was often not ultimately concerned about whether homosexuals had a fixed "orientation" toward their own sex or not. It was intended to help the patient control unwanted behaviors.

Behaviorism didn't care so much about what was "inside" a patient—its practitioners were focused on outward acts.

An early example discusses how behavior was "reinforced by [the patient's] first homosexual experiences, a learned pattern thus being established."[13] Another early behaviorist approach saw

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[11] De Cecco, 63.

[12] Davison, "Cold War Pavlov," 96.

[13] Basil James, "Case of Homosexuality Treated by Aversion Therapy," *British Medical Journal* (17 March 1962): 769.

"homosexuality as a learned behaviour pattern and not as a disease."[14] One early researcher emphasized in a lecture that with aversion therapy "sexual orientation is not changed, but increased awareness of feelings is developed, giving the client greater choice in the expression of these feelings."[15]

A later example from 1974 tells how researchers rejected the idea that homosexuality was a disease, but likewise argued that it was not something "constitutional," or innate: "Conceptions of homosexuality as a sickness or as a constitutional personality type were discounted." Instead, "the therapist gave the client an account of homosexuality as a *learned pattern of behavior*."[16]

Is aversion therapy the same thing as "conversion therapy" for homosexuality?

Not exactly. At most, aversion therapy is seen as an early type of conversion therapy. . Conversion therapy "is an umbrella term" for a "poorly defined" set of approaches (some secular, some religious) that aim "to suppress same-sex attraction."[17] Other authors include aversion therapy under a broader rubric of "sexual orientation and gender identity and expression change efforts (SOGIECE)," which "aim to deny or suppress feelings and desires related to non-heterosexual identities."[18]

Conversion therapy used or uses a wide variety of approaches, including aversion, psychodynamic approaches, hormonal treatment, and religious/spiritual practices such as prayer, exorcism, or scripture study.[19] It occurs in both professional and non-professional forums,

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[14] JG Thorpe, E Schmidt, and D Castell, "A Comparison of Positive and Negative (Aversive) Conditioning in the Treatment of Homosexuality," *Behavior Research and Therapy* 1/2–4 (1963): 361.

[15] Ronald W. Field, "Book Reviews: A Neo-Pavlovian View of Behaviour Therapy: Tape 2-Aversion Therapy of Homosexuality," in *Medical Journal of Australia* (20 September 1975): 489.

[16] Lynn P. Rhem and Ronald H. Rozensky, "Multiple behavior therapy techniques with a homosexual client: a case study," *Journal of Behavioral, Therapeutic, & Experimental Psychiatry* 5 (1974): 54, emphasis added.

[17] Travis Salway and Florence Ashley, "Ridding Canadian medicine of conversion therapy," *Canadian Medical Association Journal* 194/1 (10 January 2022): E17–E18, https://doi.org/10.1503/cmaj.211709.

[18] Trevor Goodyear *et al.,* "'They Want You to Kill Your Inner Queer but Somehow Leave the Human Alive': Delineating the Impacts of Sexual Orientation and Gender Identity and Expression Change Efforts," *The Journal of Sex Research* (19 April 2021): 1.

[19] Goodyear *et al.,* 2.

"in a remarkably wide range of settings: churches, camps, conferences, online chats, prayer groups, regulated and unregulated counsellors' offices, and medical offices."[20]

As the name implies, being a "behavioral" therapy, aversion was focused on behavior, not identity. As we will see, most aversion therapy efforts targeted behavior. Many of the researchers did not believe in a "homosexual orientation" in the modern sense, and so were not focused on changing that.

Besides homosexual behavior, what else was treated with aversion therapy?

Aversion therapy is only one type of behavioral therapy. Other behavioral therapies were widely used, though we will not discuss them here. Aversion therapy specifically was used in the treatment of many behaviors, including:

- feeble-mindedness,
- epilepsy,
- left- or right-handedness,
- catatonia,
- alcoholism,
- pedophiliac behavior,
- smoking,[21]
- over-eating or obesity,
- exhibitionism,
- compulsive gambling,[23]
- compulsive rumination, behavior, and masturbation,
- writer's cramp and hand spasms,
- phobias,
- hysterical spasmodic torticollis,
- suicidal thoughts,[24]
- compulsive hair pulling,[25]
- tics,[26]

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[20] Salway and Ashley, "Ridding Canadian medicine," E17–E18.

[21] Mary Eisele Beavers, "Smoking Control: A Comparison of Three Aversive Conditioning Treatments," Ph D. dissertation, University of Arizona, 1973.

[23] N[athaniel] McConaghy, MS Armstrong, and A. Blaszczynski, "Expectancy, covert sensitization and imaginal desensitization in compulsive sexuality," *Acta Psychiatrica Scandinavica* 72 (1985): 176–187.

[24] John Paul, Foreyt "Control of Overeating by Aversion Therapy," Ph.D. dissertation, Florida State University, 1969, 78–114.

[25] C.A. Bayer, "Self-monitoring and mild aversion treatment of trichotillomania," *Journal of Behavior Therapy and Experimental Psychiatry* 3 (1972): 139–141; Patricia P. Miller, "Trichotillomania: Is Exposure and Response Prevention an Effective Treatment?" Ph D. dissertation, University of Albany, State University of New York, 1998, 7.

[26] Ellen L. Sharenow, "A Comparison of Similar Versus Dissimilar Competing Response Practice in the Treatment of Muscle Tics," master's thesis, Western Michigan University, 1985, 1.

- fetishism,
- transvestism,[22]
- nail-biting,[27]
- sadism.[28]

We can see that unlike conversion therapy, aversion therapy was used for far more than homosexual behavior. Psychologists and physicians encountered patients with a wide variety of problems and unwanted behaviors. "Psychodynamic" approaches—the intensive one-on-one talk therapy first used by Freud—were not terribly successful for many problems. They also required hundreds of hours of highly trained professionals' time, and were thus expensive. Researchers were keen to find something that would be more effective and work more quickly. Aversion therapy was appealing because someone with relatively little training could perform the treatment by adhering to a script. This would magnify the number of patients that could be helped.

In the 1970s, aversion therapy was *the* cutting-edge scientific therapy. We can sense the excitement and optimism even in the dry language of scientific reports.

Motives

Were most of these researchers "homophobic"?

If by "homophobic" we mean "motivated by distaste or hatred toward homosexuals," then in the main, no. Psychologists and psychiatrists tended to be more liberal in their views about homosexual behavior than society at large.

Many behaviorists were in favor of legal protection for gay citizens, and decriminalization of same-sex acts. Even those psychoanalysts who regarded homosexual behavior as unhealthy generally did not see it as a moral failing, or worthy of criminal penalties or social persecution.[29]

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[22] MP Feldman, MJ MacCulloch, Mary L. MacCulloch, "The Aversion Therapy Treatment of a Heterogeneous Group of Five Cases of Sexual Deviation," *Acta Psychiatrica Scandinavica* 44 (1968): 113–124

[27] J. Vargas and V. Adesso "A comparison of aversion therapies for nail-biting behavior," *Behavioral Therapy* 7 (1976): 322–329.

[28] Feldman, MacCulloch, and MacCulloch, " Aversion Therapy Treatment of a Heterogeneous Group," 113–124.

[29] Charles Socarides, a psychoanalyst who regarded homosexuality as pathological, nevertheless strongly agreed with a report's call "for society's toleration and understanding of the homosexual condition and the gradual removal of persecutory laws against such activities between consulting adults. These positions were good and well taken." [Charles W. Socarides, "Scientific Politics and Scientific Logic: The Issue of Homosexuality," *Journal of Psychiatry* 19/3

Over time, there was also a growing recognition that persecution and societal factors played a large role in homosexuals' psychological difficulties.[30]

Then why did the researchers want to "change" gay people?

Researchers realized that homosexual behavior carried a huge burden and stigma in the culture of the time. They wanted to relieve suffering. Researchers frequently emphasized that they would only treat those who expressed a desire to change their feelings and/or behavior.[31] Some of their patients were married men, and the clinicians wished to help solve the problem that homosexual activity was causing in the marriage.[32]

Behaviorists objected to efforts to force the unwilling into therapy, and many regarded those sent to "treatment" as an alternative to being jailed for violating sodomy laws as unlikely to be successful.[33]

(Winter 1992): 310.] He also insisted that it was unchosen: The homosexual *has no choice* as regards his or her sexual object (329, italics in original). See also J Fort, CM Steiner, and F Conrad, "Attitudes of mental health professionals toward homosexuality and its treatment," in HM Ruitenbeck, editor, *Homosexuality: A changing picture* (London: Souvenir Press, 1966), 157–158.

[30] Gerald C. Davison, "Homosexuality: The Ethical Challenge," presidential address to eighth Annual Convention of the Association for Advancement of Behavior Therapy, Chicago, 2 November 1974; published in *Journal of Consulting and Clinical Psychology* 44/2 (1976): 157–162; Charles Silverstein, "Homosexuality and the Ethics of Behavioral Intervention," *Journal of Homosexuality* 2/3 (1977): 205–211.

[31] G. Terence Wilson and Gerald C. Davison, "Behavior Therapy and Homosexuality: A Critical Perspective," *Behavior Therapy* 5 (1974): 25; Lynn P. Rhem and Ronald H. Rozensky, "Multiple behavior therapy techniques with a homosexual client: a case study," *Journal of Behavioral, Therapeutic & Experimental Psychiatry* 5 (1974): 54; Ronald W. Field, "Book Reviews: A Neo-Pavlovian View of Behaviour Therapy: Tape 2-Aversion Therapy of Homosexuality," in *Medical Journal of Australia* (20 September 1975): 489; Ward Houser, "Aversion therapy," in *The Encyclopedia of Homosexuality*, edited by Wayne R. Dynes, Routledge Revivals edition (Gardland Publishing, Inc: New York & London, 1990), 101.

[32] Donald E. Larson, "An adaptation of the Feldman and MacCulloch approach to treatment of homosexuality by the application of anticipatory avoidance learning," *Behavioral Research and Therapy* 8 (1970): 210; N[athaniel] McConaghy, "Subjective and Penile Plethysmograph Responses to Aversion Therapy for Homosexuality: A Follow-up Study," *British Journal of Psychiatry* (1970), 560; Lee Birk, William Huddleston, Elizabeth Miller, and Bertram Colder, "Avoidance Conditioning for Homosexuality," *Archives of General Psychiatry* 25 (October 1971): 317–318.

[33] Kurt Freund, "Some problems in the treatment of homosexuality," in Hans Jurgen Eysenck, editor, *Behaviour Therapy and the Neuroses: Readings in Modern Methods of Treatment Derived from Learning Theory* (Symposium Publications Division, Pergamon Press, 1960), 312-326.

Scientific work before 1970

When was homosexuality first treated with aversion therapy?

Electric shock was first used as an aversive therapy for homosexuality in 1935.[34] This use of aversion does not seem to have been explored much further until the 1960s. An influential early report was Kurt Freund's 1960 paper, which reported the use of caffeine and apomorphine as an aversive stimulus.[35] (Apomorphine is a non-addictive drug that induces severe nausea.) Freund treated sixty-seven homosexuals with classical aversive conditioning using this method. Twenty patients were there for court-ordered treatment, and only three of these had any improvement at all. Of the remaining forty-seven, after three years 12 [~25%] had shown some long-term heterosexual change. A second follow up two years later found even lower success rates: three had returned to homosexual behavior, and many of the others did not find women other than their wives sexually attractive.[36]

Freund's lack of success was noted in the research literature. In 1969, a review of aversion therapy data noted that "Clearly these results [of Freund in 1960] do not encourage an attitude of optimism either to the use of chemical aversion or to a classical conditioning approach."[37]

What's the difference between "classical" and "operant" conditioning?

"Classical conditioning" refers to involuntary responses—Pavlov's drooling dog was the first, classic example. The dog did not "choose" to salivate when a bell was rung. Its body had simply learned to associate the bell with food, and salivated automatically.

"Operant conditioning" was a more sophisticated concept, in which the animal or person would be either punished or rewarded for taking certain actions. The general failure of Freund's classical

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[34] LW Max, "Breaking up a homosexual fixation by the conditional reaction technique: A case study," *Psychological Bulletin* 32 (1935): 734.

[35] Kurt Freund, "Some problems," 312–326.

[36] MP Feldman, "Aversion Therapy of Sexual Deviations: A critical review," *Psychological Bulletin* 65/2 (February 1966): 67.

[37] MP Feldman, "Aversion Therapy of Sexual Deviations: A critical review," 67.

conditioning approach meant that future researchers focused on operant approaches. A dog could be trained to do a trick by giving him food whenever he performed. The dog would learn that it would be fed if he did the trick, and so choose to do so.

Was nausea therapy tried any further?

In 1962, Basil James described the general failure of psychodynamic treatment, underlining "the feeling of therapeutic impotence which the practitioner so often feels when faced with the problem of homosexuality."[38] He described a single case study of a Kinsey 6 (i.e., "exclusively homosexual") patient using apomorphine.

The patient was "skeptical," but he demonstrated a remarkable change. He "has felt no attraction at all to the same sex since the treatment, whereas previously this attraction had been present throughout every day. Sexual fantasy is entirely heterosexual and he soon acquired a regular girl friend."[39] James was enthusiastic about the possibilities:

> The [aversion] treatment is brief, is in no way analytical, and can be adapted to the individual patient. Although the period of follow-up is comparatively short, the patient's heterosexual attraction is increasing with time rather than decreasing, and it would be easy to give a "booster" course of treatment should he show signs of relapse. The method depends very largely on the co-operation of the patient and his desire to be rid of his homosexual feelings. In his case other methods of treatment had completely failed.[40]

What about electric shocks?

The use of nausea as the negative stimulus had several disadvantages. It was difficult to control precisely—one had to administer the drug and then wait for its effect, so an immediate, repeated reward or punishment as needed for operant conditioning was not possible.[41]

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[38] Basil James, "Case of Homosexuality Treated by Aversion Therapy," *British Medical Journal* (17 March 1962): 768.

[39] James, "Case of Homosexuality," 768.

[40] James, "Case of Homosexuality," 770.

[41] See discussion in JG Thorpe, E Schmidt, and D Castell, "A Comparison of Positive and Negative (Aversive) Conditioning in the Treatment of Homosexuality," *Behavior Research and Therapy* 1/2–4 (1963): 357; Edward J. Callahax and Harold Leitenberg, "Aversion therapy for sexual deviation: contingent shock and covert sensitization," *Journal of Abnormal Psychology* 81/1 (1973): 60–61.

The strength of the nausea could also vary from patient to patient.[42] Vomiting was obviously very unpleasant for the patient, and the psychiatric hospital nurses and other professionals would not have enjoyed it either.[43]

Electrical shock had been used in animals and humans previously, and was an attractive alternative "because it is safe, is less unpleasant for the patient and allows easier timing of conditional and unconditional stimuli. It also allows the use of operant conditioning schedules in place of the classical method. With these modifications it has proved possible to produce improvement of certain symptoms without causing undue distress to the patient."[44] From the early 1960s onward, this was the aversive stimulus of choice.[45]

I've seen electric shock therapy on TV, and it doesn't look mild! It looks *very* unpleasant.

It is important to distinguish between two uses of electricity in psychiatry. The first is "electroconvulsive therapy" (ECT). This was the use of electricity to treat psychiatric disorders by causing a seizure. It is well-studied, and quite effective. It continues to have an important role in psychiatry.[46] TV and movies have given many a distorted idea of the process: we often see the hero strapped down by a villain, given a stick or leather strap to bite on, and then the application of massive doses of electricity as he writhes in pain and convulses violently.

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[42] John Bancroft, *Deviant Sexual Behaviour: Modification and Assessment* (Oxford: Clarendon Press, 1974), 34–35.

[43] "Chemical [i.e., nausea-causing] aversion is highly unpleasant, not only for the patient but also for the therapist and the nursing staff," (MP Feldman, "Aversion Therapy of Sexual Deviations: A critical review," *Psychological Bulletin* 65/2 (February 1966): 77). "The treatment is unpleasant, not only for the patient, but also for the therapist and the nursing staff. It is not uncommon for attendants to object to participating in this form of treatment and there can be no doubt that it arouses antagonism in some members of the hospital staff. Complaints about the method being unaesthetic and even harrowing are not entirely without justification—it is certainly a method which does not lend itself to popularity. The unpleasant nature of this treatment also makes it rather difficult to arrange for patients to be treated on an out-patient basis" (S Rachman, "Aversion therapy: Chemical or electrical?" *Behavioral Research and Therapy* 2/2-4 (1964): 289–299.)

[44] Isaac M. Marks and Michael G. Gelder, "Transvestism and Fetishism: Clinical and Psychological Changes during Faradic Aversion," *British Journal of Psychiatry* 113 (1967): 711-729.

[45] John Bancroft, *Deviant Sexual Behaviour: Modification and Assessment* (Oxford: Clarendon Press, 1974), 35.

[46] See Harold A. Sackeim, "Modern Electroconvulsive Therapy: Vastly Improved yet Greatly Underused," *JAMA Psychiatry* 74/8 (August 2017): 779-780.

This is not at all realistic. Instead, the patient is put into brief anaesthesia and given a muscle paralytic. The shock is applied, but the patient is not aware of it, and does not physically convulse or thrash around. They are then wakened from anaesthesia.

The treatment being discussed here is completely different. It involves the use of mild, low-current shocks to a wrist or leg, like a "zap" from touching a battery with wet fingers. We will discuss the precise details as we go along.

Was there follow-up to James' case study?

Yes. A year later, Thorpe and colleagues began using electricity instead of nausea-producing drugs. At first, the researchers encouraged the patient to masturbate to female pictures, hoping that females would become associated with the "reward" of orgasm.

This was unsuccessful, and so the researchers then used a new technique—they added "aversive" responses with an "electric grid" upon which the patient stood in bare feet, which would deliver "a painful electric shock" when the patient was exposed to nude male pictures.[47] Eight months later, the patient still reported only occasional homosexual acts, and much more heterosexual functioning.

The authors concluded by pointing out how poorly aversion therapy had worked for alcoholics, but "the position with regard to homosexuals would appear to be far more promising."[48]

These are awfully small "studies"—only a single patient!

Yes, and the small samples sizes was to be a serious problem in all of this research.

Nevertheless, work continued. In 1965 a researcher reported success with a small portable "zapper" that a drug-addicted patient could use on themselves at home—but once again this was a single patient.[49]

A more significant effort was reported by Schmidt *et al.* in the same year. They treated a variety of behavioral issues, but their largest group of patients were homosexuals. There were three

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[47] Thrope *et al.*, 358–359.

[48] Thrope *et al.*, 362.

[49] Joseph Wolpe, "Conditioned Inhibition of Craving in Drug Addiction: a pilot experiment," *Behavioral Research and Therapy* 3 (April 1965): 285-288.

different treatments offered: negative reinforcement (shock), positive reinforcement, and a third group who received both.

Practicing homosexuals largely declined treatment. Those who regarded "themselves to be homosexuals and feel attracted to men but who have never really indulged in homosexual practices," all agreed to participate. (The higher success with non-practicing homosexuals could have suggested to researchers that more engrained behavior was more difficult to change, since sexual desires had been repeatedly reinforced positively by the pleasures of sex.)

The study was significantly weakened by its decision to mix homosexuals (8 patients), phobias (2), alcoholism (1), and transvestitism (1). The researchers combined those who agreed to continue, and found over all that 83% had "marked improvement" and the rest "moderate." (Of the homosexual group, 7 were marked and 1 moderate.[50]) Longer term results were encouraging, though their optimistic conclusions are weakened by some patients not being contacted for follow-up. Most importantly, they concluded that combined negative and positive reinforcement were best.[51]

Were there any bigger studies?

Yes. A landmark 1967 study was the largest and best so far. It focused only on homosexuality, and included 43 patients. Its design would be hugely influential, and would be duplicated repeatedly.

In this case, the patient was exposed to either nude male or female slides. If he delayed too long in "dismissing" the male slides, he would receive a shock. For "positive" reinforcement, a female slide would appear after the male slide was dismissed.[52]

The researchers enthused that their success rate of around 60% was far better than anything demonstrated by psychodynamic therapy (27% at most). They believed that this was "mainly due to the use of an aversion therapy technique which has been carefully designed to make the most effective use of the findings of the experimental psychology of learning."[53] The same authors argued elsewhere that personality factors could also predict success with their method: "We

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[50] Elsa Schmidt, David Castell, and Paul Brown, "A retrospective study of 42 cases of behaviour therapy," *Behavioral Research and Therapy* 3 (1965): 12–14.

[51] Schmidt *et al.,* 18.

[52] MJ MacCulloch and MP Feldman, "Aversion Therapy in Management of 43 Homosexuals," *British Medical Journal* 2 (1967): 594.

[53] MacCulloch and Feldman, 597.

conclude that it is now possible to select homosexual patients who have a good prognosis for anticipatory avoidance aversion therapy."[54]

What kind of shocks were being used?

At this point, the "shock mat" seems to have been abandoned.[55] Further researchers used the technique described above.

A metal disc was hooked to a battery—usually from 6 to 12 volts DC.[56] The disc was placed either on the hand, wrist, or calf. This allowed a small shock to be delivered, typically for less than 1 second.

Researchers were not always careful to specify exactly how strong a shock was used. Reported numbers (not all from homosexual aversion tests) can be seen in this table:

Study authors and date	Lowest shock dose	Highest shock dose
Epstein and Roupenian (1970)[57]	"very unpleasant, but not painful"	
Callahax and Leitenberg (1973)[58]	0.5 milliamps	4.5 milliamps
Weiss (1974)[59]	0.8 milliamp	1 milliamp

[54] MJ MacCulloch and MP Feldman, "Personality and the Treatment of Homosexuality," *Acta Psychiatrica Scandinavica* 43/3 (1967): 300–317.

[55] Thorpe *et al.,* "A Comparison of Positive and Negative (Aversive) Conditioning," 360.

[56] MP Feldman, MJ MacCulloch, JF Orford, and V Mellor, "The Application of Anticipatory Avoidance Learning to the Treatment of Homosexuality," *Acta Psychiatrica Scandinavica* 45/2 (June 1969): 114; B. Wijesinge,"Massed aversion treatment of sexual deviance," *Journal of Behavior Therapy and Experimental Psychiatry* 8/2 (1977): 135–137;

[57] Seymour Epstein and Armen Roupenian, "Heart rate and skin conductance during experimentally induced anxiety: The effect of uncertainty about receiving a noxious stimulus," *Journal of Personality and Social Psychology* 16/1 (September 1970): 21.

[58] Edward J. Callahax and Harold Leitenberg, "Aversion therapy for sexual deviation: contingent shock and covert sensitization," *Journal of Abnormal Psychology* 81/1 (1973): 70.

[59] Leslie Ellin Bloch Weiss, "An Exploratory Investigation of Aversion-Relief Paradigms with Human Subjects," Ph.D. dissertation, University of Hawaii, 1974, 52.

Conrad and Wincze (1976)[60]	"About" 4.5 milliamps	"About" 4.5 milliamps
Greenough (1976)[61]	Average 2.5 milliamps	5 milliamps
Wijesinge (1977)[62]	Subjectively "mildly unpleasant"	Subjectively "very unpleasant"
Surkis (1977) [63]	"Maximum you can comfortably tolerate"	

In 1977, part of one protocol introduced subjects to the experiment like this: "the experimenter self-administered a shock at full intensity (ouch!) to demonstrate the worst that could happen, while at the same time explaining that individuals have different tolerances to electricity, and what one may not feel, another may find painful." Subjects were told to "set the shock intensity for the maximum that you can comfortably tolerate." [64]

So . . . how much electric current is that?

It is important to remember that both electrical wires were placed on the same body part. As a result, the electrical current did not flow through the entire body (it would be important to avoid electricity to the heart, for example). There was a local effect only.

The Electronic Library of Construction Occupational Safety describes one second at 1 milliamp as "just a faint tingle," and 5 milliamps as "slight shock felt. Disturbing, but not painful … strong

[60] Stanley R. Conrad and John P. Wincze, "Orgasmic Reconditioning: A Controlled Study of Its Effects upon the Sexual Arousal and Behavior of Adult Male Homosexuals," *Behavior Therapy* 7 (1976): 159.

[61] Timothy John Greenough, "An Analogue Study of Specific Parameters of Overt and Covert Aversive Conditioning," Ph.D. dissertation, University of Western Ontario, February 1976.

[62] B. Wijesinge,"Massed aversion treatment of sexual deviance," *Journal of Behavior Therapy and Experimental Psychiatry* 8/2 (1977): 135.

[63] Herman Surkis, "The modification of smoking behaviour: a research evaluation of aversion therapy, hypnotherapy, and a combined technique," master's thesis, Wilfrid Laurier University, May 1977, 47.

[64] Surkis, 47.

involuntary [muscle] movements can cause injuries."[65] (The duration of shock in the BYU experiment was 0.5 second.[66]) Tissue burns happen at 5,000 milliamps.[67]

Compare to TENS machine

For context, consider a transcutaneous electrical nerve stimulation (TENS) machine. These devices apply an electrical current to muscles or other tissues to help with pain relief. As with the aversion therapy, the electrical current does not pass through the whole body, but only to a limited area because the electrical leads are close together.

One present-day clinic describes the voltages involved:

> The amount of energy you receive from an electric current is determined by the amps times the volts times the time. TENS units use only a very small number of amps. In a typical unit, the settings don't go higher than 100 mA. Your house current reaches your breaker box with a current of up to 220 A, or 220,000 mA, and each circuit in your house may have a circuit breaker that will usually trip at about 15-20A. This means that for the same amount of time, a TENS machine will expose you to less than 1/1000 the amount of energy a house current does before a breaker trips.
>
> In other words, a TENS pulse delivers a small amount of energy, making it a safe level of current. If it's set too high, you might experience some mild discomfort, but you won't be injured before you have time to adjust TENS to a more comfortable level.[68]

TENS machines tend to deliver pulses of 100 microseconds, while aversion therapy experiments were typically around a second or less. But given that TENS machines provide between 20 and 100x the electrical current of aversion therapy, it is difficult to see it as either dangerous or

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[65] Center for Construction Research and Training, "Dangers of Electrical Shock," Electronic Library of Construction Occupational Safety (accessed 17 January 2022), https://www.elcosh.org/document/1624/888/d000543/section2.html.

[66] See note 144.

[67] CDC Workplace Safety and Health, Electrical Safety: Safety and Health for Electrical Trades - Student manual (Department of Health and Human Services, USA, publication No. 2002-123), 6, https://www.elcosh.org/record/document/1624/d000543.pdf

[68] TMJ Therapy and Sleep Center of Colorado, "How the Current In TENS Compares to Your House Current," webpage (accessed 15 January 2022), https://www.tmjtherapyandsleepcenter.com/blog/current-tens-compares-house-current/

injurious, particularly when the client gets to choose the voltage, and is free to discontinue the experiment if he wishes.

What were the ethics of using a small shock?

Researchers were aware that, slight as it was, electric shock might still disturb some of their audience on ethical grounds. One group replied:

> A final argument pertains to the possible ethical undesirability of a treatment which involves inflicting electric shocks—albeit from low voltage batteries. Two points may be made in reply. First, the patients are the best judges as to which is more bearable—the considerable distress which many feel as a consequence of their homosexual orientation, or a short period of weeks, for perhaps 12 hours of which they are in receipt of a number of electric shocks. Of our total of 73 patients, 63 completed their courses of aversion treatment. Second, the therapist now has the ability to predict the likelihood of success.[69]

This stance would anticipate the later debates about how "freely" homosexuals were choosing therapy at all (discussed below).[70]

Were there any other challenges to using shock?

Above all else, individual variation was the biggest challenge:

> Individuals also vary enormously in the amount of shock they can tolerate. It is a common experience to find that one patient will be exceedingly sensitive even at the lowest setting of the shock-box, whereas the next will find the maximum shock hardly painful. It is not technically easy to produce a. safe shock-box which will be predictably strong enough for all subjects, particularly in view of the considerable tolerance to shock that can develop during the course of treatment. Some of this variation may be due to the changes in pain threshold brought about by changes in the level of anxiety.[71]

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[69] MI MacCulloch, CJ Birtles, and MP Feldman, "Anticipatory Avoidance Learning for the Treatment of Homosexuality: Recent Developments and an Automatic Aversion Therapy System," *Behavior Therapy* 2 (1971):157–158.

[70] See notes 119–128.

[71] John Bancroft, *Deviant Sexual Behaviour: Modification and Assessment* (Oxford: Clarendon Press, 1974), 41.

By the end of the 1960s, where were we?

A review of aversion therapy for all undesired sexual behaviors concluded:

> The great majority of aversion therapists have used classical conditioning, that is, the attempt is made to associate anxiety or fear with the previously attractive homosexual stimulus. Only a small minority have used instrumental conditioning, in which the avoidance or escape from the punishing stimulus is contingent on the performance of a specific operant response—generally the avoidance of the previously attractive stimulus.[72]

Classical conditioning was out; operant conditioning was in.

The decade concluded with on-going enthusiasm. For example, successful use in transvestitism and fetishism,[73] other sexual "deviations,"[74] encouraged on-going hopes. An important theoretical paper by Feldman *et al*. allowed others to duplicate their methods. The authors were particularly keen on the ability to record the readings and responses of patients. Behaviorism was all about gathering data.[75]

Another pilot study captures the mood well:

> Until recently it was a widely held opinion that little could be done to alter the sexual orientation of homosexuals (Curran and Parr, 1957). Most therapists confined their efforts to helping the homosexual to adjust to his role. Now opinions are beginning to change. Bieber et al. (1962) with psychoanalysis and MacCulloch and Feldman (1967) with aversion therapy have reported a significant number of successes—where homosexual orientation has been lost and heterosexual orientation gained. There is no shortage of patients who seek such a transformation and who suffer in one way or another from their homosexual role. It is becoming increasingly clear that in these patients the term homosexuality covers a range of clinical problems, some of which will be resistant

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[72] Feldman, "Aversion Therapy of Sexual Deviations," 61.

[73] Isaac M. Marks and Michael G. Gelder, "Transvestism and Fetishism: Clinical and Psychological Changes during Faradic Aversion," *British Journal of Psychiatry* 113 (1967): 711–729.

[74] MP Feldman, MJ MacCulloch, Mary L. MacCulloch, "The Aversion Therapy Treatment of a Heterogeneous Group of Five Cases of Sexual Deviation," *Acta Psychiatrica Scandinavica* 44 (1968): 113–124

[75] MP Feldman, MJ MacCulloch, JF Orford, and V Mellor, "The Application of Anticipatory Avoidance Learning to the Treatment of Homosexuality," *Acta Psychiatrica Scandinavica* 45/2 (June 1969): 109–117.

> to such therapeutic attempts, and some of which will respond satisfactorily. But as yet we are largely ignorant of the factors which decide such outcomes. …
>
> Further justification for continued effort comes from the results achieved by MacCulloch and Feldman (1967). These workers reported a 57 per cent. success rate in 43 homosexuals treated by electric aversion. Although direct comparison with their results is not possible, there is little doubt that their results are superior to those reported here.[76]

The 1970s

The 1970s saw enormous changes in how psychiatry and psychology regarded homosexuality. The American Psychiatric Association removed homosexuality *per se* from their list of official diseases in 1973. At the same time, there remained great enthusiasm for aversive therapy for those who were dissatisfied with their homosexual inclinations. President Oaks led BYU from 1971–1980, so this period is crucial in understanding the historical situation of his presidency.

How did research techniques change?

Behaviorists were keen on objective data, and so there was an effort to use standard scales to assess sexual desires pre- and post-treatment. The 1970s also saw the introduction of the "plethysmograph,"—this was something like a small blood pressure cuff.[77] It was placed around the penis to measure the degree of sexual excitement, since it was believed that this might more accurately reflect the patient's "true" state than self-report.[78]

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[76] John Bancroft, "Aversion Therapy of Homosexuality: A pilot study of 10 cases," *British Journal of Psychiatry* 115 (1969): 1418, 1428.

[77] Bancroft has an appendix with detailed images, descriptions, and data traces in *Deviant Sexual Behavior*, 227–233.

[78] Edward J. Callahax and Harold Leitenberg, "Aversion therapy for sexual deviation: contingent shock and covert sensitization," *Journal of Abnormal Psychology* 81/1 (1973): 60–73; Timothy John Greenough, "An Analogue Study of Specific Parameters of Overt and Covert Aversive Conditioning," Ph.D. dissertation, University of Western Ontario, February 1976.

What did researchers think about the evidence for aversion therapy?

Researchers are rarely in universal agreement, and this was true in the early 1970s. A brief look at some of the published conclusions shows the growing confidence in aversion methods:

McConaghy (1970)

> *Value of aversive treatment*. Though at follow-up only seven patients in the present study considered that their sexual orientation had changed from predominantly homosexual to predominantly heterosexual, it is considered that other criteria of evaluating response are also important. Some patients who remained exclusively homosexual reported that they were no longer continuously preoccupied with homosexual thoughts and felt more emotionally stable and able to live and work more effectively. Others were able to control compulsions to make homosexual contacts in public lavatories, which had caused them to be arrested one or more times previously. Of the nine married men who presented at follow-up, six stated their marital sexual relationship had markedly improved. This included two of the three who had ceased having intercourse with their wives some years before treatment. It was concluded that of the 35 whose subjective reports were accepted at follow-up, 10 patients showed marked, 15 some and ten no improvement.[79]

Ph.D. dissertation (1971)

> Thorpe, Schmidt, Brown and Castell (1964) reported encouraging results of an aversion relief therapy procedure which they used in treatment of homosexuality, phobias and obsessive-compulsive behavior.[80]

Callahax and Leitenberg (1973)

A comparison of shock aversion therapy to standard therapy and a negative imagery technique showed “no substantial difference.” Rather than conclude that perhaps none

[79] McConaghy, "Subjective and Penile Plethysmograph," 117, 555–560.

[80] Beatrice Ila Scheinbaum Manno, "Weight reduction as a function of the timing of reinforcement in a covert aversive conditioning paradigm," Ph.D. dissertation, University of Southern California, 1971, 18.

of the techniques were of much value, they concluded: “in general … both treatments *combined led to a favorable outcome*.”[81]

Tanner (1973)

Tanner used low (2.5 milliamp) and high (5 milliamp) shocks and found the latter more effective. This likely increased the belief that a genuine effect was being studied.[82]

In the same year, Tanner would write, “There is more evidence of its effectiveness in modifying homosexual behavior than there is of any other mode of treatment.”[83]

Were there no skeptics in the early 1970s?

Yes. Some researchers believed that the techniques were working, but that the reasons given were mistaken:

> aversion therapy aimed at eliminating sexual deviation is increasingly advocated as the treatment of choice, due in part to the growing application of the experimental behavioral sciences to the clinic and in part to the relative success of this technique compared to psychoanalytic psychotherapy.[84]

The author went on to question whether claims about “aversion relief” were adding anything to the “aversion therapy” and highlighted the need for more research:

> in view of the well-documented observation that heterosexual responsiveness increases during aversion therapy in the absence of any attempt to accomplish this goal, all clinical reports that aversion relief is effective are suspect since aversion relief has never been used in the absence of aversion therapy to isolate treatment effects. … The observation noted independently by several investigators that aversive techniques alone set the occasion for rises in

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[81] Edward J. Callahax and Harold Leitenberg, "Aversion therapy for sexual deviation: contingent shock and covert sensitization," *Journal of Abnormal Psychology* 81/1 (1973): 73.

[82] Barry A. Tanner, "Shock Intensity and Fear of Shock in the Modification of Homosexual Behavior in Males by Avoidance Learning," *Behavior Research and Therapy* 11 (1973): 213–218.

[83] Barry A. Tanner, "Aversive shock issues: Physical danger, emotional harm, effectiveness and 'dehumanization'," *Journal of Behavior Therapy and Experimental Psychiatry* 4 (1973): 113–116.

[84] David H. Barlow, "Increasing Heterosexual Responsiveness in the Treatment of Sexual Deviation: A Review of the Clinical and Experimental Evidence’," *Behavior Therapy* 4 (1973): 656.

> heterosexual responsiveness is a paradoxical and puzzling phenomenon worthy of further investigation.[85]

Anyone who didn't think that it didn't work at all?

Yes. There were some who argued against the techniques altogether. As early as 1964, some regarded it as cruel and harsh.[86]

Charles Silverstein, a gay therapist, was a staunch opponent of any attempt to treat homosexuality as anything but a benign and normal behavior.

He would later insist that anyone working with patients to change orientation was in a "sadomasochistic relationship," while aversion therapists were guilty of "violence in the name of science." Even psychoanalysis was said to be "primarily the acting out of the sadomasochism of both parties." He dismissed any reports of successful change as "probably based on a rather small sample of homosexual masochists."[87]

(There is irony in Silverstein's complaint that pathologizing homosexuality is a way of delegitimizing gay sex via psychiatry's cultural authority, while smearing all his opponents with the psychiatric construct of "sadomasochism" to delegitimize *them*.)

Looking back in 2007, Silverstein was less critical of those involved in the research:

> I did not consider these men, most of whom made their reputations in aversion therapy or psychoanalysis, cruel. They were diligent in their attempt to find the holy grail of treatment that would change a person's sexual orientation, and they were motivated by a sincere desire to help.[88]

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[85] David H. Barlow, "Increasing Heterosexual Responsiveness in the Treatment of Sexual Deviation: A Review of the Clinical and Experimental Evidence'," *Behavior Therapy* 4 (1973): 659, 667.

[86] FA Whitlock, "Correspondence," *British Medical Journal* (15 February 1964):437 (Note that another correspondent, Clifford Allen, praised the same technique as "a harmless and useful method of aversion therapy … [that] should be of great use for outpatients" on the same page.)

[87] Charles Silverstein, "Homosexuality and the Ethics of Behavioral Intervention," *Journal of Homosexuality* 2/3 (1977): 208.

[88] Charles Silverstein, "Wearing Two Hats: The Psychologist as Activist and Therapist," *Journal of Gay and Lesbian Psychotherapy* 11/3–4 (2007): 25.

Tell me about 1973 and the American Psychiatric Association (APA)

Homosexual rights groups had long resented psychiatry's label of their sexual preferences as an illness.[89] In the early 1970s, they began a concerted campaign to get this changed.

We can sympathize with their position, and even agree that it resulted in the proper course of action—labeling homosexual orientation a "mental illness" is unwise.

To understand the period, however, we must understand that this change was largely brought about through agitation and political pressure. It was not the result of a sober assessment of the scientific evidence. As one gay historian noted, it was the result of

> a sustained campaign of protests by lesbian and gay activists at APA conferences and meetings throughout the early 1970s, with the collaboration of closeted psychiatrists within the APA. …
>
> Using "guerrilla theater tactics and more straightforward shouting matches," they denounced psychiatrists who advocated and practiced aversion therapy. ...
>
> Over the course of four years, the protesters followed the APA from annual meeting to annual meeting around the country. As they did so, their strategies shifted from disruption and denunciation to appropriation and inclusion, and the range of key actors involved diversified as they were aided by conference organizers and sympathetic psychiatrists within the APA, including a closeted group of high-ranking members who called themselves the "GAYPA."[90]

But science still won the day, right?

Many did not believe so, and in retrospect it is hard to see the decision as scientific (though it accords with what we know now).

The recommendation to remove homosexuality from the manual (called the *DSM-II*) was written by Robert Spitzer. In Spitzer's account, this was not a case where the data convinced him. Instead, he made the decision on emotional grounds:

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[89] Silverstein, "Wearing Two Hats," 10, 15–17.

[90] Geeti Das, "Mostly Normal: American Psychiatric Taxonomy, Sexuality, and Neoliberal Mechanisms of Exclusion," *Sexuality Research and Social Policy* 13 (2016): 390–393.

> [he] met an activist who took him to a clandestine after-party where he witnessed a psychiatrist burst into tears at being in a space for gay psychiatrists for the first time. Stunned at the sudden outing of many familiar faces, and avowedly moved by sympathy, he decided to draft the resolution for depathologization immediately.[91]

Again, we can admire Spitzer's humanitarian instincts, and even conclude that the decision was right, though not reached via science: "Spitzer … came to see these individuals as underdogs and as being in pain, and decided that he wanted to help them."[92]

But to understand this period, we cannot miss the fact that this decision was being made on political and emotional grounds—not purely scientific ones. (Some pointed out that Spitzer himself had no publication record on matters of sexuality.[93]) That made the decision questionable to many, and it stirred an enormous debate within psychiatry. Spitzer's camp narrowly won, but that does not mean that there was a scientific consensus.

Those who believed, on what they believed was a scientific basis, that homosexuality was pathological were not persuaded. To those with philosophical or religious opposition to homosexual acts, it appeared to be the imposition of one philosophical view over another:

> Those who opposed the removal of homosexuality from *DSM-II* argued that it was the civil rights issue rather than the logic of Spitzer's position that was uppermost in the minds of those who had voted in favor .... politically liberal psychiatrists had allowed their social values to interfere with their scientific judgment.[94]

"We wanted," wrote Silverstein in 2007, "the whole house of moral cards to collapse so that all forms of variant sexuality would be acceptable. … We reasoned that the psychiatric professions

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[91] Geeti Das, "Mostly Normal: American Psychiatric Taxonomy, Sexuality, and Neoliberal Mechanisms of Exclusion," *Sexuality Research and Social Policy* 13 (2016): 393.

[92] Peter Zachar and Kenneth S. Kendler, "The removal of pluto from the class of planets and homosexuality from the class of psychiatric disorders: a comparison," *Philosophy, Ethics, and Humanities in Medicine* 7/4 (2012): 3, http://www.peh-med.com/content/7/1/4.

[93] Charles W. Socarides, "Scientific Politics and Scientific Logic: The Issue of Homosexuality," *Journal of Psychiatry* 19/3 (Winter 1992): 310.

[94] Ronald Bayer, *Homosexuality and American Psychiatry: The Politics of Diagnosis* (Princeton University Press: Princeton, NJ, 1987), 148.

were 'gatekeepers' of society's attitude toward sexuality. Change their minds about variant forms of sexuality, and the rest of society … would fall in step."[95]

This radical agenda was all too clear to those who disagreed with Spitzer's motion.

Aren't all such decisions influenced by non-scientific factors?

Absolutely—no such decision is entirely free of human politics and emotion, but this one involved those factors more than most. Two historians who agreed with the decision nevertheless noted:

> The controversies over psychiatric classification in the past 30 years have garnered considerable attention. The existence of rancorous debates about how to classify is associated with claims that the developers of psychiatric diagnostic systems inappropriately clothe themselves in the aura of science without being scientific.
>
> … many psychiatrists vilified the decision on homosexuality as scientifically unsound, harmful to legitimate patients, immoral, politically motivated and a concession to the mob. Comparisons with dogmatic pronouncements of church councils were made as well. … [There] was a sentiment among some conservative psychiatrists that not just the profession, but also morality and civilization itself, had been betrayed.[96]

One analyst wrote later of how criticism of those who did not agree "w[as] augmented by hate-filled letters, threatening attacks over the telephone, and even threats of terrorist action against those who continued to speak of their scientific findings."[97]

Silverstein would later argue: "'truth' is irrelevant in explaining social advances, as they are determined by politics. Politics is power and power determines truth as well as its companion, goodness."[98] A good example of this attitude is Silverstein's account of the term "homophobia":

> The first step in developing a new theoretical model was the invention and propagation of the term "homophobia," the feelings of aversion some people feel

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[95] Silverstein, "Wearing Two Hats," 17.

[96] Peter Zachar and Kenneth S. Kendler, "The removal of pluto from the class of planets and homosexuality from the class of psychiatric disorders: a comparison," *Philosophy, Ethics, and Humanities in Medicine* 7/4 (2012), 1, 4, http://www.peh-med.com/content/7/1/4.

[97] Charles W. Socarides, "Scientific Politics and Scientific Logic: The Issue of Homosexuality," *Journal of Psychiatry* 19/3 (Winter 1992): 310.

[98] Silverstein, "Wearing Two Hats," 17.

> toward homosexuals. This term was quickly adopted and was a brilliant strategy of name-calling by the gay community. If we suffered from "homosexuality," they suffered from "homophobia." The political use of the term quickly spread to academia.[99]

Do we have any sense what the majority of psychiatrists believed?

There was a vote by the membership that sustained the decision—but only a minority voted. Letters from the APA presidential candidates were sent encouraging psychiatrists to vote in favor, though activists hid that the letter was written and its mailing financed by the National Gay Task Force, a pressure group.[100]

In 1977—four years later—a survey was conducted to see what psychiatrists thought. "Analysis of the first 2,500 responses to a poll of 10,000 psychiatrists found that 69 percent believed that homosexuality usually represented a pathological adaptation. Only 18 percent disagreed with this proposition."[101]

Despite the passage of time, the majority of the profession still seemed to differ with the APA's new policy.

Given the APA decision to no longer call it an illness, why did anyone continue to treat homosexuality?

The 1973 decision only removed homosexuality *per se* from the *DSM-II*. That is, merely having homosexual feelings or desires was not diagnostic of having a mental illness. Another diagnosis was created: Sexual Orientation Disorder (SOD)—this included those (gay or straight) who were troubled by their sexual orientation.

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[99] Silverstein, "Wearing Two Hats," 23.

[100] Ronald Bayer, *Homosexuality and American Psychiatry: The Politics of Diagnosis* (Princeton University Press: Princeton, NJ, 1987), 145–146, for the aftermath see 151–157.

[101] Bayer, 167; citing "Sexual Survey #4: Current Thinking on Homosexuality," *Medical Aspects of Human Sexuality* 11 (November 1977): 110–111.

The intensely political nature of the APA change is also evident abroad. In Great Britain and at the World Health Organization (WHO), homosexuality was classed as an illness until 1992.[102] Arguably, in those venues, the politics operated in the opposite direction. Aversion therapy continued in "NHS and military hospitals throughout the UK from the 1950s to the 1980s."[103]

In short, in 1973 (and for a long time thereafter) there was no consensus about the scientific status of homosexuality. The APA had reached an organizational decision, but it does not seem to have been shared by the majority of American psychiatrists, much less those abroad.

And, in any case, anyone troubled by their homosexuality was still eligible for treatment as SOD. Given that before 1973 most behaviorists opposed the involuntary treatment of homosexuality anyway, not much changed on the aversion therapy front.

A 1973 survey of therapists in the heavily-gay San Francisco area found that although 98% believed homosexuals could function normally in society, and 99% opposed criminalization of homosexual acts, 38% would be willing to help those who sought to change their sexual orientation. Less than half were unwilling to do so.[104]

BYU in the 1970s

Can you tell me about aversion therapy use at BYU in the 1970s?

Yes. Aversion therapy was used by some at BYU. We will examine one PhD. dissertation written by Max McBride in 1976.

First, however, we will look at what researchers were saying about aversion therapy from the APA decision until McBride's study. This will allow us to examine McBride's dissertation in its time.

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[102] T Dickinson, M Cook, J Playle, and C Hallett, "Nurses and subordination: a historical study of mental nurses' perceptions on administering aversion therapy for 'sexual deviations'," *Nursing Inquiry* 2014; 21: 283.

[103] Tommy Dickinson, "Nursing history: aversion therapy," *Mental Health Practice* 13/5 (February 2010): 31.

[104] Donna Aileen Coffin, "Windows in the Closet: Perspectives on Homosexuality for the helping professions," master's thesis, University of Arizona, 1986, 91; citing J Fort, CM Steiner, and F Conrad, "Attitudes of mental health professionals toward homosexuality and its treatment," in HM Ruitenbeck, editor, *Homosexuality: A changing picture* (London: Souvenir Press, 1966), 157–158.

Following that, we will review two "urban legends" about this therapy—the question of genitals being shocked, and the question of suicide.

Scientific literature from 1974–1976

A 1974 review of the literature noted:

- "aversion therapy is the most common and preferred method of treatment of homosexual behavior, with systematic desensitization a somewhat distant second contender."
- "We echo Bachman and Teasdale's (1969) surprise at the considerable success Feldman and MacCulloch have achieved with the use of their … technique (the efficacy of which is further substantiated by Birk et al. 1971 study), not because of theoretical reasons relating to the specifics of the conditioning paradigm involved, but because the logic of their research paradigm precluded a behavioral analysis of the presenting problem. A more complete assessment together with the use of another technique(s) might have resulted in *even greater outcome efficacy*."[105]

Thus in 1974, aversion therapy was the most common treatment method, and might even be improved upon according to these authors. That year also saw the publication of another successful case study.[106]

A textbook on the treatment of "deviant sexual behavior" was published that same year. It included an extensive review of the aversive techniques and results to date.[107] Several studies are described as achieving results of "33 per cent or less," while the superior results of MacCulloch *et al*. are described as "something of a mystery."[108] An average response was estimated at around 40% overall, not much different from psychodynamic successes (39%).[109]

In 1975, a taped lecture by one of the field's leading researchers was reviewed in the *Medical Journal of Australia*, and the reviewer was enthusiastic. He shows no sign of believing that the research community had rejected the evidence base of aversion therapy: "These lectures,

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[105] G. Terence Wilson and Gerald C. Davison, "Behavior Therapy and Homosexuality: A Critical Perspective," *Behavior Therapy* 5 (1974): 25, emphasis added.

[106] Lynn P. Rhem and Ronald H. Rozensky, "Multiple behavior therapy techniques with a homosexual client: a case study," *Journal of Behavioral, Therapeutic & Experimental Psychiatry* 5 (1974): 54.

[107] Bancroft, *Deviant Sexual Behavior*, 35–42, 52–143.

[108] Bancroft, *Deviant Sexual Behavior*, 145, 147.

[109] Bancroft, *Deviant Sexual Behavior*, 148.

theoretically, should be of use in introducing behaviour therapy concepts, clinical application, evaluation and limitations generally, especially to audiences remote from centres teaching and practising behaviour therapy."[110]

A 1976 paper detailed success in treating a teacher who was a homosexual pedophile. He sought therapy because of attraction to the students he coached. After aversion therapy, his penile response to underage boys were unchanged, but he "had become much more interested in girls of his age, sexually aroused by them, and willing to pursue their company. He also reported almost no desire to involve himself with the boys he coached." The authors concluded by noting that such self-reports were easily fabricated.[111]

Scientific publications like the above are a useful way of tracking what researchers believed to be true. Similarly, it is interesting to evaluate PhD dissertations and master's theses published during these years. They show what trainees and their advisers and dissertation committees believed.

One dissertation from 1976 noted:

- Aversion therapy … has been frequently used to eliminate maladaptive approach behaviors." These behaviors include the various forms of sexual deviation, alcoholism, drug abuse, obesity, and smoking. In these cases the primary aim of therapy has been the development of aversive control over the undesirable habits." [112]
- A non-electrical "technique has also been employed successfully in the termination of a variety of undesirable behaviors; alcoholism, smoking, sexual deviations, and obesity."[113]
- "Electric shock has recently become the most popular form of aversive stimulus. [Multiple Authors] have used electrical aversion with alcoholic addi[c]tion ... [and] in the treatment of Heroin addiction. Finally, Marks and Gelder and Evans have used shock in the treatment of sexual deviation. The results with this stimulus

[110] Ronald W. Field, "Book Reviews: A Neo-Pavlovian View of Behaviour Therapy: Tape 2-Aversion Therapy of Homosexuality," in *Medical Journal of Australia* (20 September 1975): 489.

[111] Stanley R. Conrad and John P. Wincze, "Orgasmic Reconditioning: A Controlled Study of Its Effects upon the Sexual Arousal and Behavior of Adult Male Homosexuals," *Behavior Therapy* 7 (1976): 163, 166.

[112] Timothy John Greenough, "An Analogue Study of Specific Parameters of Overt and Covert Aversive Conditioning," Ph.D. dissertation, University of Western Ontario, February 1976.

[113] Greenough, 1.

have been relatively successful, tending to be more effective with sexual deviations than drug addictions."[114]

- "Similar procedures have been employed with transvestites, drug addicts, and obese clients. In general, these studies have been relatively effective, resulting in 40-60% success across a variety of deviant behaviors."[115]
- "Feldman and MacCulloch have reported good results in the treatment of homosexuals reporting 64% success at 6 months follow up. However, MacCulloch, Feldman, Orford, and MacCulloch, using an identical procedure with alcoholics, reported zero success with four patients."[116]

A second 1976 dissertation quoted Tanner's defense of shock therapy approvingly.[117] A master's thesis urged "that electric shock be considered the optimal aversive agent because precise control over the rate of onset. duration. intensity. and temporal proximity to the C[onditioned] S[timulus] was possible."[118]

It seems clear that electric aversion therapy was not being abandoned—for homosexuality or many other conditions.

Philosophy and value judgments

By contrast, in the latter half of the 1970s, some behaviorists began to discourage aversion therapy.

We might think that this was because they regarded the evidence as having showed it had failed. Instead, some did not think it mattered whether the treatment worked or not.

In 1974, Gerald Davison—president of the American Psychological Association—said:

> Behavior therapy is nothing if it does not represent a profound commitment to dispassionate inquiry. The best of the literature, and there is much of it, illustrates

[114] Greenough, 8.

[115] Greenough, 10

[116] Greenough, 11.

[117] HD Harrison, " Aversive Control and Contingency Management: Two Environmental Treatment Procedures and Educational Progress in a Remedial Learning Center at a Minimum Security Penal Institution," D.Ed. dissertation, Memphis State University, April 1976, 39.

[118] Kenneth F. Foti, "Behavioral Treatment of Alcoholism: an Evaluative Review," Western Michigan University, master's thesis, 1976, 21.

> a sober appraisal of other approaches to behavior change as well as candid appraisals of what behaviorists themselves have accomplished.[119]

Davison granted that behaviorist scientists were both sincere and producing good work. Despite this, he believed that even offering to help homosexuals change behavior contributed to prejudice against them, and so it was wrong—especially because the social pressures against them made it essentially impossible to choose "freely."

Davison also explicitly described himself as a "determinist"—one who believed that behavior was caused by inevitable physical processes with pre-determined outcomes, rather than chosen by free will. It seems inconsistent to complain about a lack of free choice when his scientific philosophy declared genuine free choice an impossibility.[120]

(Strangely, earlier that year, Davison had co-authored an article in which he says that the data "indicate quite clearly that the majority of behavior therapists would, and in fact do, attempt to foster homosexual adjustment where appropriate and reject treating homosexuals against their wishes."[121] It is odd to then see him claim there is an inevitable violation of patient autonomy, especially when no one has free will anyway.)

Davison—effectiveness doesn't matter

To Davison, it was wrong to attempt to change homosexual behavior even if you could:

> I was interested for some time in documenting the failure of various [62] behavior change regimens in eliminating homosexual inclinations. Of particular interest was the question of whether aversion therapy of various kinds had proven successful (if you will) in stamping out homosexual behavior and inclinations. And indeed, I tend to believe the evidence is still lacking for a suppression of homosexual behavior or ideation via aversive procedures. Nonetheless, even if one were to

[119] Gerald C. Davison, "Homosexuality: The Ethical Challenge," presidential address to Eighth Annual Convention of the Association for Advancement of Behavior Therapy, Chicago, 2 November 1974; published in *Journal of Consulting and Clinical Psychology* 44/2 (1976): 157.

[120] Davison, "Homosexuality: The Ethical Challenge," 157, 160–161.

[121] G. Terence Wilson and Gerald C. Davison, "Behavior Therapy and Homosexuality: A Critical Perspective," *Behavior Therapy* 5 (1974): 25.

> demonstrate that a particular sexual preference could be wiped out … I am convinced. that data on efficacy are quite irrelevant.[122]

Davison, then, had made his decision on non-scientific grounds. He did not care if aversion therapy worked—he believed it wrong in any case.

Davison—a double standard?

What he did not address, however, is the question of why his view on this ought to prevail when the science was not settled. Another therapist could with equal sincerity and equal justification say that he believed that homosexuals should be helped if they desire it. Society and Davison had no more right to impose their view of what homosexuals "should" do than the aversion therapists did.

Davison worried that offering such therapies—even if they are wanted—implied to homosexuals that they *must* change their behavior. But, *not* spending any time on such therapies would then likewise imply that homosexuals cannot or should not change their behavior. Neither position is scientific, and the choice will depend on our world-view.

Davison had changed his argument from a paper published earlier that year:

> aversive therapy programs have carefully avoided imposing society's values on the homosexual participants. Indeed, we have elsewhere raised the question as to *whether any behavioral change can be imposed upon an unwilling client*, who would seem to have at his/her disposal any number of countercontrol devices to nullify the intended effects of a technique.[123]

This makes it sound as if the patient's free will is functioning just fine.

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[122] Gerald C. Davison, "Homosexuality: The Ethical Challenge," presidential address to Eighth Annual Convention of the Association for Advancement of Behavior Therapy, Chicago, 2 November 1974; published in *Journal of Consulting and Clinical Psychology* 44/2 (1976): 162.

[123] G. Terence Wilson and Gerald C. Davison, "Behavior Therapy and Homosexuality: A Critical Perspective," *Behavior Therapy* 5 (1974): 24, emphasis added.

Davison—the matter was not settled by 1976

Davison's address occasioned lively debate.[124] A key point was that clear, informed consent and an exploration of *why* the patient wished to change was an essential first step.[125]

In 1978 (two years after McBride's BYU experiments) Davison acknowledged that there was still no consensus by saying, "I hope the debate continues."[126] Once more, he underlined that scientific evidence was not the reason for his stance: "My earlier proposal to terminate change-of-orientation programs rests on moral not empirical grounds. Arguments based on whether therapists can or cannot alter sexual preferences *are irrelevant*."[127]

Davison emphasized that "Psychologists, like other scientists, do not merely go out and 'gather data.' They hold preconceived ideas of what they will find and how they will decide they have found it."[128] He showed no sign that he appreciated that this applied at least equally to his own stance. He wanted to apply a charge of social influence and relativism against his opponents, even though his own stance was vulnerable to precisely the same critique.

So, tell me about the McBride study at BYU?[129]

After this review of the peer-reviewed literature, we can see that the McBride study fits squarely into the scientific context of its time. Aversion was regarded as a promising approach for a host of problems, and the most promising available for homosexuality specifically.

Electric aversion was the aversive method treatment of choice, and great efforts had been made to make it as objective, recordable, and repeatable as possible. There was still considerable debate about the optimal method, and precisely what was bringing about the changes the

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[124] For the psychoanalytic perspective, see Irving Bieber, "A Discussion of Homosexuality: The Ethical Challenge,'" *Journal of Consulting and Clinical Psychology* 44/2 (1976): 163–166.

[125] Seymour L. Halleck, "Another Response to 'Homosexuality: The Ethical Challenge'," *Journal of Consulting and Clinical Psychology* 44/2 (1976): 167-170.

[126] Gerald C. Davison, "Not Can but Ought: The Treatment of Homosexuality," *Journal of Consulting and Clinical Psychology* 46/1 (1978): 172.

[127] Davison, "Not Can but Ought," 170, emphasis added.

[128] Davison, "Not Can but Ought," 171.

[129] Max Ford McBride, "Effect of Visual Stimuli in Electric Aversion Therapy," Ph.D. dissertation, Brigham Young University, 1976.

researchers believed they were seeing. It was regarded as ethically appropriate in willing volunteers.

Concerns had been expressed about some difficulties with the research to date: small sample sizes, lack of controls, lack of long-term follow-up.[130] But these were widely seen among behaviorists as reason for more and better research, not abandonment of a promising technique.

To be sure, there was great social conflict and upheaval about the moral status of homosexual behavior. But, at least some of the psychiatry and psychological community's stance on these issues was transparently political, having (in the view of perhaps the majority) shunted the science to one side.

There were arguments against using aversion therapy, but some of these explicitly rejected the question of whether the therapy worked or not—again, not a particularly "scientific" stance. Even those who argued that aversion therapy did not work included a large dose of moralism in their claims, insisting that homosexual behavior was completely normal and certainly not sinful.[131]

None of these considerations would have strengthened the arguments to a Latter-day Saint scientist or member in 1976. It certainly did not for many secularist scientists either.

Wasn't McBride's therapy "approved by BYU"?

Researcher Greg Prince refers to McBride's work as a "university-approved protocol."[132] He is cited similarly in the *Salt Lake Tribune.*[133] While technically true, this could be misleading. McBride's work was approved by his department and his dissertation committee. In that sense, the protocol had institutional approval—as all research should. But, if the expression is taken to mean that university administration or Church leaders knew about it and approved it, that

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[130] See, for example, John Paul Foreyt, "Control of Overeating by Aversion Therapy," Ph.D. dissertation, Florida State University, 1969, 115–118; Leslie Ellin Bloch Weiss, "An Exploratory Investigation of Aversion-Relief Paradigms with Human Subjects," Ph.D. dissertation, University of Hawaii, 1974; Stanley R. Conrad and John P. Wincze, "Orgasmic Reconditioning: A Controlled Study of Its Effects upon the Sexual Arousal and Behavior of Adult Male Homosexuals," *Behavior Therapy* 7 (1976): 164–166.

[131] See, for example, Charles Silverstein, insisting that aversion therapy "serv[es] the same goal of social control as religious doctrine has in the past." Stephen J. Sansweet, *The Punishment Cure: How aversion therapy is being used to eliminate SMOKING, DRINKING, OBESITY, HOMOSEXUALITY ... and practically anything else* (Mason-Charter: New York, 1975), 80.

[132] Gregory A. Prince, *Gay Rights and the Mormon Church: Intended Actions, Unintended Consequences* (University of Utah Press, 2019), 90.

[133] "Dallin Oaks says shock therapy of gays didn't happen at BYU while he was president. Records show otherwise," *Salt Lake Tribune* (16 November 2021).

requires further evidence that has not been presented. It is also unlikely; it would be unusual for a student research study to come to the attention of university leadership.

Prince's account also neglects to mention that McBride's disclosure statement to the study participants explicitly disclaims endorsement by BYU:

> It was mandatory that all S[ubject]s chosen to participate sign and have witnessed a prepared statement explaining (a) the experimental nature of the treatment procedure, (b) the use of aversive electric shock, (c) the showing of 35 mm slides that might be construed by S[ubject] as possibly offensive, and (d) that **Brigham Young University was not in any direct way endorsing the procedures used**. This was to [e]nsure that all S[ubject]s were in full agreement and understanding as to what the treatment procedure would involve, provide and demand from them.[134]

What was the protocol used by McBride?

McBride was interested in a single question—was the use of nude photos necessary for the aversion procedure to succeed? Or, could other non-explicit material be used in the same way? (Both groups also received assertiveness training as a non-aversive method.[135])

McBride was squarely in the behaviorist tradition. As with other researchers discussed above,[136] his focus was on *behavior*, not sexual orientation in our modern sense:

> The chief goal of aversion therapy is to reduce the probability of inappropriate response patterns which interfere with normal societal adjustment. The diminution or modification of inappropriate response patterns will encourage the likelihood of acquiring and strengthening appropriate alternative behaviors.[137]

Of the 17 subjects who entered the study, 14 completed. They all expressed "a desire for treatment" and either self-referred or were referred from community agencies. Prior to agreeing to participate, the subjects were informed that the treatment was experimental, that shock aversion would be used, and that BYU did not endorse the therapy.[138]

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[134] McBride, 49, emphasis added.

[135] McBride, 51–53, 81.

[136] See notes 12–16..

[137] McBride, 3.

[138] McBride 42–43.

How else did McBride refer to the earlier literature?

Besides a review of the relevant papers, McBride used a Sexual Behavior Inventory based on a "life history questionnaire and sexual disposition questionnaire" published previously.[139]

McBride used the same aversive technique as Feldman and MacCulloch's 1965 work.[140] Slides of males received the aversion stimulus; slides of females were rewarded. The patient's response was monitored by the plethysmograph, the objective measure of penile erection.[141]

What kind of shock technique was used?

McBride followed a previously published procedure to determine the proper "dose" of shock.[142] Before the experiment, a three second shock was given to the biceps every ten seconds. Shocks began at 0.5 milliamps, and each increased by 0.5 milliamps. The maximum shock was 4.5 milliamps. The shock level was selected when the patient described it as "barely tolerable" or "painful." During treatment, if the shock was too painful, the current was decreased. If the patient found himself habituated to it so that it was no longer aversive, it was increased.[143]

During the experiment, each shock lasted 0.5 second.[144]

What were the results?

McBride found that both groups rated themselves as "improved," with less homosexual inclination. Despite both groups rating their subjective improvement similarly, those who had used nude male images for their negative visual stimulus had greater objective evidence (the

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[139] McBride, 55, citing Arnold A. Lazarus, *Behavior therapy & Beyond* (New York, McGraw-Hill, 197[1]) and Lee Birk, William Huddleston, Elizabeth Miller, "Avoidance Conditioning for Homosexuality," *Archives of General Psychiatry* 25/4 (1971): 314-323.

[140] McBride, 4, 23–26.

[141] McBride, 35–41.

[142] McBride, 55. The paper referenced is Seymour Epstein and Armen Roupenian, "Heart rate and skin conductance during experimentally induced anxiety: The effect of uncertainty about receiving a noxious stimulus," *Journal of Personality and Social Psychology* 16/1 (September 1970): 20–28.

[143] McBride, 46.

[144] McBride, 27. See notes 54–65 for this value in context with other studies.

plethysmograph data) of decreased attraction for males. This finding led McBride to conclude that the more explicit images were more potent in developing the proper conditioning.[145]

Nude female images caused similar plethysmograph improvement in both groups after treatment. But those who had used clothed females in the study rated them as more attractive subjectively.[146]

Conclusion—McBride

McBride's work was not novel. It referenced the behaviorist literature of the previous decade and a half. It used the same experimental set-up, the same aversion techniques, and the same assessment measures as past work.

Some present-day activists want to make McBride's work into the irrational work of a religiously fanatical and homophobic Church. It was not. It was mainstream, peer-reviewed science.

Urban legends

Did the McBride study involve shock to the patient's genitals?

No. Greg Prince, a researcher who opposes the Church's stance on the sinfulness of same-sex behavior, labeled this "an urban legend":

> Urban legends persist … [including the claim that] *it involved connecting electrodes to male genitalia.* It did not, at least initially in the university-approved protocol.[147]

Even some academic work has been disgracefully shoddy on this point. A 2009 master's thesis from Utah State University claimed that "aversion therapy was based on the principles of classical

[145] McBride, 74–75.

[146] McBride, 77–78.

[147] Prince, 90, italics in original.

conditioning."[148] As we have seen, this is false—the aversion therapy of the 1970s was based on operant conditioning.

The same thesis goes on to claim that it involved "pairing an aversive stimulus (usually an electric shock to the genitals, sometimes a drug intended to induce vomiting)." The only citation given for this claim is a reference to McBride's dissertation.

As we have seen, McBride clearly did *not* mention using genital shocks, and doing so would have invalidated his research since it did not match the other researchers' techniques—he needed the objective plethysmograph data, as previous researchers had emphasized.

In the same vein, the use of nausea-inducing drugs had been abandoned in the early 1960s, and were likewise not used in McBride's work. No evidence in the USU thesis supports these claims, and the sole footnote provided does not either.

It is this kind of sloppy thinking that creates urban legends, which may be useful polemically but doesn't serve the truth.

"However," Prince adds, "there is evidence that during the mid-1990s, in non-approved protocols, electrodes were attached to male genitalia during treatment that occurred on the BYU campus as well as off-campus under supervision of BYU faculty."[149]

What kind of evidence does Prince refer to?

The evidence cited by Prince is a blog, the *Daily Kos*.[150] The reported events date from 1995, and describe an experimental set-up precisely like McBride's and the behaviorists' of the 1960–1970s. The witness claims to have scars on his genitals from this procedure.

It is theoretically possible that this did happen—and if it did, it would be grossly unethical by the standards of the 1970s *and* the 1990s. But the account does not make a lot of sense.

By the 1970s, the procedure described used the penis pressure sensor (not a shock electrode) as part of the technique. There is no report of penile shocks anywhere in the literature.

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[148] Cory John Myler, " Latter-day Saint religiosity and attitudes towards sexual minorities," master's thesis, Utah State University, 2009, 23–24.

[149] Prince, 90.

[150] See Prince, 333n4, citing "Head of Mormon Church: 'Gays Have a Problem,'" *Daily Kos*, 29 December 2004, https://www.dailykos.com/stories/2004/12/29/82433/-.

Applying an electric shock to genitals would defeat the means by which the treatment was intended to work—the "positive reinforcement" of increased erectile volume that the behaviorists hoped to measure when the female picture was shown. Shocking the penis would prevent any erection at all.[151] It would create the problem with the nausea drugs all over again—nausea couldn't be turned on and off quickly to get the right reinforcement. The effect of a shock to the genitals would not suddenly vanish and allow an easy erection.

One wonders if the account has been conflated—there *were* shocks to the arm or leg, and the penis *was* attached to the measuring instrument, but it was not shocked.

Objective confirmation of the scarring would be more convincing—and if present ought to lead to the prosecution of the therapist(s) involved. The lack of hard evidence thus far suggests we should not take this account at face value without better data.

Were there suicides caused by the therapy?

Prince likewise says:

> [Another urban legend is that] "*suicides resulted from its use at BYU*. While there are several reports alleging this, none has been accompanied by authoritative documentation."[152]

One troubling habit is the tendency of some gay advocates to weaponize suicide and blame a person or a group or an event for suicides.

This is both scientifically inaccurate and dangerous.

As one expert on suicide noted,

> Psychological pain or stress alone—*however great the loss or disappointment, however profound the shame or rejection—is rarely sufficient cause for suicide*. Much of the decision to die is in the construing of events, and most minds, when healthy, do not construe any event as devastating enough to warrant suicide.[153]

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[151] See further at note 187.

[152] Prince, 90, italics in original. See also note 181.

[153] Kay Redfield Jamison, *Night Falls Fast: Understanding Suicide* (Alfred A. Knopf: New York, 1999), 91, italics added.

And, evidence-based guidelines for preventing suicide contagion have a strong recommendation that this facile narrative ignores: “Avoid … simplistic reasons for the suicide.”[154]

Was the university administration aware of this research?

Likely not. When we understand the historical context of aversion therapy research generally, and McBride’s work specifically, we see why.

McBride was conducting a small research study in a single department.

Research procedures are different today than they were in the early and mid-1970s. Today, universities are required to have Institutional Review Boards (IRBs) which give close scrutiny to the ethics of human experiments. Proposed standards for IRBs were published by the FDA on 8 August 1978 (well after McBride's work). Public comment was sought until 6 June 1979.[156] U.S. federal government regulations did not require IRB participation until 16 January 1981.[157]

Guidance to psychologists in 1954, 1968, and 1973 made no mention of IRB review.[158] By 1982, however, such review was described as "mandatory."[159]

Prior to these federal regulations, such studies were managed by the researchers' department. The administration did not approve, vet, or survey such matters. It would have been strange, then, for others to be aware of the details of most research conducted. They would be even less likely to know what therapists did in the privacy of their offices.

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[154] Josh Nepon, et al., "Media Guidelines for Reporting Suicide," Policy Paper (Canadian Psychiatric Association), 3, http://publications.cpa-apc.org/media.php?mid=733&xwm=true.

[156] "Rules and Regulations," *Federal Register* 46/17 (27 January 1981): 8958–8959, https://archives.federalregister.gov/issue_slice/1981/1/27/8944-8978.pdf#page=32. See also the "Belmont Report" issued during the same time frame: National Commission for the Protection of Human Subjects of Biomedical and Behavioral Research, "Ethical Principles and Guidelines for the Protection of Human Subjects of Research," (18 April 1979), https://www.hhs.gov/ohrp/sites/default/files/the-belmont-report-508c_FINAL.pdf; American Psychological Association, " Ethical principles in the conduct of research with human participants," *American Psychologist* 28/1 (January 1973): 79–80.

[157] *Federal Register* 46/17 (27 January 1981): 8975–8979.

[158] Irwin A. Berg, "The use of human subjects in psychological research," *American Psychologist* 9/3 (March 1954): 108–111; American Psychological Association, "Ethical Standards of Psychologists," *American Psychologist* 23/5 (May 1968): 357–361.

[159] Committee for the Protection of Human Participants in Research, "Ethical principles in the conduct of research with human participants," American Psychological Association (Washington, DC: APA, 1982), 29.

It is not surprising that professionally-trained psychologists were performing the same therapies and research that their colleagues were performing on both sides of the Atlantic.

(Mental health professionals and researchers are and were expected to operate within the proper ethical and scientific bounds of their discipline. Confidentiality and non-coercion were key professional values—this would make it far *less* likely that others would hear about any details.

McBride tells us that the patients either self-referred or came as referrals from "various local agencies. Neither source would be likely to discuss the matter with others.

A participant from the 1970s

Has anyone asked therapists at BYU about this?

Eugene Thorne is a clinical psychologist who was at BYU's department of psychology from 1966 "to around 1980," and chaired McBride's dissertation committee.[173] He gave an extensive interview in which he discussed the history of research and treatment in this field at BYU.[174] Thorne describes how

> from somewhere around 1970 to 1973, I had become quite interested in publications that were occurring regarding aversion therapy in a variety of places throughout the world and laboratories in various other settings, hospital otherwise and their impressive positive effect on changing the attraction of persons who had same sex attractions.
>
> And I thought that it may be worthy of doing further research. It showed some promise and I thought that it would be worthy of my efforts along with others in trying to find how to improve this kind of therapy. I conducted a couple of researches that I reported on at the time and probably prior to 1974 and then I turned to a different subject almost altogether and became totally focused in that.
>
> … as far as I knew, I was the only one at BYU that was even interested in the topic and I was made interested in it by reviewing the literature from a number of different places and countries that were claiming to have very promising data that

[173] McBride, ii–iii.

[174] Steven Densley, Jr., "FAIR Examination 8: Aversion Therapy at BYU–Dr. Eugene Thorne," (1 February 2012), https://www.fairlatterdaysaints.org/blog/2012/02/01/fair-examination-8-aversion-therapy-at-byu-dr-eugene-thorne, transcript in authors' possession.

> showed that aversive conditioning was able to improve an ego-dystonic [homosexual] person's feeling about themselves, for example.[175]

Thorne—reputation of the researchers

Those publishing on the subject were well-regarded:

> People of high reputation with good credentials that were believable—reporting that their subjects or their clients or patients, whatever they call them were changed, that they were now better that they didn't have as much or even any same sex attraction.[176]

How did Thorne receive referrals? Did BYU send them?

Many of his clients were self-referrals. He "wouldn't even accept anybody from the BYU police, or the ecclesiastical leaders, from the administration. No one ever approached me from any of those."[177]

When asked if "BYU standards office was threatening people that if you don't go and participate in this aversion therapy treatment, that we're going to kick out of the university. You didn't get any kinds of referrals like that?" Thorne replied:

> Absolutely none. I read that some of those things were claimed. I just would be surprised—I'm amazed that anybody would write that. Somebody, I guess, could have done it but I don't know of any.[178]

"You are not aware of anybody from the BYU administration, you are not aware of anyone from the Church who was, I guess, rounding up homosexuals and sending them out for aversion therapy?"

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[175] Thorne Interview, 1, video time circa 4:00 and 3, video time circa 9:45.

[176] Thorne Interview, 19, video time circa 1:05:00.

[177] Thorne interview, 10, video time circa 35:00.

[178] Thorne interview, 10, video time circa 35:00.

Replied Thorne: "No ... Now, none of the general authorities or bishops ever came to me, but I know that [homosexual behavior] was becoming an open topic [that they were speaking about]."[179]

Did Thorne report the names of those who came to him?

No.

> Interviewer: You are not, though, turning in the names of people who you are seeing to the university?
>
> Thorne: Yes.
>
> Interviewer: You are not consulting it? You are not consulting with their bishops or their stake presidents? So, aside for maybe spouse that knew that someone was participating in this type of study they were anonymous? Subjects were not published?
>
> Thorne: Yes, right. Their spouse would know and that would be it.[180]

Thorne—Were there suicides?

> I never heard of a suicide at BYU except in the years I was there—maybe one or something. It seems like somebody had jumped off one of the cliffs. I think it was a girl—and maybe it was in Rock Canyon or something like that—… unrelated to therapy. I have never heard of anybody in therapy ever even suggesting they were interested in that. Well, unless that was what they were there for therapy for. They were thinking of suicide. But that wouldn't be aversion therapy that you are trying to work them through.[181]

Thorne—other adverse events

As for other adverse events, Thorne reported:

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[179] Thorne interview, 10, video time circa 35:40.

[180] Thorne interview, 11, video time circa 36:00.

[181] Thorne interview, 16, video time circa 55:00.

> Nor did any of my subjects ever repeat, or report I should say, that they ever felt sick or that they felt in any way that it was frightening to them and they always knew in my research that if they ever had anything that made them feel that it was too much or it was not doing what it was supposed to be doing or they wanted to stop for one reason or another they could turn it right off right then. …
>
> If they had even a bad taste in their mouth, that's never been reported, not even a change of thoughts or panic or something like that, I mean, to the sense that they became frightened. If they did, they were to let me know. They just turn the switch, shut it off.[182]
>
> [T]hey could turn the whole sequence off. I mean, if they were saying—supposing they thought it hurt, more than they thought— they could turn it off.[183]

Thorne's account is plausible—it matches the published scientific reports of how this research was conducted.

Thorne—Strength of shocks used

> If they've got the electrode right over the bicep muscle, sometimes you can see the muscle jerk, because it creates a movement of the muscle but nothing dramatic. You can see a little flinch or something and that's about it.[184]

When asked if he had ever seen skin damage from the technique, Thorne replied, "Never. Never saw anything. Not even a red spot. If anything, maybe where the [blood-pressure-like electrified] cuff [was] might be [a] mark. But within a moment or two that disappeared."[185]

> Interviewer: How did they decide, how did you decide how high the level of electricity would be?
>
> Thorne: Well, *we* didn't. … [A]s far as the intensity was concerned, they were instructed, all right now, turn this knob—it was a red knob—and it will deliver to you a shock that will increase as you increase the rheostat in movement, and you

[182] Thorne interview, 9, video time circa 31:00.

[183] Thorne interview, 9, video time circa 48:30.

[184] Thorne interview, 8, video time circa 30:00.

[185] Thorne interview, 9, video time circa 30:30.

> stop where you find it uncomfortable or barely tolerable. So, they had total control of the intensity.
>
> Interviewer: "Not intolerable." So, something short of intolerable.
>
> Thorne: No, they wouldn't have stayed in the research, I don't think, if that would have been intolerable. At any rate, then the duration in some of the trials were like "bing," a split second. So, you didn't make it very long. I think the longest shock was on would be maybe a 10th of a second, I suppose, if I guessed.[186]

Thorne—use on genitals?

Thorne was adamant that no genital shock was applied:

> That would be totally inappropriate. You are not trying to condition the way the genitals work. They are working perfectly, properly. What you are trying to condition is the arousal, the thing that arouses them and allows them reach climax or have ejaculation.[187]

Did Thorne use the penile sensor for objective measurement?

> No, I didn't. I asked them at the end of each aversion session to go through the slides and give them a rating as to how attractive they—how easy they could find these thoughts of interacting with these subjects on the pictures attractive, and instead of 10 or nine, they were beginning to report three to two, even none. I even find it aversive, I mean it's negative. …
>
> And then, later, some of my graduate students had acquired, I think it's called the plethysmograph, and they, as described to me, they allowed the [male] subjects to place this … on their penis and … the more the penis engorged was a direct demonstration of arousal. The more the attraction was there. Then no matter what number they gave us, those numbers gave them something about

[186] Thorne interview, 12, video time circa 39:30.

[187] Thorne interview, 9, video time circa 32:00.

> engorgement. Well, that doesn't happen unless you are becoming aroused, at least as far as I know.[188]

Thorne—perception of the *DSM-II* issue in the 1970s

> But it was clear to me—and this is just my impression—that they were – that is the APA, American Psychiatric Association—was under great stress from a variety of groups, including the gay, lesbian, transvestite, transsexual groups who were becoming much more politically powerful to accept that we get the psychiatric association and the psychology association to accept homosexuality as being normal or at least find ways of protecting them[189]

After McBride

1976–1980

Kurt Freund's classical conditioning work in the early 1960s had stimulated much of the later burst of enthusiasm for aversion therapy. In 1977, Freund reported follow-up on his treatment group and insisted, "virtually not one cure remained a cure."[190] He urged that aversion therapy not be used as a treatment for homosexuality until there was evidence that behavioral approaches worked, or that it be used only as a second-tier option if the client wouldn't or couldn't be helped to embrace their homosexuality.[191]

This was not as discouraging to the behaviorists as we might think it should be. Freund's initial results had not been impressive even in 1960, and the relative failure of his approach was often remarked upon.[192] At the end of the 1960s, one dissertation's view of "the future" pointed out that Freud's methods had produced "dismal results," necessitating a move "away from pure

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[188] Thorne interview, 12, video time circa 41:00.

[189] Thorne interview, 2, video time circa 4:30

[190] Kurt Freund, "Should Homosexuality Arouse Therapeutic Concern?" *Journal of Homosexuality* 2/3 (1977): 238.

[191] Freund, 239.

[192] MP Feldman, "Aversion Therapy of Sexual Deviations: A critical review," Psychological Bulletin 65/2 (February 1966): 72–74; Edward J. Callahax and Harold Leitenberg, "Aversion therapy for sexual deviation: contingent shock and covert sensitization," *Journal of Abnormal Psychology* 81/1 (1973): 60; Sheelah James, "Treatment of Homosexuality ll. Superiority of Desensitization/Arousal as Compared with Anticipatory Avoidance Conditioning: Results of a Controlled Trial," *Behavior Therapy* 9 (1978): 28.

classical conditioning"—remember, the aversion therapies of the 1970s were largely based on operant models.[193] What's more, Freund had used nausea-induction with drugs, while aversion therapies were using the more precise and controllable electric aversion.

McBride's work was not, then, the last gasp of aversion therapies.

In 1977, a five-year trial was reported on the successful techniques which MacCulloch and Feldman had described, and which McBride had followed at BYU.[194] Tellingly, the five-year effort had only 47 male participants, of which only 37 completed—demonstrating how difficult this type of research was, and putting the 14 subjects of McBride's effort into context.[195]

Based upon Kinsey scales, 31% of patients improved.[196] The authors observed that earlier researchers were not to be blamed for reporting more success than their larger trial had shown:

> In retrospect, it is easy to be critical of Feldman and MacCulloch for promoting a method which, although apparently theoretically sound, relied too heavily on the findings of experimental psychology; for their optimism over its therapeutic efficacy; and for claims of general applicability. But Wolpe's (1958) original claims of successful treatment of 90% of neurotic patients have not been generally repeated, and it is becoming obvious, as Russell pointed out after a detailed review of the literature, that to an unknown extent behavior therapy derives much from enthusiasm and suggestion which is not apparent to clinical researchers at the time. ...
>
> Recognition of these defects in the Feldman and MacCulloch technique have led to greater insights into the problems of treating homosexuals and to emphasis on a more comprehensive behavioral approach.

Despite this discouraging result, 1977 also saw other authors describe how

> two types of latency behavior are shown to be related to differing degrees of clinical efficacy during [aversion] treatment sessions in terms of reduced

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[193] John Paul Foreyt, "Control of Overeating by Aversion Therapy," Ph.D. dissertation, Florida State University, 1969, 125.

[194] Sheelah James, A Orwin, and RK Turner, "Treatment of homosexuality: I. Analysis of failure following a trial of anticipatory avoidance conditioning and the development of an alternative treatment system," *Behavior Therapy* 8 (1977): 840–848.

[195] James *et al.,* "Treatment of homosexuality: I," 843.

[196] James *et al.,* "Treatment of homosexuality: I," 845.

> homoerotic interest measured on a psychometric test. ... The relationship was then used to predict the overall attitude change in a number of patients by using the avoidance latency data alone. These predictions were in accordance with eventual clinical outcomes and were superior indicators of clinical success compared with psychometric assessment.[197]

They then highlighted both the objective nature of their findings, and their ability to predict outcomes: "A powerful test of a theory is its ability to predict, and we have used our derived relationships to predict both clinical outcome and sexual attitude change due to treatment."[198]

This is not a research program on its last legs.

The same year also saw the publication of a mammoth two-volume *Handbook of Behavior Therapy with Sexual Problems* .[199] The introduction emphasized that

> It is often difficult to alter undesired sexual patterns which have been exhibited and reinforced over extended periods of time. Aversive conditioning frequently has been effective in altering such behaviors as undesired homosexual responses … which have generally been unresponsive to other approaches. …
>
> The value of any intervention plan is determined by whether it works (i.e., whether it changes behavior in a desirable direction), not whether it somehow sounds good or feels good.[200]

The textbook included several key papers on aversion therapy in general, and its use in homosexuality in particular.[201]

In 1978, James published further on her 5-year trial's disappointing results with aversion therapy. She had compared their talk-based "desensitization/arousal" techniques—

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[197] MacCulloch, Waddington, and Sambrooks, "Avoidance latencies," 562.

[198] MacCulloch, Waddington, and Sambrooks, "Avoidance latencies," 573–575.

[199] Joel Fischer and Harvey L. Gochros, *Handbook of Behavior Therapy with Sexual Problems*, 2 volumes (Pergamon Press, 1977).

[200] Fisher and Gochros, "Introduction," 1:xlii–xliv.

[201] Representative chapter titles include: "Aversion Therapy Applied to Taped Sequences of Deviant behavior in Exhibitionism and other Sexual Deviations: A Preliminary Report," "An Automated Technique for Aversive Conditioning in Sexual Deviations," "Aversion Therapy for Sexual Deviation: Contingent Shock and Covert Sensitization," "Aversion therapy in Management of 43 Homosexuals," "Alteration of Sexual Preferences via Conditioning Therapies," "The Desensitization of a Homosexual."

which did not require shock—with shock-based aversive techniques. The former were more successful.[202]

A separate 1978 paper, however, endorsed the ethics of treating willing homosexual patients, and reported that "automated aversion procedures have been shown to be more effective than psychotherapy and more effective than placebo conditioning or a waiting list control condition." The authors suggested that opposition to aversion therapy "in spite of favorable reports of its effectiveness," might be due to both the use of aversion and to changing attitudes toward homosexuality.[203]

After 1980

James' work dampened enthusiasm for aversion as the first choice. By 1982, a behaviorist textbook would recommend aversion as second-line treatment:

> As the present evidence indicates that all treatments aimed at reducing compulsive drive in both sexual and nonsexual behaviors are equally effective, the one that seems least likely to reduce the patient's self-esteem would seem to be the treatment of choice. In this reviewer's experience this treatment is imaginal desensitization. …
>
> At one-month follow-up, about 70% of patients report a significant reduction in the compulsive drive to carry out the behavior. A minority of those who do not report this response and wish to have a second course of therapy show a similar response to an alternative treatment. such as aversive therapy. But usually this response is transient. However, those patients who do report an initial definite response but relapse after some months or years usually show a more permanent response to a repetition of the original treatment.[204]

As had long been the case with behaviorists—including McBride—change of sexual orientation was not the goal, but control of unwanted behavior:

> Aversive therapy acts not by reducing primary homosexual drive, but by reducing the arousal produced by failure to complete habitual sexual acts. This hypothesis

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[202] Sheelah James, "Treatment of Homosexuality ll," 28–36.

[203] Malcolm J. MacCulloch, John L. Waddington, and Jean E. Sambrooks, "Avoidance Latencies Reliably Reflect Sexual Attitude Change during Aversion Therapy for Homosexuality," *Behavior Therapy* 9 (1978): 562–564.

[204] Nathaniel McConaghy, "Sexual Deviation," in *International Handbook of Behavior Modification and Therapy*, edited by Alan S. Bellack, Michel Hersen, Alan E. Kazdin (Plenum Press: New York and London, 1982), 698.

> accounts for the otherwise discrepant findings that aversive therapy, in comparison with placebo treatment, does not alter the patients' penile arousal to pictures of males, yet significantly reduces their urges to carry out homosexual behavior. It also accounts for the otherwise surprising evidence that systematic desensitization seems at least as effective as aversive therapy in increasing the ability of homosexuals to control their sexual behavior, without necessarily increasing heterosexual behavior.[205]

Interestingly, one year earlier the Church's manual for therapists working with homosexual clients contained no recommendation of electrical aversion therapies, and even cautions, "Some of the methods suggested [in reference works], such as masturbation therapy and some forms of aversion therapy, are inappropriate for use in LDS Social Services."

The Church's manual did, however, suggest techniques that mirror the desensitization/arousal approach described by James in 1978 and recommended as the first line approach in this textbook published a year later.[206]

They—like McBride during the Oaks administration at BYU—were current with the best science and professional guidance available.

Conclusion

As late as 2000, a psychology textbook could write of aversion therapy for pedophiles:

> A real-life example of the use of aversion therapy comes from Marshall and Barbaree (1988). They taught child-molesters to administer themselves smelling salts whenever they had erotic thoughts involving children. They also used penile plethysmography to help condition the men out of attraction to children. This means that the men wore a pressure-sensitive penis-ring which, if stretched, would complete an electric circuit and administer a painful shock. They were shown pictures of children, and, whenever they responded physically they would receive a shock. The aim was that the men would begin to associate erotic thoughts of children with a noxious smell and electric shocks. At follow-up, 13 per cent of the treatment group reoffended as opposed to 34 per cent of a control group, showing that the aversion therapy was quite effective. *This may sound like*

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[205] McConaghy, "Sexual Deviation," 692.

[206] Compare James, "Treatment of Homosexuality II," 31 with LDS Social Services, *Professional Development Program: Understanding and Changing Homosexual Orientation Problems* (Salt Lake City, UT: The Church of Jesus Christ of Latter-day Saints, 1981), 19–21, 25–26.

> *a rather barbaric procedure, but you should be aware that it was done with the consent of the offenders, who expressed a wish to change their behaviour. The aversion procedure was also accompanied by supportive counselling*, so that as far as possible it was experienced as therapy rather than a punishment.[207]

The same technique is here used for pedophiles as was used in the 1970s for homosexuals—with about the same success rate.

Note, however, that the author discourages us from seeing this as barbaric, but strives to help students see that these were legitimate efforts to help consenting patients overcome a behavior they wished to extinguish. He believes even limited success was worth it.

It turns out that what we conclude about attempts to help with aversion therapy tells us what we have decided—on non-scientific grounds—about homosexual behavior. We ought to evaluate sincere professionals and researchers in the context of their times, and not based on what decades of further research have taught us.

[207] Jarvis, 25.