# Curing sexual deviance : medical approaches to sexual offenders in England, 1919-1959

# Curing sexual deviance

## Medical approaches to sexual offenders in England, 1919-1959

Janet Weston
Department of History, Classics, and Archaeology
Birkbeck, University of London

Submitted for the degree of Doctor of Philosophy
September 2015

**Declaration:**

I confirm that all material presented in this thesis is my own work, except where otherwise indicated.

Signed .....

# Abstract

This thesis examines medical approaches to sexual offenders in England between 1919 and 1959. It explores how doctors conceptualised sexual crimes and those who committed them, and how these ideas were implemented in medical and legal settings. It uses medical and criminological texts alongside information about specific court proceedings and offenders' lives to set out two overarching arguments. Firstly, it contends that sexual crime, and the sexual offender, are useful categories for analysis. Examining the medical theories that were put forward about the 'sexual offender', broadly defined, and the ways in which such theories were used, reveals important features of medico-legal thought and practice in relation to sexuality, crime, and 'normal' or healthy behaviour. This broad category has often been overlooked in favour of research into much more specific sexual identities, acts, or offences. Secondly, this thesis argues that clinical theories in relation to sexual offenders were remarkably diverse, but that this diversity and resultant flexibility were key to their usefulness for doctors and the judiciary alike. Doctors did not hold firmly to any single aetiological model, nor claim that all sexual offenders could be cured. The legal and penal systems could deploy medical approaches to justify extremely varied decisions, individualising responses to sexual crime insofar as the legal system would allow. The ways in which medical theories were incorporated and shaped by the legal system, and the flexible nature of these theories themselves, extended the variety of possible outcomes for sexual offenders without fundamentally altering their status. These medical approaches, established over the early to mid-twentieth century in England, laid important foundations for later years. This project opens up new ways of understanding medico-legal theory and practice as they relate to a wide range of human sexual behaviour.

# Acknowledgements

This research was funded by a studentship from the School of Social Sciences, History, and Philosophy at Birkbeck, and I would like to extend my thanks to the anonymous donor whose generosity made this possible. Their support of postgraduate research, and of Birkbeck in particular, deserves recognition.

I have benefited enormously from the wisdom and enthusiasm of many scholars, at Birkbeck and beyond. Joanna Bourke has been an exemplary supervisor, and her insights and support have been indispensible. Sean Brady's interest and encouragement in the earliest stages of this project, and indeed throughout, were invaluable. Special mention must go to Hazel Croft, Stef Eastoe, and Susie Shapland for their time and feedback.

I am grateful to the archivists who have searched their repositories and responded to my queries, even when their answers were in the negative. Staff at Birmingham Archives and Heritage, the London Metropolitan Archives, the Modern Records Centre in Warwick, and the West Yorkshire Archive Service have all been particularly helpful. I am also grateful to the staff of the Centre for Crime and Justice Studies, who very kindly allowed me access to their historical records.

The decision to return to university to undertake this project was a momentous one, and my family and friends have excelled themselves in their displays of confidence that this project was both achievable and worthwhile. For this and much more besides, my particular thanks go to Owen Roberts. His boundless support, encouragement, and a remarkable willingness to discuss and debate this thesis at length, have made all the difference.

# Table of Contents

# List of Figures



# Abbreviations

| | |
|---|---|
| BMA | British Medical Association |
| *BMJ* | British Medical Journal |
| DSM | Diagnostic and Statistical Manual of Mental Disorders |
| ECT | Electro-convulsive therapy |
| ISTD | Institute for the Scientific Treatment of Delinquency |
| *JMS* | Journal of Mental Science |
| KC | King's Counsel |
| NHS | National Health Service |
| RAF | Royal Air Force |
| SOTP | Sexual Offender Treatment Programme |
| UK | United Kingdom |
| USA | United States of America |
| VD | Venereal disease |

# Chapter 1: Introduction

In the late 1960s, Russell George, a convicted sex offender, reflected upon others 'like me' and wished vehemently that someone could 'get them to see there is something the matter with them, but that it's something there's treatment for, that it can be cured'.[1] This was a remarkable statement. Medical treatment to 'cure' offenders of their criminal conduct had been all but unheard of fifty years earlier, and sexual crime had certainly not merited any particular attention from doctors in England. By the time of Russell George's most recent conviction and referral to a psychiatrist, ideas of medical cures for criminal tendencies had achieved acceptance in many quarters, and treatment to address the supposed causes of sexual crimes was being offered in a range of settings. Even now, treatment for sexual offenders occupies a distinctive, and occasionally high-profile, place within the English penal system.[2] This thesis seeks to address the evolution of this medical approach to sexual deviance, and the nature and extent of its reach. How did doctors interpret, diagnose, and attempt to cure someone like Russell George? How did his treatment by a psychiatrist, as an alternative to imprisonment, become one possible solution to his crime?

---

[1] Tony Parker, *The Twisting Lane* (London: Faber and Faber, 2013 [1969]) p.43. All names used in this book were pseudonyms.

[2] A national strategy for the psychological treatment of sexual offenders, based upon Cognitive Behavioural Therapy, was introduced in 1991. For a summary of current provision for sexual offenders in custody, see *HM Chief Inspector of Prisons for England and Wales Annual Report 2012-13* (London: The Stationery Office, 2013) p.49. Some recent newspaper coverage includes Wesley Johnson, 'Sex Offenders Being Released from Prison without Accessing Treatment Programme', *Independent,* 12 January 2012 <http://www.independent.co.uk/news/uk/crime/sex-offenders-being-released-from-prison-without-accessing-treatment-programme-7843641.html> [accessed 21 June 2012]; Decca Aikenhead, 'Chemical Castration: The Soft Option?', *Guardian,* 18 January 2013 <http://www.theguardian.com/society/2013/jan/18/chemical-castration-soft-option-sex-offenders> [accessed 19 January 2013]; Emily Dugan, 'Sex Offenders Freed from Prison without Treatment Will "Create More Victims"', *Independent,* 3 February 2014 <http://www.independent.co.uk/news/uk/crime/exclusive-sex-offenders-freed-from-prison-without-treatment-will-create-more-victims-9102847.html> [accessed 3 February 2014].

## 1.1 Summary of arguments

This thesis presents two overarching arguments. Firstly, it contends that sexual crime and the sexual offender, in their broadest senses, are fruitful categories of analysis. The 'sexual offender' has often been conceptualised as a particular problem over the course of the twentieth century, requiring medical interpretation. Tracing the medical theories which have evolved in response to this, and the ways in which they were used, reveals important features of medico-legal thought and practice which are at risk of being obscured if sexuality is considered more narrowly. Histories of sexuality have tended to focus upon particular categories of sexual identity or activity that are familiar and meaningful to us now, but may not have been so to the historical actors under investigation. Homosexuality in particular has come under scrutiny, in the form of projects to locate homosexual individuals and acts in history, or to explore the ways in which same-sex intimate relationships have differed from today's idea of homosexuality.[3] These efforts either to identify or to complicate particular aspects of sexual life in the past with reference to contemporary sexual identities, dubbed 'ancestral genealogy' and 'queer genealogy' respectively by cultural historian Laura Doan,[4] may be productive on their own terms, but tend to enforce distinctions that may be historically inaccurate. Moving away from early-twenty-first-century conceptions of sexual deviance and sexual crime therefore adds depth to our understanding of the history of sexuality and its encounters with medicine.

[3] A few key works in the history of homosexuality include John Boswell, *Rediscovering Gay History: Archetypes of Gay Love in Christian History* (London: Gay Christian Movement, 1982); David M. Halperin, *One Hundred Years of Homosexuality, and Other Essays on Greek Love* (New York; London: Routledge, 1990); Jeffrey Weeks, *Coming Out: Homosexual Politics in Britain from the Nineteenth Century to the Present* (London: Quartet, 1990 [1977]).
[4] Laura L. Doan, *Disturbing Practices: History, Sexuality, and Women's Experience of Modern War* (Chicago: University of Chicago Press, 2013) pp.14-15.

This is not to suggest that medical views and interpretations of the 'sexual offender' were consistent or coherent. Medical theories of sexual offenders reflected widely held perceptions of normal and abnormal sexual and criminal behaviour, and, in its curiosity regarding offences that appeared to lack an easily identifiable motive, the medical profession focused upon some forms of sexual crime more than others. Crimes associated with the 'perversions' tended to prompt much greater interest and enquiry than heterosexual violence. However, medical interest and intervention were not confined to homosexuality or prostitution, the two manifestations of sexual crime that have often garnered the most attention. They also addressed indecent exposure, assaults of children, crimes connected to sadism, and even theft. Crimes that may have seemed radically different at first glance could be explained through strikingly similar mechanisms by doctors, whose assessments of offenders ranged from the curable to the hopeless case. The sexual offender, as understood by doctors, was a broader and less stable category than it might first appear.

The second overarching argument of this thesis is that clinical theory and practice in relation to sexual offenders were remarkably diverse, but that this diversity was key to their usefulness for doctors and the judiciary alike. Doctors did not generally adhere to any single theory of causation, nor claim that any particular disorder could be addressed successfully by their methods of treatment. Their careful weighting of many different possible factors, from home environment and age to sexual history and personality, allowed their diagnoses and prognoses to remain extremely flexible. In its acceptance of 'ontological anarchy', this flexibility allowed a potentially fragmented profession to remain united.[5] It also enabled doctors to explain the wide variety of outcomes that appeared to emanate from their research and treatments, and

[5] Martyn Pickersgill, 'The Endurance of Uncertainty: Antisociality and Ontological Anarchy in British Psychiatry, 1950–2010', *Science in Context,* 27 (2014), 143-175.

responded to judicial and penal concerns and structures as well. The plurality of medical thought regarding sexual offenders meant that expert evidence could be a necessary feature of one case but irrelevant in another, allowing the judiciary to exercise their discretion and to justify a range of conclusions about the sexual offenders appearing in court.

Medical approaches were closely connected to the interests and requirements of the legal and penal systems, with the nature and demands of the English legal system influencing the presence, absence, and impact of expert views of sexual crime within judicial settings. However, although some disagreement between judges and doctors took place, the two professions should not be understood as simply operating in opposition to one another. Administrative and conceptual hurdles within medicine and law alike also limited the extent to which medical theories could find practical application. Medical evidence addressing the possible causes of sexual crime, based upon the examination of the defendant, became more common but could not be included in every case. Equally, alternatives to conventional methods of punishment grew in number, but were not open to everyone convicted of sexual crime. Interventions to study and treat sexual offenders were limited in scope in England, particularly when compared to Scandinavia, Germany, and the USA. The interactions of medical, legal, and penal theory and practice in England served to create greater flexibility in dealing with sexual offenders, without enabling medical models to become dominant.

Focusing upon the early to mid-twentieth century, this thesis argues that this was a particularly significant period for medical models of sexual deviance in England. Although the first outpouring of Western medical interest in sex and sexuality is

commonly attributed to the sexologists of the late nineteenth and early twentieth centuries, only in the interwar years did doctors in England begin to acknowledge sexual abnormality or disorder as an acceptable medical specialism.[6] This period was also significant for forensic medicine, as expert evidence regarding the state of a defendant's mind was gradually accepted as influential over sentencing decisions. Attention to English medicine, as distinct from its cousins in continental Europe and the USA, reveals that the sexual pathologies emerged as part of English medical thought later than has commonly been understood, and that their appearance was closely connected to a broader interest in the rehabilitation and reform of the criminal.[7] The adoption of this temporal and geographical focus highlights the connections between medical interest and theories regarding proscribed sexual behaviour, and changing ideas about crime, punishment, and mental disorder. Medical approaches to sexual crime in England can perhaps be best understood within the context of mid-twentieth-century impulses towards the rehabilitation of offenders. Given this connection, the often-overlooked fields of twentieth-century prison medicine and forensic psychiatry have an important role to play in this story, as they shaped and were shaped by newly psychoanalytical and psychological theories of crime.

The growth of medical interest in sexual deviance was a gradual process, but this thesis takes as its starting point a modest but significant development for the medical profession, especially forensic medicine, which occurred in 1919. At a meeting of the Birmingham Justices that year, it was agreed that in relation to many crimes, 'some mental instability is the fundamental cause' and 'the problem has now become acute'. In an experimental response to this impending crisis, a section of Birmingham

[6] This focus on the nineteenth century is largely attributable to Michel Foucault, *The History of Sexuality: An Introduction*, trans. Robert Hurley vol. 1 (London: Penguin, 1990 [1976]).
[7] 'English' medicine is also distinct from its Scottish counterpart, about which more will be said later in this chapter.

Prison's hospital was set apart for cases of 'mental disturbance', and 'a special Medical Officer' was sent as quickly as possible to 'furnish all possible assistance'.[8] Dr Maurice Hamblin Smith was something of an expert in mental disorder, a self-professed 'convinced and unrepentant Freudian' whose two decades of experience working within prisons had led him to conclude that 'every offender presents a problem in mental pathology'.[9] His Home Office-endorsed appointment to focus on mental illnesses amongst prisoners marked official engagement with the exploration of medical approaches to criminality, and reflected post-war anxiety surrounding mental disturbance amongst young men as well as growing interest in psychoanalysis amongst doctors in England.

Over the following decades, discussions proliferated around the use of medicine to rehabilitate or 'cure' offenders, reducing the chances of reoffending. The 'sexual offender' was frequently cited as a type of criminal that was particularly likely to suffer from mental disorder, and therefore demanded careful medical enquiry. However, 'sexual offender' was often taken to be synonymous with 'sexual pervert', and not all sexual crimes were given equal weight. Some offences generated particular concern at particular times, while others were widely ignored. Numerous historians of homosexuality have identified the post-war period as a significant one in terms of the emergence of medical debate and interpretation, not least of all thanks to changes in newspaper reporting.[10] Although this thesis will have as a recurring theme the changes

[8] *Report of the Commissioners of Prisons and the Directors of Convict Prisons, with Appendices, for the Year Ended 31st March, 1919* (London: H. M. Stationery Office, 1919) pp.16-17.
[9] M. Hamblin Smith, *The Psychology of the Criminal*, 2nd edn (London: Methuen, 1933) p.vii. See also 'Psychological Treatment of Crime, 1921-41', The National Archives (London), HO 45/18736.
[10] For example, Chris Waters, 'Disorders of the Mind, Disorders of the Body Social: Peter Wildeblood and the Making of the Modern Homosexual', in *Moments of Modernity,* ed. by Becky Conekin, Frank Mort, and Chris Waters (London: Rivers Oram, 1999), pp.134-151 (p.140). A similar point is set out in Chris Waters, 'Sexology', in *Advances in the Modern History of Sexuality,* ed. by Harry Cocks and Matt Houlbrook (Basingstoke: Palgrave Macmillan, 2006), pp.41-63 and Sean Brady, *Masculinity and Male Homosexuality in Britain, 1861-1913* (Basingstoke: Palgrave

that occurred in the 1940s and 1950s in medical theory and practice, it will also emphasise that, when sexual deviance as a whole is considered, these changes were a matter of degree, not kind. Discussion about homosexuality did fill many column inches and much Parliamentary time in the aftermath of the Second World War, but doctors continued to investigate other sexual crimes and their goals of rehabilitation and therapeutic optimism did not begin to wane until the end of the 1950s.

By 1959, which this thesis takes as its end-point, efforts to cure sexual offenders of their deviant behaviours remained modest in scale, but were nevertheless well established. Provision for the psychiatric treatment of convicted offenders had been enshrined in law, and a conceptually revolutionary prison was under construction in Grendon Underwood, Buckinghamshire, which would operate under the control of a psychiatrist as a therapeutic community for offenders. The press had introduced many psychiatric ideas about sexual conduct and crime to the general public, and treatment for sexual deviance was available on the NHS. However, profound changes were also on the horizon. Crime rates began to rise and prisons became gravely overcrowded, to an extent unprecedented in the twentieth century. Perhaps not coincidentally, at the same time as the prisons filled, mental hospitals were emptying. The Mental Health Act of 1959 gradually brought about de-institutionalisation, and its provisions for mentally disordered offenders proved ineffective. Prison medicine came under attack, as did psychiatry as a whole.[11] Efforts in treatment began to focus narrowly on juveniles, and on the problem of alcohol and drug addiction, and soon the entire programme of

---

Macmillan, 2005) p.157. On post-war newspapers, see Adrian Bingham, *Family Newspapers?: Sex, Private Life, and the British Popular Press 1918-1978* (Oxford: Oxford University Press, 2009) p.12, pp.160-174.

[11] These critiques can be found in *The Organisation of the Prison Medical Service* (London: H. M. Stationery Office, 1964); Thomas Szasz, *The Myth of Mental Illness: Foundations of a Theory of Personal Conduct* (New York: Harper and Row, 1961). The loss of confidence in rehabilitation is epitomised by Robert Martinson's now-famous 'nothing works' essay: Robert Martinson, 'What Works? Questions and Answers about Prison Reform', *The Public Interest,* 0.35 (1974), 22.

rehabilitation over punishment was in decline. At the same time, changing attitudes towards sexual behaviour threw into doubt determinations of the normal, the healthy, and the criminal. The project to cure sexual offenders was to be placed on hold.[12]

## 1.2 Theoretical considerations

In order to trace medical theory and practice in relation to sexual offenders, the activities and ideas under scrutiny here are primarily those of medical professionals. These were mostly individuals with medical qualifications practising as doctors in clinics, hospitals, or prisons, but could also include psychologists, psychoanalysts and psychotherapists, psychiatric social workers, and others involved in researching or treating sexual deviance from a medical perspective. The views and reactions of legal and judicial workers, civil servants, prison officials, criminologists, and campaigners are also relevant, in that they illuminate the spread and reception of medical ideas and indicate some of the ways in which they were used. The adoption of this approach is not to suggest that medico-legal attitudes were solely responsible for changing perceptions of sexual crime and deviance, however. As Victoria Bates has argued with reference to a slightly earlier period, the expertise of these professions was inextricably linked to broader social interests, beliefs, and concerns.[13] Matters of religion, family structures and relationships, education, gender, and many other changing facets of life during this period were influential, and informed medico-legal perspectives. For the most part, though, they lie beyond the scope of this thesis. The focus here is on medical

[12] Campaigns for homosexual law reform, the Paedophile Information Exchange, and new ideas with roots in the feminist movement are the main examples of this. A sexual offenders' treatment programme was re-introduced to the prison system in the early 1990s: C. Jones, 'Establishing a Sex Offender Treatment Programme within a Prison', *British Journal of Psychiatry: Bulletin,* 20 (1996), 261-263.

[13] Victoria Bates, '"Not an Exact Science": Medical Approaches to Age and Sexual Offences in England, 1850-1914', (PhD thesis, University of Exeter, 2012).

interventions into the problem of sexual crime, and so doctors and the medico-legal structures within which they worked will receive the lion's share of attention.

This consideration of medical thought and practice in England does not presuppose a unified or all-powerful national medical profession, nor a growing number of psychiatrists intent upon identifying ever-larger fields of human behaviour and emotion as abnormal or pathological.[14] Since the 1960s and the prominent contributions of Thomas Szasz and Michel Foucault to the ways in which mental illness, past and present, has been understood, many of the principles and activities of psychiatry have come under attack.[15] This project has been influenced by such works to the extent that they have suggested challenges to the authority of medicine, but it adopts a critical stance towards psychiatry rather than a wholly negative one. It also recognises that, although the doctors considered here were at times providing potentially life-altering diagnoses and treatments, contributing authoritatively to debates on health and normality, and influencing their patients' liberty, this was not always a mainstream or coherent effort, nor were the goals of medicine always possible or far-reaching, nor resisted by patients.[16] As Annemarie Mol has so clearly summarised, we 'no longer believe in coherent sets of norms imposed in a single order', preferring instead to think

[14] This responds to Ludmilla Jordanova's call for recognition of the many threads, relationships, and individuals at work in creating scientific ideas. Ludmilla Jordanova, 'Has the Social History of Medicine Come of Age?', in *Locating Medical History: The Stories and Their Meanings,* ed. by Frank Huisman and John Harley Warner (Baltimore; London: Johns Hopkins University Press, 2004), pp. 338-363 (p.350).

[15] Szasz, *The Myth of Mental Illness: Foundations of a Theory of Personal Conduct*; Michel Foucault, *History of Madness*, trans. Jonathan Murphy (London: Routledge, 2006); and Andrew Scull, *Social Order/Mental Disorder: Anglo-American Psychiatry in Historical Perspective* (Berkeley: University of California Press, 1989). For a critique from the same perspective of prison medicine in particular, see Joe Sim, *Medical Power in Prisons: The Prison Medical Service in England 1774-1989* (Milton Keynes: Open University Press, 1990).

[16] The often limited impact of medicine on individual lives has been discussed in Erin G. Carlston, '"A Finer Differentiation": Female Homosexuality and the American Medical Community, 1926-1940', in *Science and Homosexualities,* ed. by Vernon A. Rosario (New York; London: Routledge, 1997), pp.177-196; George Chauncey, 'From Sexual Inversion to Homosexuality: Medicine and the Changing Conceptualization of Female Deviance', *Salmagundi,* (1982), 114-146.

of multiples: multiple networks, individuals, and spheres of influence, as well as multiple opinions within one profession.[17] Disagreements within medicine and the limitations of medical influence must be recognised, to flesh out the story and to avoid any impression of medical hegemony.

It is also important to avoid 'manichean divisions of the world into oppressors and victims', a trait identified by historian and sociologist Jeffrey Weeks within histories of sexuality but equally applicable to histories of psychiatry and deviance.[18] Just as medicine has sometimes been characterised as an oppressive normalising force, so too have the objects of its diagnostic efforts been cast as passive sufferers. Research into sexology has illustrated the need to avoid this simplification, drawing attention not only to humane intentions on the part of doctors, but also to collaborative attitudes between doctors and their patients.[19] This complexity is, perhaps, particularly strongly in evidence in the context of medicine and sexual crime. The extent to which medical approaches were embraced by sexual offenders and their lawyers will feature in the chapters that follow. Also worth remembering is the fact that 'doctors' and 'sexual offenders' did not constitute two mutually exclusive groups.[20] That some individuals occupied both categories was a rarely acknowledged fact, but it challenges any notion of clearly defined boundaries, intentions, or outcomes.

---

[17] Annemarie Mol, *The Body Multiple* (Durham; London: Duke University Press, 2002) pp.62-68.
[18] Jeffrey Weeks, 'Invented Moralities', *History Workshop,* (1991), 151-166 (p.164).
[19] For example, Lesley Hall, 'Heroes or Villains? Reconsidering British fin de siècle Sexology', in *New Sexual Agendas,* ed. by Lynne Segal (Basingstoke: Macmillan, 1997), pp.3-16; Joanne J. Meyerowitz, *How Sex Changed: A History of Transsexuality in the United States* (Cambridge, MA; London: Harvard University Press, 2002); Harry Oosterhuis, *Stepchildren of Nature: Krafft-Ebing, Psychiatry, and the Making of Sexual Identity* (Chicago: University of Chicago Press, 2000).
[20] There are accounts in the press of doctors prosecuted for sexual crimes, and undoubtedly many more committed offences without detection. For example, 'Dawlish Sensation: Wormwood Scrubbs Official Charged', *Western Times,* 21 September 1928, p.6.

Histories of medicine and sexuality can also question divisions between health and illness, and the ways in which these are defined. The emphasis placed by some historians of medicine upon the social processes through which any particular disease is 'framed', to use the concept introduced by Charles Rosenberg, has been found wanting, with Roger Cooter arguing that it represents an ineffectual compromise between somatic and social explanations for disease categories.[21] Attention to the 'framing' of disease allows for the presence of specific biological phenomena, perceived by patient or doctor, but also a 'collective effort to make cognitive and policy sense out of those perceptions' which shapes the resultant disease definitions and their consequences.[22] This attempt at even-handed agnosticism remains valuable within the context of medical, and primarily psychiatric, diagnoses connected to such a fluid concept as sexual deviance. Indeed, a similar agnosticism is in evidence amongst many of the doctors involved in researching the sexual offender, albeit founded upon rather different ideas of biological and social forces. This similarity and difference serve to highlight and interrogate that which Rhodri Hayward has identified as a flaw within 'framing': a tendency to remain blind to the 'unstable status of natural and cultural categories' themselves.[23] Doctors of the mid-twentieth century may have suspected that sexual offending could best be understood through a matrix of influential forces, but their perceptions of the biological and the social were rather different from our own.

The nature of sexuality, like disease, has been the subject of conceptual conflict. The desire to provide medical explanations for sexual conduct, especially in its non-

[21] Charles E. Rosenberg, 'Disease in History: Frames and Framers', *The Milbank Quarterly,* 67 (1989), 1-15; Roger Cooter, '"Framing" the End of the Social History of Medicine', in *Locating Medical History: The Stories and their Meanings,* ed. by Frank Huisman and John Harley Warner (Baltimore; London: Johns Hopkins University Press, 2004), pp.309-337; and also Rhodri Hayward, '"Much Exaggerated": The End of the History of Medicine', *Journal of Contemporary History,* 40 (2005), 167-178.
[22] Rosenberg, 'Disease in History: Frames and Framers', p.4.
[23] Hayward, '"Much Exaggerated"', p.176.

heterosexual forms, is as popular today as it ever was amongst the psychiatrists of the mid-twentieth century. A presentation at the American Association for the Advancement of Science conference in February 2014 was widely reported in the UK for its findings that 'male sexual orientation is influenced by genes', generating column inches almost as numerous as those responding to geneticist Dean Hamer's related research two decades earlier.[24] Recent research has also suggested that sexual offending might 'run in a family's genes', in a clear echo of the medical theories of the past.[25] This quest to uncover genetic answers to questions about sexual behaviour is mirrored in some histories of sexuality, perhaps best exemplified by historian of medicine Edward Shorter. He has made plain his view that it 'is in capital letters nature not nurture that drives desire', and sees practical issues around health, hygiene, and private space as the causes of changing sexual practices across time and place.[26] This he situates in opposition to the 'social-construction view' associated with Michel Foucault, sociologists Mary McIntosh and Jeffrey Weeks, and historian David Halperin. In Halperin's words, 'sexuality is a cultural production', presently centred around a division between homo-

[24] For some of the coverage of the 2014 research, see Ian Sample, 'Male Sexual Orientation Influenced by Genes, Study Shows', *Guardian,* 14 February 2014 <http://www.theguardian.com/science/2014/feb/14/genes-influence-male-sexual-orientation-study> [accessed 15 February 2014]; Sarah Knapton, 'Being Homosexual Is Only Partly Due to Gay Gene, Research Finds', *Telegraph,* 14 February 2014 <http://www.telegraph.co.uk/science/science-news/10637532/Being-homosexual-is-only-partly-due-to-gay-gene-research-finds.html> [accessed 14 February 2014]; and for coverage of Dean Hamer's findings, see Steve Connor, 'Research Confirms "Gay Gene" Discovery', *Independent,* 31 October 1995 <http://www.independent.co.uk/news/research-confirms-gay-gene-discovery-1580244.html> [accessed 18 February 2014]. Theorist Jennifer Terry has characterised this persistent interest in a definitive aetiology for sexual difference as the 'seductive power of science'. Jennifer Terry, 'The Seductive Power of Science in the Making of Deviant Subjectivity', in *Science and Homosexualities,* ed. by Vernon A. Rosario (New York; London: Routledge, 1997), pp.271-295.

[25] Niklas Långström, Kelly M. Babchishin, Seena Fazel, Paul Lichtenstein, and Thomas Frisell, 'Sexual Offending Runs in Families: A 37-year Nationwide Study', *International Journal of Epidemiology,* 44 (2015), 713-720; Jenny Hope, 'Sex Crimes May Run in a Family's Male Genes: Brothers of Men Convicted of Offences Five Times More Likely to Commit Similar Crimes', *Daily Mail,* 9 April 2015 <http://www.dailymail.co.uk/news/article-3031261/Sex-crimes-run-family-s-male-genes-Brothers-men-convicted-offences-five-times-likely-commit-similar-crimes.html> [accessed 9 April 2015].

[26] Edward Shorter, *Written in the Flesh: A History of Desire* (Toronto; London: University of Toronto Press, 2005) p.4.

and heterosexuality and imbued with particular significance or 'cultural weight'.[27] That the significance and meanings attributed to different sexual acts has changed over time is an underlying theme of this thesis.

As philosopher Ian Hacking has observed, there is limited value in pointing out that some self-evidently social creations, from classification systems to international economies, are socially constructed.[28] It is therefore apparent that this thesis is based upon the understanding that sexual crime is defined by legislation, and that sexual deviance only exists in relation to widely agreed views of morality. However, it is worth clarifying that the term 'sexual deviance' is used here to apply to any behaviours that were seen as both deviant and also in some way sexual. Both elements of the term are prone to fluctuations in meaning over time and in different contexts. Bigamy, for example, was regularly included as a sexual offence in official statistics, but was not felt to be such by the medical profession,[29] while Chapter 3 of this thesis will discuss some of the crimes such as theft that were sometimes classed as sexual in nature by doctors. Furthermore, medical enquiry into sexual offences tended to ignore any clear demarcation between the illegal and the socially proscribed or 'abnormal'. 'Deviance' has often been conflated with abnormality and illness as well as criminality; as Georges Canguilhem and others have observed, the normal and the deviant or pathological have

[27] Halperin, *One Hundred Years of Homosexuality*, p.25, p.28. Further examples of a similar perspective include Janice Irvine, 'Regulated Passions: The Invention of Inhibited Sexual Desire and Sexual Addiction', in *Deviant Bodies: Critical Perspectives on Difference in Science and Popular Culture,* ed. by Jennifer Terry and Jacqueline Urla (Bloomington, IN: Indiana University Press, 1995), pp. 314-337; and I. D. Crozier, 'The Medical Construction of Homosexuality and Its Relation to the Law in Nineteenth-Century England', *Medical History,* 45 (2001), 61-82.

[28] Ian Hacking, *The Social Construction of What?* (Cambridge, MA; London: Harvard University Press, 1999), especially p.10.

[29] See, for example, the discussion of sexual offences in *Criminal Statistics Relating to Criminal Proceedings, Police, Coroners, Prisons, and Criminal Lunatics, for the Year 1922* (London: H. M. Stationery Office, 1924) p.6, and, in contrast, bigamy's separate listing in *Report of the Commissioners of Prisons for the Year 1949* (London: H. M. Stationery Office, 1950) p.17. Bigamy was not mentioned at all in William Norwood East, 'The Interpretation of Some Sexual Offences', *Journal of Mental Science,* 71 (1925), 410-424, nor in Anthony Storr, *Sexual Deviation* (London: Heinemann, 1965).

been understood as direct opposites as well as fixed and objectively identifiable points.[30] One of the abiding concerns of this thesis is this conflation of criminality, abnormality, and illness in relation to sexual conduct. How did it happen that certain sexual crimes (but not all) came to be understood as markers of illness? As described by historian Joan Scott, this objective is 'one that takes the emergence of concepts and identities as historical events in need of explanation'.[31] The emergence of the sexual offender as a distinct type of criminal and a medical concern requires such explanation.

Neither 'sexual deviance' nor the sexual offender is a coherent or consistent category. Evolutions within medical theory regarding abnormal, unhealthy, or criminal sexual conduct nevertheless make sexual deviance a useful analytical category. It allows for the examination of ideas of sexual crime and misconduct in a way that transgresses current conceptions of sexual identities, and even our understanding of which acts hold sexual significance. The sexual offenders who found themselves the subjects of medical enquiry were, as a result, an equally varied group, including those convicted of legally recognised sexual offences, those convicted of all manner of other crimes attributed to sexual deviance, and those never convicted but understood by the medical profession to possess abnormal or anti-social sexual tendencies. Particular impulses or acts, and the medico-legal interest that surrounded them, marked out some individuals as a group of a distinctive type. A consideration of this group as a whole contributes to a deeper understanding of historical perceptions of sexuality, psychiatry, and crime.

Despite the new perspectives that this approach offers, it is not without problems. 'Analyses of the regulation of sexualities', as historian Matt Houlbrook has

[30] Georges Canguilhem, *The Normal and the Pathological*, trans. Carolyn R. Fawcett and Robert S. Cohen (New York: Zone Books, 1989).
[31] Joan Scott, 'The Evidence of Experience', *Critical Inquiry,* 17 (1991), 773-797 (p.792).

observed, 'deconstruct the formation of dominant sexual codes yet simultaneously replicate those very categories'.[32] In other words, focusing upon deviance risks allowing the 'normal' to escape inspection, and reiterating connections between particular sexual acts and criminality or pathology that remain persistent today. These include the conflation of homosexuality and paedophilia, for example, or the long-standing presence of sado-masochism as a diagnosis within psychiatry textbooks. The use of the historical category of 'sexual deviance', encompassing many different acts, illnesses, and crimes emphasises such connections. The 'offenders' featured in the following pages are sometimes not criminal at all, particularly by today's laws, and there was not always an obvious victim. Others, however, were guilty of appalling violence and abuse, persistent assaults, and conduct that was probably frightening for those involved, at best. However, this examination of medical views surrounding sexual deviance will address the ideas of 'normal' against which deviance was understood, and will scrutinise some of the assumptions and beliefs that lay behind systems of classifying, pathologising, and defining. Shining a light on these views as a whole is, I argue, not only important in order to capture a wider understanding of medical theories of both deviance and mental illness, but also to acknowledge and explore these echoes of the past that remain.[33]

Lastly, it is necessary to explain two points of language. The use of 'England' and 'English' throughout this thesis should not be read as inaccurate synonyms for Britain and British. The Scottish legal system, based upon Roman law and enjoying the use of a 'diminished responsibility' defence throughout the period in question, was quite different in both theory and practice from that in England. Scotland also had a slightly different psychiatric tradition, enjoying closer ties with America and a much stronger

[32] Matt Houlbrook, '"Lady Austin's Camp Boys": Constituting the Queer Subject in 1930s London', *Gender & History,* 14 (2002), 31-61 (p.33).
[33] This is influenced by Heather Love, *Feeling Backward: Loss and the Politics of Queer History* (Cambridge, MA; London: Harvard University Press, 2007).

history of forensic medicine. Although the border between the two nations was permeable and doctors as well as ideas did move across it, these important differences suggest that Scottish medico-legal thought may have its own history.[34] Furthermore, as Jeffrey Meek has suggested, significant national differences suggest a 'cultural gulf' between Scotland and England and Wales, certainly in relation to homosexual law reform.[35] This gulf may very well be present in relation to sexuality more broadly, and would require separate consideration. England and Wales arguably have more in common, with shared laws, doctors, prisons, and governance, and it seems unlikely that medical approaches to sexual crime were significantly different in Wales. In practice, the differences between urban centres and rural areas were probably much more weighty. However, doctors based in Welsh prisons or clinics are notably absent from debates regarding sexual deviance, and the focus here is on doctors working primarily in England.[36]

Secondly, this thesis uses terms such as 'perversion', 'abnormality', 'sexual offence', and 'sexual deviance' throughout. These terms were often used indiscriminately and interchangeably by doctors during the period under examination, and to a large extent I have followed their usage. This is not only to avoid the endless repetition of such clumsy and anachronistic phrases as 'socially proscribed sexual conduct', but also to signify the important conceptual foundations, rooted in broadly construed beliefs about what was normal, healthy, socially acceptable, and legal, of so much medical thought. Such language should not be taken to mean that any of those

[34] Recent explorations of the history of sexuality in Scotland have included Roger Davidson and Gayle Davis, *The Sexual State: Sexuality and Scottish Governance, 1950-80* (Edinburgh: Edinburgh University Press, 2012) and Jeffrey Meek, *Queer Voices in Post-War Scotland: Male Homosexuality, Religion and Society* (Basingstoke: Palgrave Macmillan, 2015).
[35] Meek, *Queer Voices in Post-War Scotland*, p.3.
[36] The exception is official statistics and prison reports, which combine England and Wales.

mentioned had necessarily broken the law, nor as signifiers of disapproval or condemnation of all of the acts and impulses in question.

### 1.3 Historiographical contexts

Histories of sexuality have rapidly multiplied since the late 1960s and early 1970s, when activism and academic interest coincided in their emphasis upon challenges to dominant assumptions and beliefs. Significant work by Jeffrey Weeks, John D'Emilio and Estelle Freedman, and Roy Porter and Lesley Hall, amongst many others, firmly established that sexual attitudes, acts, and identities could and should receive serious scholarly attention.[37] Historical research has explored a great many facets of sexual life, from prostitution to pornography, and in many cases has striven to capture the lives of those who seem to occupy non-normative sexual roles.[38] Perhaps the largest outpouring, though, has been dedicated to the exploration of same-sex desire. Mary McIntosh, Michel Foucault, David Halperin, George Chauncey, and Jeffrey Weeks played key roles in the introduction of new perspectives of homosexuality in the past, and enquiry into the subject on the part of historians of modern Britain shows little sign of abating.[39] Of

[37] Weeks, *Coming Out*; Jeffrey Weeks, *Against Nature: Essays on History, Sexuality, and Identity* (London; Concord, MA: Rivers Oram Press, 1991); John D'Emilio and Estelle B. Freedman, *Intimate Matters: A History of Sexuality in America* (New York: Harper & Row, 1988); Roy Porter and Lesley Hall, *The Facts of Life: The Creation of Sexual Knowledge in Britain, 1650-1950* (New Haven; London: Yale University Press, 1995).

[38] Just a few examples include Judith R. Walkowitz, *Prostitution and Victorian Society: Women, Class and the State* (Cambridge: Cambridge University Press, 1980); Lucy Bland, *Banishing the Beast: Feminism, Sex, and Morality* (London: Tauris Parke, 2002 [1995]); Laura L. Doan, *Fashioning Sapphism: The Origins of a Modern English Lesbian Culture* (New York; Chichester: Columbia University Press, 2001); Heike Bauer and Matt Cook, *Queer 1950s: Rethinking Sexuality in the Postwar Years* (Basingstoke: Palgrave Macmillan, 2012); Matt Cook, *Queer Domesticities: Homosexuality and Home Life in Twentieth-Century London* (Basingstoke: Palgrave Macmillan, 2014); Matt Houlbrook, *Queer London: Perils and Pleasures in the Sexual Metropolis, 1918-1957* (Chicago: University of Chicago Press, 2006).

[39] Mary McIntosh, 'The Homosexual Role', *Social Problems,* 16 (1968), 182-192; Foucault, *History of Sexuality*; Halperin, *One Hundred Years of Homosexuality*; George Chauncey, *Gay New York: The Making of the Gay Male World, 1890-1940* (London: Flamingo, 1995); Weeks, *Coming Out*. More recent research includes Brady, *Masculinity and Male Homosexuality*; Sebastian Buckle, *The Way Out: A History of Homosexuality in Modern Britain* (London: I. B. Tauris, 2015); H. G. Cocks, *Nameless Offences: Homosexual Desire in the Nineteenth Century* (London: I. B. Tauris,

particular interest have been the ways in which homosexuality has been regulated, not only in law but also by medical science. Sexologists from Magnus Hirschfeld to Alfred Kinsey have enjoyed considerable attention for their role in introducing medical language and concepts to Western understandings of sexual difference.[40] Jennifer Terry, Chiara Beccalossi, Harry Oosterhuis, Ivan Crozier, and Chris Waters have all conducted careful examinations of the evolution of such medical ideas, and the ways in which they have been embraced, rejected, and deployed by different groups at different times.[41]

Forms of sexual transgression other than homosexuality have received rather less attention. Cross-dressing and transgender have been explored by Alison Oram and Joanne Meyerowitz, who have endeavored to trace the interrelationship between medical and popular ideas of gender and the formation of trans* identities.[42] For legal

---

2003); Meek, *Queer Voices in Post-War Scotland*; Emma Vickers, *Queen and Country: Same-Sex Desire in the British Armed Forces, 1939-1945* (Manchester: Manchester University Press, 2013).

[40] See Paul Robinson, *The Modernization of Sex: Havelock Ellis, Alfred Kinsey, William Masters and Virginia Johnson* (London: Elek, 1976); Toni Brennan and Peter Hegarty, 'Who Was Magnus Hirschfeld and Why Do We Need to Know?', *History & Philosophy of Psychology,* 9 (2007), 12-2; Vern L. Bullough, *Science in the Bedroom: A History of Sex Research* (New York: BasicBooks, 1994); Heike Bauer, 'Sexology Backward: Hirschfeld, Kinsey and the Reshaping of Sex Research in the 1950s', in *Queer 1950s: Rethinking Sexuality in the Postwar Years,* ed. by Heike Bauer and Matt Cook (Basingstoke: Palgrave Macmillan, 2012), pp.133-149; Hall, 'Heroes or Villains? Reconsidering British fin de siècle Sexology' and H. G. Cocks, 'Saucy Stories: Pornography, Sexology and the Marketing of Sexual Knowledge in Britain, c. 1918-70', *Social History,* 29 (2004), 465-484 (especially p.471).

[41] Terry, 'The Seductive Power of Science in the Making of Deviant Subjectivity'; Jennifer Terry, 'Anxious Slippages between "Us" and "Them": A Brief History of the Scientific Search for Homosexual Bodies', in *Critical Perspectives on Difference in Science and Popular Culture,* ed. by Jennifer Terry and Jacqueline Urla (Bloomington, IN: Indiana University Press, 1995), pp.129-169; Chiara Beccalossi, 'Madness and Sexual Psychopathies as the Magnifying Glass of the Normal: Italian Psychiatry and Sexuality c.1880–1910', *Social History of Medicine,* 27 (2014), 303-325; Oosterhuis, *Stepchildren of Nature*; I. D. Crozier, 'Taking Prisoners: Havelock Ellis, Sigmund Freud, and the Construction of Homosexuality, 1897–1951', *Social History of Medicine,* 13 (2000), 447-466; Ivan Crozier, 'Nineteenth-Century British Psychiatric Writing about Homosexuality before Havelock Ellis: The Missing Story', *Journal of the History of Medicine and Allied Sciences,* 63 (2008), 65-102; Chris Waters, 'Havelock Ellis, Sigmund Freud and the State: Discourses of Homosexual Identity in Interwar Britain', in *Sexology in Culture: Labelling Bodies and Desires,* ed. by Lucy Bland and Laura L. Doan (Cambridge: Polity Press, 1998), pp.165-179.

[42] Alison Oram, *Her Husband Was a Woman! Women's Gender-Crossing in Modern British Popular Culture* (London: Routledge, 2007); Meyerowitz, *How Sex Changed*. See also Jay Prosser, 'Transsexuals and the Transsexologists: Inversion and the Emergence of Transsexual Subjectivity',

rather than medical contexts, Matt Houlbrook and James Vernon have both used particular trials and their media representations to demonstrate the different ways in which acts and appearances that challenge gendered and sexual boundaries might be read.[43] Sado-masochism as pathology has also been considered, situated by Alison Moore in relation to medico-social views of gender and fears of 'excess' in many forms.[44] Joanna Bourke, Garthine Walker, Victoria Bates, and others have recently turned to sexual violence in its more clearly criminal manifestations, addressing how such crimes, their perpetrators, and their victims have been understood by doctors and more widely.[45] Analyses of sexual psychopath legislation, which emerged in North America across the middle of the twentieth century, have also considered medical knowledge as one of many influences over the creation of new methods of dealing with sexual offenders and, importantly, have scrutinised the particular types of offence that were most commonly perceived as 'psychopathic'.[46] These have all contributed to our understanding of medicine and proscribed sexual conduct, but medical attitudes towards sexual offenders, broadly construed, have yet to be analysed. In so doing, this thesis provides context for some of the better-known stories of the pathologisation of sexuality, and highlights points of similarity and departure in how doctors and those

---

in *Sexology in Culture: Labelling Bodies and Desires,* ed. by Lucy Bland and Laura L. Doan (Cambridge: Polity Press, 1998), pp.116-131.

[43] Houlbrook, 'Lady Austin's Camp Boys'; and James Vernon, '"For Some Queer Reason": The Trials and Tribulations of Colonel Barker's Masquerade in Interwar Britain', *Signs,* 26 (2000), 37-62.

[44] Alison Moore, 'Rethinking Gendered Perversion and Degeneration in Visions of Sadism and Masochism, 1886-1930', *Journal of the History of Sexuality,* 18 (2009), 138-157.

[45] Joanna Bourke, *Rape: A History from 1860 to the Present Day* (London: Virago, 2007); Garthine Walker, 'Everyman or a Monster? The Rapist in Early Modern England, c.1600–1750', *History Workshop Journal,* 76 (2013), 5-31; Bates, '"Not an Exact Science"'. See also Mathew Thomson, *Lost Freedom: The Landscape of the Child and the British Post-War Settlement* (Oxford: Oxford University Press, 2013), chapter 6.

[46] Estelle B. Freedman, '"Uncontrolled Desires": The Response to the Sexual Psychopath, 1920-1960', *The Journal of American History,* 74 (1987), 83-106; Simon A. Cole, 'From the Sexual Psychopath Statute to "Megan's Law": Psychiatric Knowledge in the Diagnosis, Treatment, and Adjudication of Sex Criminals in New Jersey, 1949-1999', *Journal of the History of Medicine and Allied Sciences,* 55 (2000), 292-314; Elise Chenier, 'The Criminal Sexual Psychopath in Canada: Sex, Psychiatry and the Law at Mid-Century', *Canadian Bulletin of Medical History,* 20 (2003), 75-101.

with whom they worked conceptualised different displays of sexual deviance. This adds to our understanding of how sexuality has been interpreted and regulated in the recent past.

It is also the case that histories of sexuality and medicine have often overlooked the early to mid-twentieth century and the specificities of the British, or English, context. Both of these will be under scrutiny here, enhancing the work of Lesley Hall, Matt Houlbrook, Ivan Crozier, and Chris Waters in particular in building a fuller picture of British sexual science over these decades. Such national distinctions were first emphasised by historian Robert Nye, who took France as his case study to argue that 'it is important also to understand the ways in which national, scientific, legal and cultural traditions have put their stamp on scientific and medical discourse'.[47] As more detailed work on medicine in relation to sexuality in Britain has been undertaken, it has become increasingly common to see references to the particularities of the British case. Rather than the turn of the century, which has often been the focus for those examining continental medicine, historians of homosexuality have identified the post-war years as key for medical approaches in Britain.[48]

These histories have also emphasised the marginal nature of sexology within British medicine.[49] That British medicine was slower to take up such controversial subjects, assuming a hostile position towards continental sexology and perhaps even remaining remarkably ill-informed about sex in general, finds support from Lesley Hall. In her analyses of a wide range of material related to sexology, including the minutes of

[47] Robert A. Nye, 'The History of Sexuality in Context: National Sexological Traditions', *Science in Context,* 4 (1991), 387-406 (p.402).
[48] Waters, 'Disorders of the Mind', p.140; Waters, 'Sexology'; Brady, *Masculinity and Male Homosexuality*, p.11, p.119, p.157.
[49] Brady, *Masculinity and Male Homosexuality*, p.10, p.119, pp.138-145; Waters, 'Sexology', p.46.

the British Society for the Study of Sex Psychology and letters sent to Marie Stopes in the interwar years, she has located reticence and widespread ignorance regarding sex amongst the British medical profession until the second half of the twentieth century at the earliest. Even in the 1960s, she finds doctors in Britain bemoaning the paucity of the medical curriculum on the subject.[50] This persistence of 'Victorian sexual attitudes and codes of behaviour' in Britain has been traced in oral history interviews too, with sexologists and reformers characterised as 'mavericks and campaigners' rather than representative of social attitudes more broadly.[51] The extent to which English society as a whole changed its perspective towards any particular sexual transgressions or sexual offenders themselves lies beyond the scope of this thesis, but it will make a case for the importance of the years leading up to 1960 for English medical thought.

This was also an important period for English psychiatry, particularly in its forensic applications, and criminology. As the following chapters will suggest, sexology, forensic psychiatry, and criminology were all belatedly established as serious disciplines in England over the same period of time, and shared many of the same characteristics and preoccupations. It is no coincidence that both sexology and criminology in England in their early permutations have been described as 'pragmatic and empirical, lacking the theoretical constructs emanating from the continent'.[52] A greater focus on practice rather than theory is not all that they had in common. The interest of interwar

[50] Lesley Hall, '"Somehow Very Distasteful": Doctors, Men and Sexual Problems between the Wars', *Journal of Contemporary History,* 20 (1985), 553-57; Lesley Hall, *Hidden Anxieties: Male Sexuality, 1900-1950* (Cambridge: Polity Press, 1991); Lesley Hall, '"The English Have Hot-Water Bottles": The Morganatic Marriage between Sexology and Medicine in Britain since William Acton', in *Sexual Knowledge, Sexual Science: The History of Attitudes to Sexuality,* ed. by Roy Porter and Mikulas C. Teich (Cambridge: Cambridge University Press, 1994), pp.350-366; Lesley Hall, '"Disinterested Enthusiasm for Sexual Misconduct": The British Society for the Study of Sex Psychology, 1913-47', *Journal of Contemporary History,* 30 (1995), 665-686.

[51] Simon Szreter, 'Victorian Britain, 1831–1963: Towards a Social History of Sexuality', *Journal of Victorian Culture,* 1 (1996), 136-149 (p.139, p.145).

[52] Hall, '"The English Have Hot-Water Bottles"', p.363; David Garland, 'British Criminology before 1935', *British Journal of Criminology,* 28 (1988), 1-17 (especially pp.2-4).

criminologists in studying the causes of sexual crime, and in developing medical theories on the subject, has occasionally been acknowledged. Harry Cocks recognised the contribution of criminology in his exploration of obscenity laws and sexual science, and Chris Waters has argued that those engaged in researching delinquency in general in the interwar years, and then homosexual offenders in particular, were an essential force in the spread of medical approaches to crime.[53] This hints at the growing field of knowledge about sex and crime, both of which could be construed as medical problems, that was emerging at the time.

The ways in which crime and the criminal in general have been understood and managed in England are therefore enormously relevant. Clive Emsley's surveys of crime and punishment offer valuable overviews of the ways in which attitudes towards crime have changed, as has research into the delinquent or criminal woman.[54] However, the discipline of criminology itself has received relatively little critical and historical interest, and the paucity of research is even more pronounced in the cases of prisons, the probation service, and other twentieth-century elements of the machinery of criminal justice.[55] Scholarship from the 1980s tended to present enormously critical interpretations of changes occurring in twentieth-century penology, which was once characterised as 'progressive' but came to be seen as intrusive and dominated to an

[53] Cocks, 'Saucy Stories', p.473; Waters, 'Havelock Ellis, Sigmund Freud and the State', especially p.167.
[54] Clive Emsley, *Crime and Society in Twentieth-Century England* (Harlow: Longman, 2011); Shani D'Cruze and Louise A. Jackson, *Women, Crime and Justice in England since 1660* (Basingstoke: Palgrave Macmillan, 2009); Lisa Downing, *The Subject of Murder: Gender, Exceptionality, and the Modern Killer* (Chicago; London: University of Chicago Press, 2013).
[55] Criminology is given a rather Whiggish summary in David A. Jones, *History of Criminology: A Philosophical Perspective* (New York: Greenwood Press, 1986). The probation service has received one book-length treatment: Philip Whitehead and Roger Statham, *The History of Probation: Politics, Power and Cultural Change 1876-2005* (Crayford: Shaw & Sons, 2006). Legal aid, the practice of defence law, and the operation of the lower courts, meanwhile, appear to have attracted little interest from historians or legal scholars.

excessive degree by the 'treatment ideal'.[56] The delivery of medical care within prisons, and the growing involvement of psychologists and psychiatrists in the criminal justice system, have been received equally critically. In the only book-length study of prison medicine in England, Joe Sim argued via Foucault that rather than moving 'from barbarism to enlightenment', this branch of medicine has been intimately engaged in matters of discipline and punishment, involving itself in 'physical and chemical programmes of control' as well as an ideology that focused upon the individual rather than social causes of crime.[57] Attempting to reassess twentieth-century penology and criminology, and their connections to the 'psy' disciplines, would be a mammoth task. By approaching these subjects through the lens of sexual crime, though, we can build upon these analyses, flesh out the relationships between criminology, penology, and medicine, and consider the nature and influence of prison medicine more closely.[58]

The overlapping fields of criminology, prison medicine, and forensic psychiatry featured a growing number of doctors expressing an avowed interest in delinquency,

[56] Stanley Cohen, 'Social-Control Talk: Telling Stories about Correctional Change', in *The Power to Punish: Contemporary Penality and Social Analysis,* ed. by David Garland and Peter Young (London: Heinemann Educational, 1983), pp.101-129, p.120; David Garland, *Punishment and Welfare: A History of Penal Strategies* (Aldershot: Gower, 1985); and for the USA, David J. Rothman, *Conscience and Convenience: The Asylum and Its Alternatives in Progressive America*, 2nd edn (New York: Aldine de Gruyter, 2002).

[57] Sim, *Medical Power in Prisons*, p.x. See also Joe Sim, 'The Prison Medical Service and the Deviant 1895-1948', in *The Health of Prisoners: Historical Essays,* ed. by Richard Creese, W. F. Bynum, and J. Bearn (Amsterdam; Atlanta, GA: Rodopi, 1995), pp.102-117 (p.113, p.110). A nuanced reading of the difficulties inherent within prison medicine can be found in Ian Miller, '"A Prostitution of the Profession?" Forcible Feeding, Prison Doctors, Suffrage and the British State, 1909-1914', *Social History of Medicine,* 26 (2013), 225-245. The late Paul Bowden, himself a forensic psychiatrist, compiled biographical sketches of a number of prison doctors which were largely sympathetic as well. Paul Bowden, 'Maurice Hamblin Smith: The Psychoanalytic Panacea', *Journal of Forensic Psychiatry,* 1 (1990), 103-113; Paul Bowden, 'William Norwood East: The Acceptable Face of Psychiatry', *Journal of Forensic Psychiatry,* 2 (1991), 59-78; Paul Bowden, 'William Henry de Bargue Hubert (1905-47): Reformer and Expert Witness', *Journal of Forensic Psychiatry,* 7 (1996), 323-340.

[58] The contributions of prison doctor William Norwood East have been acknowledged in Nigel Walker and Sarah McCabe, *Crime and Insanity in England* vol. 2 (Edinburgh: Edinburgh University Press, 1973), pp.25-27, p.52, although they see him as sceptical of the value of psychotherapy. The current lack of research into prison medicine will be remedied to a large extent by Catherine Cox and Hilary Marland in their project 'Prisoners, Medical Care and Entitlement to Health in England and Ireland, 1850-2000', running from 2014 to 2019.

psychology, and psychoanalysis. The Institute for the Scientific Treatment of Delinquency (ISTD) and the Tavistock clinic were both founded in the interwar years and were significant in their efforts to research, understand, and treat the causes of criminal conduct. Very little has been written to date on their activities, however, save for an affectionate official history of the Tavistock by one of its clinicians, published in 1970.[59] Historian Michal Shapira has recently published an elegant study of the role of psychoanalysis in the shaping of post-war Britain which incorporates some aspects of the work of the ISTD, and Chris Waters has briefly but more specifically acknowledged its role in the evolution of medical ideas about sexuality, and particularly the important role played by Dr Edward Glover, its co-founder and long-term director.[60]

By exploring the efforts of these clinics and their doctors alongside prison medicine, this thesis begins to develop a history of twentieth-century forensic psychiatry in England. A special issue of the *International Journal of Law and Medicine* in 2014 provided an excellent overview of forensic psychiatry across many different national contexts, drawing attention to national differences and the influence of different legal systems and particular national politics.[61] This included a survey of forensic medicine in the UK, which offered a valuable overview but emphasised the role of forensic psychiatry in developments around criminal responsibility, narrowly defined.[62] Indeed, research into the intersection of mental health medicine and the law has frequently

[59] H. V. Dicks, *Fifty Years of the Tavistock Clinic* (London: Routledge & Kegan Paul, 1970).
[60] Michal Shapira, *The War Inside: Psychoanalysis, Total War, and the Making of the Democratic Self in Postwar Britain* (Cambridge: Cambridge University Press, 2013); Waters, 'Havelock Ellis, Sigmund Freud and the State'; and Chris Waters, *Queer Treatments* (provisional title) (forthcoming).
[61] Harry Oosterhuis and Arlie Loughnan (eds), 'Madness and Crime: Historical Perspectives on Forensic Psychiatry', special edition of *International Journal of Law and Psychiatry*, 37 (2014); Tony Ward, 'Psychiatry and Criminal Responsibility in England, 1843-1936', (PhD thesis, De Montfort University, 1996); Arlie Loughnan, *Manifest Madness: Mental Incapacity in Criminal Law* (Oxford: Oxford University Press, 2012).
[62] Harry Oosterhuis and Arlie Loughnan, 'Madness and Crime: Historical Perspectives on Forensic Psychiatry', *International Journal of Law and Psychiatry,* 37 (2014), 1-16 (p.3, p.4).

focused upon the insanity plea, through which responsibility for criminal acts could be removed. The most important example of this remains Roger Smith's *Trial by Medicine* from 1981, which surveyed the evolution of the insanity plea and its relationship with the values and views of human nature that were dominant within society.[63] Joel Eigen has examined the role of the medical expert for an earlier period of English criminal history, and provided some valuable nuance to existing accounts which tend to emphasise conflict between medical and legal concepts, rather than a process of negotiation.[64] In studies of the more recent past, it is perhaps insanity in relation to infanticide that has captured most scholarly attention, with work by Hilary Marland, Arlie Loughnan, and Tony Ward examining the interplay of law, medicine, and morality in these cases.[65]

In the twentieth century, however, the interests and application of forensic psychiatry came to feature in a much wider variety of legal situations. Legal scholars have begun to consider some of these, with Arlie Loughnan's study of 'manifest madness' covering medico-legal arguments surrounding age, intoxication, and diminished responsibility as they pertain to mental incapacity, as well as insanity. One further aspect of medico-legal medicine, as this thesis will show, was its impact upon sentencing decisions in cases of sexual crime, when assessments of cause influenced decisions about culpability and the prevention of future crime alike. As Katherine

[63] Roger Smith, *Trial by Medicine: Insanity and Responsibility in Victorian Trials* (Edinburgh: Edinburgh University Press, 1981). France has also received a detailed treatment in Ruth Harris, *Murders and Madness: Medicine, Law, and Society in the Fin de Siècle* (Oxford: Clarendon, 1989), and another useful overview for England is in Walker and McCabe, *Crime and Insanity in England*.
[64] Joel Peter Eigen, *Witnessing Insanity: Madness and Mad-Doctors in the English Court* (New Haven; London: Yale University Press, 1995).
[65] Hilary Marland, *Dangerous Motherhood: Insanity and Childbirth in Victorian Britain* (Basingstoke: Palgrave Macmillan, 2004); Hilary Marland, 'Getting Away with Murder? Puerperal Insanity, Infanticide and the Defence Plea', in *Infanticide: Historical Perspectives on Child Murder and Concealment, 1550-2000,* ed. by Mark Jackson (Aldershot: Ashgate, 2002), pp. 168-192; Arlie Loughnan, 'The "Strange" Case of the Infanticide Doctrine', *Oxford Journal of Legal Studies,* 32 (2012), 685-711; Tony Ward, 'The Sad Subject of Infanticide: Law, Medicine and Child Murder, 1860-1938', *Social & Legal Studies,* 8 (1999), 163-180.

Watson has pointed out, there are many interesting points of comparison between medico-legal approaches to infanticide and proscribed sexual conduct. Both were usually private experiences, but subject to extremely strong public condemnation, and the evidence of the medical expert gradually shifted from physical signs to mental state. However, as Watson has observed, the interest of forensic psychiatry in sexuality 'remains a relatively under-researched area'.[66]

Research into medical expertise and action in relation to sexual crime in England has tended to focus upon the nineteenth century, when physical examinations and evidence, particularly of the complainant, were key.[67] Medical treatments for homosexuality have received recent attention, notably from Tommy Dickinson, a former nurse and researcher. His investigation into the experiences of nurses and patients giving or receiving aversion therapies in the 1950s and 1960s offers important insights into individual experiences.[68] Historian Roger Davidson, in his work on treatments for homosexuality in Scotland after the Second World War, has used case notes, correspondence, and staff interviews from one hospital in Edinburgh to explore medical theories and a wider variety of treatments.[69] There has, however, been more research into forensic medicine's engagement with sexual offenders, broadly defined, for other national settings. Of particular interest for this project is Theo van der Meer's careful analysis of castration of sexual offenders in The Netherlands, which has highlighted the

[66] Katherine D Watson, 'Mental Disorder, Crime and the Development of Healthcare Systems', in *Healthcare in Private and Public from the Early Modern Period to 2000,* ed. by Paul J. Weindling (London: Routledge, 2015), pp. 58-81 (especially pp.64-66, p.76).
[67] Victoria Bates, '"So Far as I Can Define without a Microscopical Examination": Venereal Disease Diagnosis in English Courts, 1850–1914', *Social History of Medicine,* 26 (2013), 38-55; Crozier, 'Medical Construction of Homosexuality'; Ivan Crozier and Gethin Rees, 'Making a Space for Medical Expertise: Medical Knowledge of Sexual Assault and the Construction of Boundaries between Forensic Medicine and the Law in Late Nineteenth-century England', *Law, Culture and the Humanities,* 8 (2011), 285-304.
[68] Tommy Dickinson, 'Mental Nursing and "Sexual Deviation": Exploring the Role of Nurses and the Experiences of Patients, 1935-1974', (PhD thesis, University of Manchester, 2012).
[69] Roger Davidson, 'Psychiatry and Homosexuality in Mid-Twentieth-Century Edinburgh: The View from Jordanburn Nerve Hospital', *History of Psychiatry,* 20 (2009), 403-424 (p.416).

lack of clarity surrounding the underlying logic behind the procedure, and indicated some of the religious concerns, policies in operation in neighbouring nations, and broader attitudes towards sexual crime that were influential.[70] Åsa Bergenheim has offered a nuanced reading of the concepts of 'self-control' and intermediate states between health and illness, as understood in psychiatry, and the range of diagnoses that were deployed in cases of sexual assault in Sweden.[71] For Norway, the recent opening of the records of criminal lunatic institutions has enabled research into the treatment of sexual and other offenders there, and in the USA, Regina Kunzel is currently working on the encounters between psychiatrists and sex- and gender-variant people in the mid-twentieth century.[72] In offering some analysis of the operation of forensic medicine in relation to sexual offenders in England, this thesis contributes to this exciting body of work, grappling with some of the problematic and still-controversial ways in which medicine has attempted to manage sexual transgression in the recent past.

In this endeavour, histories of medicine and sexology are both informative. There has been a retreat from the idea of a dominant and domineering medical profession, seeking to expand its coverage by pathologising ever more aspects of behaviour, in favour of a growing emphasis upon the absence of coherence or clarity within medicine.[73] Peter Bartrip's histories of the British Medical Association (BMA) and

[70] Theo van der Meer, 'Voluntary and Therapeutic Castration of Sex Offenders in The Netherlands (1938–1968)', *International Journal of Law and Psychiatry,* 37 (2014), 50-62.
[71] Åsa Bergenheim, 'Sexual Assault, Irresistible Impulses, and Forensic Psychiatry in Sweden', *International Journal of Law and Psychiatry,* 37 (2014), 99-108.
[72] Eivind Myhre and Oyvind Thomassen, 'The Construction of an Accepted Masculinity: Castration in High Security Psychiatric Institutions in Norway, 1923-1945', in *Masculinities in the Criminological Field,* ed. by Ingrid Lander, Signe Ravn, and Nina Jon (Farnham: Ashgate, 2014), pp. 89-109; see also the project 'The Mental Machine: Confinement of Criminal Insanity in Norway in the 20th Century', run through SIFER: <http://sifer.no/english>; Regina Kunzel, Roundtable: 'New Directions in the History of Psychiatry', American Association for the History of Medicine 2015, New Haven, CT.
[73] Chauncey, 'From Sexual Inversion to Homosexuality: Medicine and the Changing Conceptualization of Female Deviance'; Carlston, 'A Finer Differentiation'; Terry, 'Anxious

*British Medical Journal* (*BMJ*) have highlighted disunity and uncertainty, especially whenever medico-moral issues raised their head, and Katherine Angel has characterised interwar British psychiatry as 'highly fragmented', even somewhat backward.[74] Research into American medicine and homosexuality has shown that fragmentation was much in evidence there, too. As 'medical and psychiatric thinking about homosexuality had proliferated wildly', literary theorist Erin Carlston has argued, 'doctors struggled to map out and colonize the newly defined territories of human sexual behavior', and the absence of a unified medical voice meant that the actual impact of medicine was inconsistent and limited.[75] This thesis will address the limitations of medical influence in England, but will also borrow from sociologies of medicine to consider the value of its plurality for both medicine and the law. Martyn Pickersgill has examined the heterogeneity of psychiatric thought with specific reference to the contested diagnoses of psychopathy and Anti-Social Personality Disorder. He has argued that the disunity or 'anarchy' of psychiatric thought, which allows many different perspectives to co-exist, has been essential in allowing such diagnoses to remain in use even without clear consensus as to exactly what they mean.[76] Flexibility of interpretation, of diagnosis, and of outcome in medico-legal settings was an equally necessary component of the project to suggest medical approaches to sexual crime.

---

Slippages between "Us" and "Them": A Brief History of the Scientific Search for Homosexual Bodies'.

[74] P. W. J. Bartrip, *Mirror of Medicine: A History of the British Medical Journal* (Oxford: British Medical Journal and Clarendon Press, 1990); P. W. J. Bartrip, *Themselves Writ Large: The British Medical Association 1832-1966* (London: BMJ, 1996); Katherine Angel, Edgar Jones, and Michael Neve (ed.), *European Psychiatry on the Eve of War: Aubrey Lewis, the Maudsley Hospital, and the Rockefeller Foundation in the 1930s* (London: Wellcome Trust Centre for the History of Medicine, 2003) p.42, p.40.

[75] Carlston, 'A Finer Differentiation', p.177, p.193; see also Imogen Goold and Catherine Kelly, *Lawyers' Medicine: The Legislature, the Courts and Medical Practice, 1760-2000* (Oxford: Hart, 2009) p.12 and throughout.

[76] Pickersgill, 'The Endurance of Uncertainty'.

As many histories of sexuality, crime, and psychiatry acknowledge, it is difficult to trace the impact of medical, legal, or other models of deviance on the 'deviant' themselves. Roger Davidson's use of medical notes provides some tantalising glimpses of patients' responses and their eventual outcomes, but these are not explored in detail. Frank Mort's important book, *Dangerous Sexualities*, examined state intervention in the sexual realm from 1830 to around 1930, but paid little attention to the actual impact of those interventions, leaving his opening statement that '[o]fficial discourses do have concrete, if complex and often bizarre, effects on the sexuality of constructed men and women' largely unexplored.[77] Jennifer Terry has used case histories to explore points of disagreement between doctors and their sexually 'abnormal' patients, but, as with Davidson, this is inevitably shaped by the medical hand holding the pen.[78] Although some few interviews and memoirs are available to shed light on the impact of medical approaches to sexual deviance upon the 'patients' in question in mid-twentieth-century England, they are few and far between. This thesis will examine attempts to treat the sexual offender by medical means, and will offer some assessment of the impact of this short-lived enthusiasm and confidence in cure on criminal and penal practice, but the effects upon offenders themselves lie beyond its scope.

### 1.4 Primary Sources

In order to capture medical opinions and practices relating to the causes and cures of sexual crime, this thesis firstly draws upon a wide range of documents generated by and for medical professionals. These include articles, lectures, book reviews, and

[77] Frank Mort, *Dangerous Sexualities: Medico-Moral Politics in England since 1830* (London: Routledge & Kegan Paul, 1987) p.2, p.4.
[78] Jennifer Terry, 'Theorizing Deviant Historiography', *Differences,* 3 (1991), 55-74. For some further considerations of the uses of patient records, see G. B. Risse and J. H. Warner, 'Reconstructing Clinical Activities: Patient Records in Medical History', *Social History of Medicine,* 5 (1992), 183-205.

correspondence appearing in the most prominent general medical journals of the day, the *BMJ* and *The Lancet,* as well as the more specialist *Journal of Mental Science* (*JMS*; now *British Journal of Psychiatry*). All well respected and with pedigrees dating back to the early or mid-nineteenth century, these journals were widely read by doctors, with large numbers subscribing and contributing. The weekly *BMJ*, as the official journal of the BMA, saw a circulation of over 30,000 by 1913 and 88,000 by 1961.[79] It was generally relatively conservative in outlook, since the BMA has 'never been over-endowed with angry young men', as one of its members tactfully put it,[80] but it published celebrated papers and engaged with social and political issues in relation to medicine during the period in question. Also published weekly, *The Lancet* was founded in 1823 and has always competed with the *BMJ* for precedence. The quarterly *JMS* began life under the auspices of the Association of Medical Officers of Asylums and Hospitals for the Insane, the group that would eventually become the Royal College of Psychiatrists, and served as the dominant professional journal for doctors working in the field of mental disorder throughout the period under consideration. Although these journals do not represent the full extent of medical opinion, they do reflect some of the major ideas that were being shared and debated at this time.

Secondly, this thesis makes extensive use of material produced by medical professionals and located elsewhere, sometimes intended for publication and sometimes not. These include the reports and commentaries provided to the Home Office by doctors working in prisons. Although only extracts of these were usually published, they offer useful insights into day-to-day practices as well as the opinions of doctors who may not otherwise have placed their views in print. I also make use of medical textbooks and reports, pamphlets, and submissions to government

[79] Bartrip, *Mirrors of Medicine*, p.184, p.303.
[80] Bartrip, *Mirrors of Medicine*, p.vii.

departments or investigatory committees by doctors working with offenders. Although these were largely aimed at a small number of colleagues directly involved with the issues under consideration, and did not, as a rule, reach a wide readership, many of the ideas expressed therein proved durable, with some such as *The Psychological Treatment of Crime* still referenced as important sources of information long after their first appearance.[81]

A relatively small number of doctors specialised in mental disorder and crime, and some few will feature heavily in the chapters which follow. William Norwood East was a well-respected specialist in forensic psychiatry, and was the Medical Inspector of Prisons in England and Wales by the time of his retirement in the 1940s. His lengthy civil service career and substantial publishing record provide ample insight into his ideas and his role in shaping practice within prisons in particular. His *Introduction to Forensic Psychiatry in the Criminal Courts* was credited as the first textbook of its kind, and he co-authored *The Psychological Treatment of Crime*.[82] His colleague Hamblin Smith also published on similar subjects, and engaged energetically with the issue of psychological approaches to delinquency throughout the 1920s and 1930s. Edward Glover published and practised as a psychoanalyst for many decades, contributing frequently to criminological debates in print and in evidence to government-appointed committees, including the Committee on Homosexual Offences and Prostitution, chaired by Sir John Wolfenden (the Wolfenden Committee).[83] Although Glover and Norwood East shared many interests, they worked in somewhat different environments and did not always

[81] William Norwood East and William Henry de Bargue Hubert, *The Psychological Treatment of Crime* (London: H. M. Stationery Office, 1939). This work is credited as the inspiration for the construction of a psychiatric prison in the late 1950s, which was, in turn, the model for the creation of prisons specifically for the treatment of sexual offenders in the 1990s.
[82] 'Sir Norwood East, M.D., F.R.C.P.', *British Medical Journal,* 2 (1953), 1050-105; *Report of the Commissioners of Prisons for the Year 1955* (London: H. M. Stationery Office, 1956) p.17.
[83] See Waters, 'Havelock Ellis, Sigmund Freud and the State', pp.175-176.

agree with each other's approaches or conclusions, making them useful indicators of the range of medical opinion.

In order to situate medical views within this wider context of thought and action surrounding crime and punishment, this thesis also draws upon medical interactions with jurisprudence and criminology, penal reform campaigners, and others with a stake in methods of dealing with sexual crime. Doctors including Glover and Norwood East lectured and wrote for audiences working in the fields of criminology, penology, and social policy broadly defined. Journals including the *British Journal of Delinquency* (now the *British Journal of Criminology*), of which Glover was a co-founder, and the long-lived *Howard Journal of Criminal Justice* featured work by doctors and other interested parties on the subject of sexual crime. So too did publications for magistrates and probation officers and the first academic works of criminology to emerge from the Department of Criminal Science at Cambridge, founded in 1940 under the directorship of criminologist Leon Radzinowicz. Medical ideas were also recorded in the reports and research of clinics and hospitals, and the minutes of societies or committees with which doctors were involved, including the Wolfenden Committee. Minutes of meetings as well as Home Office files containing notes, correspondence, official memos, and newspaper clippings are all indicative of the activities and concerns of the day.

A full picture of actual practices as opposed to theories and claims is, however, hard to capture. The paucity of personal papers or memoirs from even the most vociferous and well-known medical professionals in the field of sexual deviance is disappointing, and medical records relating to their activities remain sealed.[84] Also

[84] It appears that none of Norwood East, Glover, Maurice Hamblin Smith, or William de Bargue Hubert left any personal papers. Although this was confirmed in personal communication with the families of Norwood East and Hubert, relatives of Glover and Smith could not be traced.

fragmentary is the material relating to medical evidence within legal and penal settings. Newspaper reports, police and court files, and the records of the Director of Public Prosecutions and the Prison Commissioners offer some insight into how medical theories were used in the process of prosecuting and sentencing sexual offenders. Such evidence illuminates practical and theoretical challenges, conceptual stumbling blocks, and, indeed, the types of criminal event in which medical evidence was invited, accepted, or ignored. The apparent absence of medical evidence in some legal proceedings, and the brevity of written reports, can also be informative. Despite the enthusiasm of certain doctors for a psychiatric approach, these silences highlight situations in which medical opinion and information were not requested by the judiciary, not offered by doctors, or not considered to be particularly important to the outcome of the case. However, it is important to recognise that the available sources are incomplete, and it is often only those cases thought to be most interesting or revealing which have been retained or reported. A true picture of the daily application of medical views is extremely difficult to re-create.

Lastly, this thesis uses a small number of memoirs and published interviews, which occasionally includes accounts from sexual offenders themselves. These are not comprehensive, and present some difficulties. First-person accounts from those guilty of crimes such as rape or indecent exposure are extremely rare, with sociologist Tony Parker's collections from the 1960s and 1970s providing the largest body of material.[85] However, as Parker himself noted in the introduction to one of these collections, each of

---

Searches of the archives of the Wellcome Collection, the Maudsley Hospital, the British Psychoanalytical Society, and the Birmingham Archives (in relation to Maurice Hamblin Smith's lengthy tenure at the local prison), amongst others, have revealed very little material relating to any of the doctors who feature prominently in this thesis.

[85] Parker, *The Twisting Lane*; Tony Parker, *The Frying-Pan: A Prison and Its Prisoners* (London: Hutchinson, 1970).

those he interviewed was not 'representative of a type, only of himself'.[86] The extent to which broader conclusions can be drawn from a very small number of interviews should be questioned. Men and especially women who committed sexual crimes in twentieth-century England have, perhaps unsurprisingly, left very few records addressing this aspect of their lives, with the notable exception of those whose criminality has since come under question. Men convicted of homosexual offences are relatively well represented, especially in writings or interviews dating from the 1950s onwards, when campaigns for legal and social change gathered pace.[87] Their stories have also been collected in more recent efforts to capture their experiences.[88] These accounts are inevitably shaped by the circumstances surrounding their production, and although analysis of the impact of this factor lies outside the scope of this thesis, its influence should be acknowledged.

### 1.5 Chapter outline

This thesis is structured around two main strands: medicine in theory, and medicine in practice. These are preceded by an introduction to the medico-legal frameworks in which doctors and offenders found themselves in the early to mid-twentieth century.

---

[86] Parker, *The Twisting Lane* [n.p.].

[87] First-person writing about male same-sex attraction can be found in, for example, 'Anomaly', *The Invert*, 2nd edn (London: Tindall & Cox, 1948); J. R. Ackerley, *My Father and Myself* (Harmondsworth: Penguin, 1984 [1968]); Peter Wildeblood, *Against the Law* (London: Penguin, 1959 [1955]); Goldsworthy Lowes Dickinson, *The Autobiography of G. Lowes Dickinson* (London: Duckworth, 1973). Although the sexual interests of some of these individuals were not limited to homosexuality, there are virtually no equivalent memoirs or autobiographical writings of the period that mention sexual deviance without homosexuality as a primary theme.

[88] These recent projects include Glenn Smith, Annie Bartlett, and Michael King, 'Treatments of Homosexuality in Britain since the 1950s: An Oral History', *British Medical Journal,* 328 (2004), 427-42; Dickinson, 'Mental Nursing and "Sexual Deviation"', summarised in Tommy Dickinson, Matt Cook, John Playle, and Christine Hallett, '"Queer" Treatments: Giving a Voice to Former Patients Who Received Treatments for Their "Sexual Deviations"', *Journal of Clinical Nursing,* 21 (2012), 1345-1354. One woman was interviewed by Smith *et al*. but her comments are not included anywhere in the article, although presumably they did contribute to the authors' conclusions. Two people in Dickinson's study were treated for transvestism and subsequently underwent gender reassignment surgery, identifying as female at the time of their interviews. All other participants were treated for homosexuality.

After discussing the significant swing towards rehabilitation and reform over punishment, Chapter 2 describes the evolution of medical interest in a borderline group of offenders from the 1910s onwards. These were seen as neither sane nor mentally deficient, and yet not entirely healthy or normal either; their mental state lay somewhere in between. Here, prison medicine began to assert itself, with prison doctors claiming for themselves a new branch of expertise in relation to the mentally disordered criminal. Prison medicine played a key role as an intermediary between the new psychiatry and the legal profession, helping to create a modest space for medical contributions. This highlights points of agreement and conflict between prison medicine and psychiatry more widely. Lastly, Chapter 2 introduces some of the legal developments that were to have an impact upon medical approaches to crime in general, and to sexual crime in particular. It argues that although both prison medicine and confidence in the treatment of sexual offenders were in decline by the end of the 1950s, the developments of the previous decades had lain an important and durable foundation.

Chapters 3 and 4 address 'Medicine in Theory'. Chapter 3 takes as its focus the growing interest in sexual offenders as a particular type of deviant, examining published research and reports from prisons, clinics, and hospitals. Beginning with the introduction of sexual deviance to the medical repertoire, it describes the connections that were made between sexual crime and mental disorder, the justifications and disagreements that were generated, the focus upon 'perversion', and the lack of attention given to female sexual offenders. Chapter 4 then examines the many and varied theories that were proposed to explain sexual deviance, which ranged far beyond the psychiatric. These included the psychoanalytic, the glandular, the hereditary, and the environmental. As well as emphasising this profusion of possible causes, it will argue

that reliance upon a 'constitutional' cause of sexual deviance remained constant, but achieved new prominence in the years after the Second World War thanks to its relevance to both homosexuality and theories of psychopathic states. The treatments that were suggested were equally varied. Although psychotherapy remained dominant, solutions within the realms of education and physical interventions were also explored. This variety of causes and cures reflected not only the diversity and fragmentation within psychiatry, but also the impulse within medico-legal circles to allow for many different possible outcomes for the sexual offender.

'Medicine in Practice' then looks at the uses to which these theories and treatments were put, in court and consulting room. Chapter 5 centres on medical interactions with legal processes. Using medical evidence and reports of trials as well as memoirs and official records, the complex relationship between doctors and the judiciary is explored. During the period under examination, the judiciary made space for medical evidence before sentencing, especially in the greater use of probation with treatment. However, the presence and absence of such evidence were influenced by the status of the defendant, his conduct, his history, and issues of procedure.[89] Doctors responded to the demands of the legal system in their evidence, often providing explanations and recommendations that were practically and conceptually acceptable, but the nature of the adversarial legal system limited the impact of medical thought. Nevertheless, forensic psychiatry did establish a foothold within the criminal justice system. The extent of this foothold is considered further in Chapter 6. Here, the scale of activity to treat sexual offenders is scrutinised, both within prisons and elsewhere, as are the highly selective criteria that were established to identify the curable candidate.

[89] The use of the masculine pronoun here reflects the fact that, although sexual offenders were sometimes women, doctors focused their attentions upon men. This will be discussed further in Chapter 3.

Factors of intelligence, enthusiasm, sexual and criminal history, contrition, and age all contributed to assessments regarding both diagnosis and prognosis. Medical interpretations of many types of sexual offender had taken root by the end of the 1950s, but their practical uses were, and remained, limited.

# Chapter 2: The 'curative treatment of crime'[1]

*'Society's attitude towards those who commit crime is undergoing a fundamental change. Interest in criminals has changed from the moral and legal to the psychological and sociological aspects.'*[2]

In the first few decades of the twentieth century, approaches to criminality in England began to undergo a profound change. The primary objective of imprisonment was shifting from punishment, with physically gruelling labour and prolonged solitary confinement, to rehabilitation.[3] In the name of the reformation of the criminal, responses to crime ceased to rely upon prisons or fines. Magistrates were encouraged to make greater use of their discretionary powers of sentencing, and new schemes to classify prisoners tried to offer some modest distinction between methods of dealing with the first-time offender, for example, and the 'professional' criminal. Changes in policy and practice accelerated in the aftermath of the First World War. 'Each crime is the single act of an individual', interwar Prison Commissioner Alexander Paterson reflected, and each offender should therefore be treated as such.[4] How, then, might the judge or magistrate gain insight into the individual before them, and decide upon their fate? The new sciences of psychology and psychiatry offered an answer. 'During the

[1] This is the headline from a newspaper article of 1920. It reports the foundation of an association for magistrates to look at 'remedial measures' for offenders, especially for 'those whose lapses are the result of mental disturbance'. 'Curative Treatment of Crime', *The Times,* 7 January 1920, p.9.

[2] John J. Landers, 'Observations on Two Hundred Dartmoor Convicts', *Journal of Mental Science,* 84 (1938), 960-979 (p.960).

[3] For a critical assessment of earlier prisons regimes, see Michael Ignatieff, *A Just Measure of Pain: The Penitentiary in the Industrial Revolution, 1750-1850* (London: Macmillan, 1978). There had been an element of rehabilitative aspiration within this regime: it was hoped, for example, that hours of solitary confinement with only a Bible for company might cause the prisoner to reflect upon his misdeeds and improve the state of his morals. Changing attitudes towards crime and punishment in the 1890s, setting the scene for the more practical changes in the first half of the twentieth century, are given careful examination in Christopher Harding, '"The Inevitable End of a Discredited System"? The Origins of the Gladstone Committee Report on Prisons, 1895', *The Historical Journal,* 31 (1988), 591-608.

[4] Alexander Paterson, *Paterson on Prisons* (London: Frederick Muller, 1951) p.46.

inter-war period', as Adrian Bingham has observed, 'medical and psychological perspectives gradually became a feature of court cases',[5] and these perspectives suggested new ways to 'cure' the criminal. Medical reports addressing an offender's state of mind, ideas for treatment as an alternative to punishment, and psychological interpretations of criminal acts all proliferated in the name of understanding and rehabilitating the offender.

It was within this context that medical approaches to sexual crime were developed and used. Since this medico-legal setting shaped medical theory and practice alike, this chapter will offer a detailed examination of its evolution, reflecting upon the influence of prison doctors, psychodynamic specialists, and the judiciary, as well as the structure of the English legal system. The first section considers practical and conceptual transformations in the management of offenders. These allowed much greater attention to be paid to the many forms of mental disorder that were thought to occupy an extensive borderland between perfect mental balance and insanity. In the spirit of rehabilitation, doctors and judges explored alternatives to traditional punishment that might allow for greater medical engagement with this group of offenders. In this, as the second section goes on to explore, prison doctors played an important role. The enthusiasms and efforts of leading prison doctors created wider opportunities for a psychological approach within prisons, thereby enabling these doctors briefly to claim a distinctive new professional niche. Prison doctors also served as a buffer between the more ambitious theories of a new generation of psychodynamic doctors working in private clinics, and the realities of putting theory into practice. Finally, this chapter turns to the influence of the judiciary and the English legal system. The workings of the law

[5] Bingham, *Family Newspapers*, p.46.

made it possible for medical approaches to feature in some circumstances, but also limited their impact and influence.

In the course of these considerations, this chapter takes its lead from recent scholarship that has suggested a complex process of exchange and negotiation between medicine and law, rather than a pitched battle for supremacy.[6] Previous analysis of mental disorder and crime often debated whether doctors were invited by judge and jury to become more involved in assessing the criminal, or whether a growing medical profession forced its way into the courtroom in something approaching a coup.[7] This chapter will argue that, although representatives of the two professions did sometimes express profound disagreement with one another, they were more frequently united in their recognition of the practical implications of new ideas. Here, as David Garland has argued in relation to criminology in England, both 'the penal and psychiatric establishments' were far more important than academic jurisprudence or psychology. As a result, there was 'a distinctive, indigenous tradition of applied medico-legal science' in England which focused on the practical over and above the theoretical.[8] Successful application of new medical ideas, rather than scrutiny of their underlying principles, was key. Attention to mental disorder and crime within the legal system therefore led to flexibility, and a greater diversity of outcomes, rather than fundamental change. This would have an important impact upon medical approaches to sexual crime.

[6] Such work includes Eigen, *Witnessing Insanity*; Goold and Kelly, *Lawyers' Medicine*; Arlie Loughnan and Tony Ward, 'Emergent Authority and Expert Knowledge: Psychiatry and Criminal Responsibility in the UK', *International Journal of Law and Psychiatry,* 37 (2014), 25-36.
[7] Conflict between medicine and law was proposed in Walker and McCabe, *Crime and Insanity in England*; Smith, *Trial by Medicine*; Kathleen Jones, *Asylums and After: A Revised History of the Mental Health Services from the Early 18th Century to the 1990s* (London: Athlone Press, 1993).
[8] Garland, 'British Criminology before 1935', p.2.

Interest in psychologically informed rehabilitation of criminals over the early to mid-twentieth century has not always been seen as a positive development. In the 1980s and 1990s, historians and other scholars questioned the prevailing belief that it had marked an important progressive step towards a more scientific and humane method of responding to social disorder. David J. Rothman, who addressed similar developments in the USA, and sociologists including Stanley Cohen who looked at the British case, proposed that the move towards individualised attention and rehabilitation, couched in the language of medicine, extended state interference rather than state aid. Attempts to reform the criminal, they argued, introduced closer monitoring of the behaviours and even the thoughts of ever more citizens. What may have had a benign, even compassionate, motivation had become little more than the machinery of unfettered intrusion into individual lives. The 'lesson extracted from history', proclaimed Cohen ominously, 'is that benevolence itself must be distrusted'.[9] By considering medical and legal changes together, this chapter will argue that the psychological approach to crime was tempered in England by the role of prison medicine and the nature of the English legal system. Whether interpreted as benevolent or controlling, its reach was limited. By the end of the 1950s, both the prison medical service and wider zeal for rehabilitation rather than punishment were beginning to decline in influence. Over the previous decades, though, essential steps had been taken to create space for a medical approach to offenders on both sides of the prison wall.

## 2.1 Rehabilitation and reform

Prisons had long been useful locations for research. Not only did they offer an audience of experimental subjects that was, quite literally, captive, but they also contained a

[9] Rothman, *Conscience and Convenience*; Cohen, 'Social-Control Talk: Telling Stories about Correctional Change', p.106.

section of the population that was troubling and potentially different in some way from the law-abiding subject. In the late nineteenth and early twentieth centuries, prison doctors in England and criminologists elsewhere were engaged in various endeavours to establish whether markers of this difference could be located in physical form, intelligence, insanity, or in some other intriguing distinction.[10] As the twentieth century dawned, it was the mental state of the offender that was coming under increasingly close scrutiny. Special provision for insane offenders had developed over the course of the nineteenth century,[11] and the Lunacy Act of 1890 had been established as the reference point for dealing with an offender found to be either an 'idiot lunatic' or 'of unsound mind'. This permitted anyone so diagnosed to be removed from prison to an asylum. It was, however, seen as inadequate by many of those involved in the daily management of the criminal.

Locating lunacy was therefore not the full extent of enquiry into the mental state of the offender. In a *fin de siècle* climate of concern about degeneration and the quality, both physical and mental, of the race, much attention was paid to those who were sane, but seemingly weak-minded and socially troublesome. A Royal Commission on the Care and Control of the Feeble-Minded was appointed in 1904 to investigate the problem. When its report of 1908 failed to lead to immediate action, the Prison Commissioners pointedly drew attention to offenders who were unsuited to ordinary prison life as a result of their 'feeble-mindedness'. In 1910, the Medical Inspector of

[10] Most famously, this included Cesare Lombroso in Italy, but also Gustav Aschaffenburg in Germany and Charles Goring in England. A young William Norwood East, of whom more later, was also beginning to publish in this field in the early twentieth century: William Norwood East, 'Physical and Moral Insensibility in the Criminal', *Journal of Mental Science,* 47 (1901), 737-758; William Norwood East, 'An Inquiry into the Susceptibility of Criminals to Atmospheric Changes', *The Lancet,* 162 (1903), 211.

[11] This is not to say that mental disorder was ignored before 1800. As Joel Eigen has shown, juries from the eighteenth as well as the nineteenth centuries frequently considered questions – and degrees – of insanity. Eigen, *Witnessing Insanity*, especially pp.34-38.

Prisons reported that 439 prisoners in England and Wales were 'formally recognised as being so feeble-minded as to be unfit for the ordinary penal discipline', and by 1913 this figure had shot up to 1,055.[12] Concern about these prisoners extended beyond the day-to-day running of a prison, as it was widely feared that their mental state rendered them highly likely to repeat their crimes, undeterred by any punishment the courts could impose.[13] As one medical superintendent argued as part of a nuanced discussion of the many causes of crime, there were 'many persons, particularly among the petty delinquents, whose mental defect does contribute markedly to their lapse into habitual delinquency'.[14] If ordinary methods of punishment had little impact on such offenders, then how else could the machinery of the state entice these weak-minded souls away from a lifetime of crime?

The answers to this question reflected a shift towards rehabilitation rather than relying upon punishment, through which, in Clive Emsley's words, 'a new, broadly liberal penal system began to emerge'.[15] Greater attention to reforming the criminal had been the stated objective of the 1898 Prison Act, which had paved the way. It had phased out many of the features of prison life that seemed needlessly punitive, and encouraged slightly more individualised management. However, in order to prevent recidivism, many commentators felt that forms of mental disorder other than insanity would have to be recognised and addressed more thoroughly. Clearly, this demanded careful psychiatric

[12] *Report of the Commissioners of Prisons and the Directors of Convict Prisons, with Appendices, for the Year ended 31st March, 1910* (London: H. M. Stationery Office, 1910) p.30, p.33; *Report of the Commissioners of Prisons and the Directors of Convict Prisons, with Appendices, for the Year Ended 31st March, 1913* (London: H. M. Stationery Office, 1913), p.31. These figures include both local and convict prisons.

[13] Their supposed propensity to have many children who were equally feeble-minded and troublesome was also raised. See, for example, W. R. Dawson, 'Some Points Concerning the Diagnosis and General Treatment of the Feeble-Minded', *Journal of Mental Science,* 56 (1910), 459-470 (pp.468-469).

[14] J. P. Sturrock, 'The Mentally Defective Criminal', *Journal of Mental Science,* 59 (1913), 314-325 (pp.316-317).

[15] Emsley, *Crime and Society in Twentieth-Century England*, p.8.

enquiry. The 'psychological and psycho-pathological method' was noted in the *JMS* in 1907 as necessary 'to prepare the way for more rational and remedial measures' in relation to the repeat offender, while the superintendent of a criminal lunatic asylum agreed that the 'psychological point of view is prominent in the most recent methods of dealing with the criminal'.[16] In practical terms, a handful of prison doctors were already attempting 'psychotherapeutic interviews' with apparently unstable offenders in their care in the first decades of the twentieth century, as both a form of treatment and a method of research.[17]

The year 1913 saw two important developments for the psychological study of the offender: the publication of *The English Convict*, and the passage of the Mental Deficiency Bill into law. *The English Convict* was a vast statistical study, which received a muted reception due to its sheer size and complexity as well as the proximity of its publication to the outbreak of war. In later years, however, it was credited with disposing once and for all with the notion that the physiology of the criminal set him apart from the rest of the population. If the body definitively did not hold the key to understanding and classifying the criminal, there was scope for alternative interpretations. Although research into physiological anomalies within the criminal population continued from time to time, after 1913 it was largely supplanted by an interest in matters of mental, not physical, makeup. The publishing career of Norwood East exemplified this change. His first articles, dating from the turn of the century, measured the visual, aural, and olfactory perceptions of a group of offenders, and their

[16] J. F. Sutherland, 'Recidivism Regarded from the Environmental and Psychopathological Standpoints', *Journal of Mental Science,* 53 (1907), 568-590 (p.570); Sturrock, 'The Mentally Defective Criminal', p.315.

[17] Mentioned in Norwood East and Hubert, *The Psychological Treatment of Crime*, p.10; Maurice Hamblin Smith was already publishing research into these issues while serving at Dartmoor, Stafford, and Portland Prisons in the 1910s. M. Hamblin Smith, 'Notes on 100 Mentally Defective Prisoners at Stafford', *Journal of Mental Science,* 59 (1913), 326-335; M. Hamblin Smith, 'Unfitness to Plead in Criminal Trials', *Journal of Mental Science,* 62 (1916), 763-774.

sensitivity to atmospheric changes.[18] His many subsequent publications focused almost exclusively on considerations of psychology and psychiatry in relation to crime, and by 1936 he affirmed that the 'student of criminology to-day, discarding phrenological speculations and anthropometrical data, turns to psychology, the science of behaviour, for an explanation of anti-social conduct'.[19]

The Mental Deficiency Act, meanwhile, finally dealt with the recommendations of the Commission on the Care and Control of the Feeble-Minded from 1908. These recommendations responded to reformers who sought to put an end to asylums housing the insane and the mentally deficient side by side, as well as eugenic impulses to place the mentally defective in gender-segregated conditions.[20] It created and defined four categories of mental deficiency, including 'moral imbecility'. This diagnosis incorporated elements of the medical idea of moral insanity or insanity of conduct, in which immorality appeared to be the only sign of mental disorder, but there are some indications that the medical profession did not find the idea entirely satisfactory and this fourth category of defect was not popular.[21] The remaining three categories of defect were used more freely to certify and remove individuals to a suitable colony. Although the full implementation of the Act was delayed, with only 3% of prisoners certified as mentally defective finding their way out of prison and into a dedicated colony during the

[18] Norwood East, 'Physical and Moral Insensibility in the Criminal'; Norwood East, 'An Inquiry into the Susceptibility of Criminals to Atmospheric Changes'.
[19] William Norwood East, *Medical Aspects of Crime* (London: J & A Churchill, 1936) p.232.
[20] The important role of asylum reformers is put forward in Pamela Dale and Joseph Melling (ed.), *Mental Illness and Learning Disability since 1850: Finding a Place for Mental Disorder in the United Kingdom* (London: Routledge, 2006) p.154. On the supposed fecundity of mentally deficient women, see Harvey G. Simmons, 'Explaining Social Policy: The English Mental Deficiency Act of 1913', *Journal of Social History,* 11 (1978), 387-403 (pp.394-395).
[21] The Royal College of Physicians commented in the 1940s that the 'question of whether or not moral defect can exist apart from intellectual defect is one upon which not all medical experts are agreed'. Memorandum to Sub-Committee to the Advisory Council on the Treatment of Offenders, in The National Archives (London), PCOM 9/454. See also 'Meetings of Branches and Divisions: Gloucestershire Branch', *British Medical Journal,* 1 (1924), 173; Mathew Thomson, *The Problem of Mental Deficiency: Eugenics, Democracy and Social Policy in Britain, c.1870-1959* (Oxford: Clarendon, 1998) p.8.

first year of operation, this situation gradually improved as local authorities shouldered their new responsibilities.[22] Increasingly, those who were certifiable as mentally defective were identified before sentencing, meaning that their time in prison would be brief. As had been the case with the insane offender decades earlier, the bearers of this particular category of mental disorder all but vanished from prisons to take up more permanent residence in institutions of another kind.[23]

This did not mean that the issue of mental disorder also vanished. If anything, the statutory definition of mental defect and subsequent removal from prison of those fulfilling its criteria only served to shine a spotlight on the remaining problem of those who escaped certification, but were still described by doctors as mentally abnormal. Their visibility was, perhaps, increased by the dramatic emptying of prisons that took place over the course of the early twentieth century. Wartime military service undoubtedly had some impact, and the prison population did briefly increase again in the 1920s after a momentous decline during the war years. Longer-term trends show a sustained decrease from a peak of nearly 200,000 admissions into prison in 1904-05, to an average of around 37,000 per year between 1930 and 1960.[24] Prompted in large part by the less-frequent use of imprisonment for debtors and minor offences, this reduction enabled prison doctors to focus their attentions on those committing more serious crimes who seemed unrepentant or undeterred by punishment, irrational in their acts, or lacking foresight or self-control.

[22] *Report of the Commissioners of Prisons and the Directors of Convict Prisons, with Appendices, for the Year Ended 31st March, 1915* (London: H. M. Stationery Office, 1915) pp.30-31.
[23] This was acknowledged in *Report of the Commissioners of Prisons and the Directors of Convict Prisons, with Appendices, for the Year Ended 31st March, 1922* (London: H. M. Stationery Office, 1922) p.31.The Mental Deficiency Acts were repealed by the Mental Health Act of 1959.
[24] *Report of Prisons for 1919*, p.4, and subsequent reports. This trend was reversed in the 1960s as prisoner numbers began to increase rapidly.

Concern about this group was reiterated time and again in the medical summaries contained within the annual reports of the Prison Commissioners. Such prisoners might display 'low intelligence and high suggestibility', 'imperfectly developed states of insanity; senility; weakmindedness due to alcoholic excess; and weakmindedness of undefined origin'. They were 'socially inefficient and mentally abnormal', 'unstable, weak-minded offenders for whom at present there is no provision' other than repeated, ineffectual punishment.[25] The very name by which they should be known remained unsettled throughout the period under examination, with doctors experimenting with 'high-grade uncertifiable defectives', the 'non sane non insane' group, or the 'mentally inefficient'.[26] By 1944, eminent psychiatrist Dr Desmond Curran and his colleague Dr Paul Mallinson could record that 'such terms as moral insanity, moral imbecility, temperamental instability, psychopathic inferiority, constitutional psychopathic inferiority, constitutional psychopathic state, and even neurotic character have been proposed', all apparently to signify the same group of people.[27]

The struggle to define and give a name to these offenders illustrated a growing agreement that the boundary between normal and abnormal, in medical and behavioural terms, was far from fixed. This was given official recognition in 1930 when the Director of Public Prosecutions, Sir E. Tindal Atkinson, acknowledged in a lecture to the National Council of Mental Hygiene that in between the professional criminal and the clear-cut case of mental defect, 'there lay an unchartered sea of crimes in which in

[25] *Report of the Commissioners of Prisons and the Directors of Convict Prisons for the year 1926* (London: H. M. Stationery Office, 1928) p.18; *Report of the Commissioners of Prisons and the Directors of Convict Prisons for the Year 1935* (London: H. M. Stationery Office, 1937) p.59; *Report of the Committee on Sexual Offences Against Young Persons* (London: H. M. Stationery Office, 1925) p.57.

[26] William Norwood East, 'Observations on Exhibitionism', *The Lancet,* 204 (1924), 370-375 (p.372); William Norwood East, 'The Non-Sane Non-Insane Offender', *Eugenics Review,* 39 (1947), 6-16; *Report of the Commissioners of Prisons and the Directors of Convict Prisons for the Year 1936* (London: H. M. Stationery Office, 1937) p.60.

[27] Desmond Curran and Paul Mallinson, 'Psychopathic Personality', *Journal of Mental Science,* 90 (1944), 266-286 (p.266).

almost infinitely varying degrees mental health was, in fact, if not in law, an issue relevant to responsibility'.[28] Determining the nature and extent of any individual's mental disorder, and its influence over the commission of criminal acts, was difficult. So, too, was gauging the importance of other contributory factors. Oxford psychiatrist Dr T. Saxby Good explained that for some criminals 'the main factor is physical', while for those with 'paranoia, paranoidal forms of dementia praecox, psychoneurotics and moral imbeciles the main factor is psychological'. 'Environmental factors are of great importance in some cases', he concluded, 'and of some importance in all'.[29] Criminality and mental state alike were entangled with physical health, psychological balance, and the conditions in which the offender lived. Unsurprisingly, clear boundaries, labels, or solutions proved impossible to produce.

For some, the logical conclusion of this complexity was that individual assessment and management were necessary for each and every criminal. The campaigning charity the Howard League for Penal Reform adopted the standpoint that 'the degree of personal responsibility varies in individual cases, that there is no hard and fast line between the “normal” and the “abnormal”', and that society should strive towards the 'individualization of punishment'.[30] Such campaigns for penal reform were propelled in large part by the writings of ex-prisoners, from suffragettes and conscientious objectors to murderers and fraudsters. These memoirs, from the 1920s,

[28] 'National Council for Mental Hygiene: Third Biennial Conference', *British Medical Journal,* 2 (1933), 1030-1034 (p.1030). Chapter 5 considers this realisation in relation to sexual crime in more detail.
[29] T. S. Good, 'The Danger in our Midst: Crime and Abnormality', *The Howard Journal of Criminal Justice,* 3 (1932), 57-65 (p.59).
[30] Executive Committee Meeting of 6 March 1928, in 'Howard League Committee Meetings 1927-1931', Modern Records Centre (Warwick), MSS.16B/1/1; Memorandum of evidence to the Select Committee on Capital Punishment, in 'Howard League Committee Meetings 1932-1937', Modern Records Centre (Warwick), MSS.16B/1/2.

often called for punishment to fit the offender, not the offence.[31] The leader of the Liberal Party, Sir Herbert Samuel, characterised this 'new attitude towards crime' as being 'in each case how far the offender was a pathological subject and how far not'.[32] This was endorsed by psychologist William Brown in an address to the National Association of Probation Officers, and by rising star of the prison medical service, Dr John Landers. Each offender represented an individual problem, and demanded individual study.[33]

The closest the courts could come to an individualised method of disposing of offenders was through the use of probation orders. Judicial discretion to discharge or 'bind over' offenders had a long history, but the formalisation of probation went hand in hand with the individualised attention and emphasis on rehabilitation of the early twentieth century. Probation had been placed on a coherent statutory footing by the Probation of Offenders Act of 1907, which also created the official role of the probation officer to 'assist offenders to carry out their undertaking' with the court.[34] Importantly, as Nigel Walker and Sarah McCabe have noted, one significant feature of the Act was to confirm that 'among the considerations which could justify a court in dismissing a charge (or discharging an offender on recognisances) was his “mental condition”'.[35] The formation of the National Association of Probation Officers soon followed, at which time 'probation was little more than an ideal', but it began to blossom after the First World

[31] Important amongst these are Stephen Hobhouse and A. Fenner Brockway, *English Prisons To-Day* (Longmans, Green, 1922); Constance Lytton, *Prisons & Prisoners: Some Personal Experiences* (London: William Heinemann, 1914) and Stuart Wood, *Shades of the Prison House: A Personal Memoir* (London: Williams & Norgate, 1932).
[32] 'Treatment of Delinquency', *British Medical Journal,* 1 (1933), 625.
[33] William Brown, 'Psychology and the Offender', *Probation Journal,* 1 (1934), 275-276 (p.275); and Landers, 'Observations on Two Hundred Dartmoor Convicts', p.960.
[34] *The Probation Service: Its Objects and Its Organisation* (London: H. M. Stationery Office, 1938) p.11.
[35] Walker and McCabe, *Crime and Insanity in England* vol. 2, p.59.

War with annual conferences and a professional journal from July 1929 onwards.[36] Probation orders increased in number, from 9,655 in 1919 to 39,352 in 1959.[37]

The wording of the 1907 Probation Act had allowed the judiciary considerable leeway to determine the conditions that could be imposed upon a probationer. He would have to be of good behaviour, but beyond this, magistrates could tailor the probation order to the individual offender. They could impose any other requirements that seemed advisable, from a particular place of residence to maintaining regular employment. Although the courts had no power to demand involuntary hospital detention without medical certification of insanity or mental defect, a co-operative offender made voluntary medical treatment a perfectly viable alternative to fines or imprisonment.[38] The Criminal Justice Act of 1948 clarified that probation orders could carry a requirement that the probationer received medical treatment, if the court felt that 'the mental condition of an offender is such as requires and as may be susceptible to treatment but is not such as to justify his being certified'. The hospital or doctor to deliver this treatment should be specified, but otherwise the courts could leave their medical advisers to follow their own preferred course of action. As Chapter 5 will discuss in more detail, treatment for sexual offenders was not unheard of before this Act. Legislation therefore provided encouragement and reassurance to the magistrate considering an order for treatment, rather than a dramatic change in policy. Probation orders themselves represented a practical solution, adding to medico-legal options rather than enforcing any one dogmatic approach.

---

[36] W. G. Worthington, 'The Case for Probation', *Probation Journal,* 1 (1930), 65-66 (p.66).

[37] Looking only at magistrates' courts, where less serious offences were tried, this change is even more marked. For 1919, figures are gleaned from *Judicial Statistics, England and Wales, Part 1: Criminal Statistics* (London: H. M. Stationery Office, 1921) and for 1959, see *Criminal Statistics Relating to Crime and Criminal Proceedings for the Year 1959* (London: H. M. Stationery Office, 1959), p.81.

[38] The extent of this practice will be explored in more detail in Chapter 5.

Over the first four decades of the twentieth century, scrutiny of the mental state of prisoners went hand in hand with anxiety that in many cases, traditional punishment was ineffective. The mentally defective, and then those who could not be certified but were nevertheless seen as mentally abnormal, presented a complex problem of almost infinite variety. A psychological approach, perhaps making use of individually tailored treatments such as probation orders, might hold the answer. In the name of advising magistrates on such probation orders, and getting to know those prisoners who occupied the borderland between normal and abnormal mentality, prison doctors could develop their own area of expertise. This little-studied branch of medicine has received more criticism than praise from historians and sociologists, thanks to its close ties with prison governance and prison punishments, and the seemingly divided loyalties of its practitioners.[39] As the next section will show, prison medicine played an important role in the presence and nature of a psychological approach to crime.

## 2.2 Developments in medicine

Prison medicine as a whole was becoming increasingly important to the management of prisons during the 1910s and 1920s. Despite the slow-moving nature of civil service structures, the Medical Inspector of Prisons was elevated to the Board of the Prison Commissioners in 1914 in recognition of the 'growing importance of the medical side of prison administration'.[40] This promotion was consolidated in 1924, when the Medical Inspector became a Commissioner 'on a footing of full equality with the other Commissioners', and in 1934 a doctor was appointed Governor of a prison for the first

[39] Particularly Sim, *Medical Power in Prisons*. The equivocal status of prison doctors is given sensitive treatment in Miller, '"A Prostitution of the Profession?" Forcible Feeding, Prison Doctors, Suffrage and the British State, 1909-1914', and their current position is considered in Luke Birmingham, Simon Wilson, and Gwen Adshead, 'Prison Medicine: Ethics and Equivalence', *British Journal of Psychiatry,* 188 (2006), 4-6.

[40] *Report of the Commissioners of Prisons and the Directors of Convict Prisons, with Appendices, for the Year Ended 31st March, 1914* (London: H. M. Stationery Office, 1914) p.25.

time.[41] Although the dawn of the 1960s saw the opening of a prison-hospital under the management of a Medical Superintendent, some twenty years after it had first been proposed, the gains made by the prison medical service had already begun to slip away. In 1950, Dr Methven had retired from his position as Deputy Chairman of the Prison Commission and in so doing, became the last doctor to serve as a Prison Commissioner. He was replaced by a non-medical civil servant. Future Directors of Medical Services remained on the Prisons Board, but without holding the status of Commissioner. When the Prison Commission was dissolved in 1963 and prison management transferred back to the Home Office, the new Prison Board did not include a doctor amongst its members.[42]

This period therefore saw a recognition of the importance of prison medicine to the penal system as a whole. Concomitant with this rise in status went an emphasis upon the specialist knowledge of the prison doctor, who came to be seen, and to see himself, as an expert in mental illness. This had its roots in the report of the Departmental Committee of Prisons of 1895, which had recommended that some particular expertise in lunacy should be a requirement for the role of prison doctor.[43] In 1918, though, the retirement of the most senior prison doctor was marked by tributes to his skill in 'all the difficult questions involved in the treatment of venereal disease in prisons, framing new dietaries to meet the requirements of the Food Controller, and with the problems of

[41] *Report of the Commissioners of Prisons and the Directors of Convict Prisons, with Appendices, for the Year Ended 31st March, 1924* (London: H. M. Stationery Office, 1924) p.33.
[42] *Report of the Commissioners of Prisons for the Year 1950* (London: H. M. Stationery Office, 1951) pp.5-6; *Prisons and Borstals: A Report on the Work of the Prison Department in the Year 1963* (London: H.M. Stationery Office, 1963), Appendix 1. Dr Methven's second in command, Dr Young, retired in the same year from the role of Director of Medical Services, which perhaps left no sufficiently experienced doctor on staff to take on the role of a Commissioner in the 1950s.
[43] *Report from the Departmental Committee on Prisons* (London: H. M. Stationery Office, 1895) p.34.

"hunger-striking"'.[44] Proficiency in managing mental disease went unmentioned. His successor was lauded for experience in prisoner problems 'both physical and mental',[45] however, and by 1923 the Prison Commissioners were celebrating their senior medical advisor's skill, knowledge, and interest in 'abnormal mentality' without commenting on his attention to the physical wellbeing of prisoners at all.[46] The annual reports of the Prison Commissioners began to emphasise the professionalism of their medical staff by giving details of their publications, which were predominantly concerned with mental disorder in one form or another.[47] So too were the lectures at the newly instituted annual conference for prison doctors. By 1935, university medical examining boards had acknowledged 'the abundant material for study in H.M. Prisons' and 'decided to accept twelve months' appointment in either of four large remand prisons as the equivalent of twelve months' mental hospital practice required for their diploma in psychological medicine'.[48] Large prisons, from the 1930s, were seen to contain just as much mental disorder as a dedicated mental hospital.

The preoccupations of individual doctors within the prison service encouraged this specialisation. Norwood East and his colleague Hamblin Smith shared an interest in adopting a psychological approach to criminality. Both had been prison medical officers since the end of the nineteenth century and enjoyed long careers in the service. Hamblin Smith developed an early interest in mental disorder and went on to become one of the editors of the leading journal for psychiatry, the *JMS*, in 1931. While serving as the

[44] *Report of the Commissioners of Prisons and the Directors of Convict Prisons, with Appendices, for the Year Ended 31st March, 1918* (London: H. M. Stationery Office, 1918) pp.27-28.
[45] *Report of the Commissioners of Prisons and the Directors of Convict Prisons, with Appendices, for the Year Ended 31st March, 1921* (London: H. M. Stationery Office, 1921) p.26.
[46] *Report of the Commissioners of Prisons and the Directors of Convict Prisons, with Appendices, for the Year Ended 31st March, 1923* (London: H. M. Stationery Office, 1923) p.42.
[47] These papers and publications are listed in the *Report of the Commissioners of Prisons and Directors of Convict Prisons for the Year 1925-26* (London: H. M. Stationery Office, 1927) pp.33-34.
[48] *Report of the Commissioners of Prisons and the Directors of Convict Prisons for the Year 1937* (London: H. M. Stationery Office, 1938) pp.46-47; *Report of Prisons for 1935*, p.56.

prison doctor of Birmingham prison from 1920 until his retirement in 1933, he lectured at Birmingham University and published many articles as well as two books, *The Psychology of the Criminal* and *Prisons and a Changing Civilisation*.[49] After his death in 1936 he was fondly remembered as a 'kindly, genial and most lovable doctor' whose service had 'coincided with a period of steady and substantial progress in prison medical administration, and in the scientific approach to crime'.[50] Perhaps thanks to Hamblin Smith's controversial faith in Freud, his relatively impressive career was thoroughly eclipsed by the achievements of Norwood East, who was promoted from senior doctor at Brixton prison to the head of the prison medical service in 1924, and then Commissioner of prisons in 1930. Norwood East published prolifically throughout the 1920s, 1930s, and into the 1940s, lectured at the Maudsley Hospital, served on several governmental committees, was 'at one time or another president of the Medico-Legal Society, the Society for the Study of Addiction, and the Psychiatric Section of the Royal Society of Medicine', and was finally knighted in 1947 for 'services to the study of criminal psychology'.[51]

Under Norwood East's careful stewardship, medical treatment along psychiatric or psychological lines was formally instituted within the prison system in 1934. He diplomatically negotiated the appointment of a part-time psychotherapist to be based at Wormwood Scrubs prison, Dr William de Bargue Hubert, who came recommended by Dr Edward Mapother of the Maudsley.[52] This appointment was, Norwood East claimed, for

[49] His articles included many for the Howard League's journal, as well as M. Hamblin Smith, 'The Mental Conditions Found in Certain Sexual Offenders', *The Lancet,* 203 (1924), 643-646; M. Hamblin Smith, 'The Psychopathic Personality', *Journal of Mental Science,* 71 (1925), 683-694.
[50] Arthur R. L. Gardner, 'In Memoriam: Dr M Hamblin Smith', *The Penal Reformer,* 3 (1936), 14-16 (p.14); William Norwood East and Alexander Walk, 'Maurice Hamblin Smith', *Journal of Mental Science,* 82 (1936), 291-293 (p.293).
[51] 'Sir Norwood East, M.D., F.R.C.P.'.
[52] Records of this process are in 'Psychological Treatment of Crime, 1921-41', The National Archives (London), HO 45/18736.

a select few prisoners to receive psychotherapy on an experimental basis 'to ascertain the value of psychological treatment in the prevention and cure of crime'.[53] By 1939, 406 cases had been referred by prison doctors from around the country and had been reviewed by Norwood East, who approved 214 for treatment in London with Hubert.[54] The results of the first four years of this programme of psychotherapy were published in what became an extremely influential report, *The Psychological Treatment of Crime*.[55] The Second World War generated significant disruption for the prison service as a whole and for this programme in particular, as Hubert joined the Royal Army Medical Corps in 1939, shortly after the publication of his and Norwood East's report. The Prison Commissioners noted apologetically that it 'was not possible at that time to set aside any prison or part of any prison for this work, nor was it possible to find a successor to Dr Hubert, and so this work ceased'. Although any 'medical officers with special qualifications for psychiatry endeavoured to assist those prisoners requiring psychological help in the prisons', they concluded 'with great regret that psychiatric treatment in prisons virtually ceased on the outbreak of war'.[56]

This setback was only temporary, and the psychotherapeutic mantle was taken up again at Wormwood Scrubs in 1943 by Dr John Mackwood. He, like Hubert, specialised in psychotherapy, and was joined in 1946 by psychologist Dr Jonathan Gould.[57] Their method of treatment was primarily group and individual psychotherapy, but their Psychological Unit at Wormwood Scrubs also developed the means to provide shock therapies. This was in line with a growing trend to treat mental disorder by

[53] Norwood East and Hubert, *The Psychological Treatment of Crime*, p.ii.
[54] Norwood East and Hubert, *The Psychological Treatment of Crime*, p.26.
[55] As Chapter 6 will discuss in more detail, this report set down the criteria for a 'treatable' prisoner. It also recommended a dedicated prison-hospital, later known as the 'East-Hubert institution', which was finally opened in 1962 in Grendon Underwood.
[56] *Report of the Commissioners of Prisons and Directors of Convict Prisons for the Years 1939-1941* (London: H.M. Stationery Office, 1946) p.62.
[57] *Report of Prisons for 1949*, pp.82-92.

physical means. From the 1930s, some doctors in private practice, perhaps most notably Dr William Sargant, had been energetically pursuing physical treatments over and above psychological and social approaches.[58] Shock or 'convulsion' therapies, using both insulin and electricity, were reportedly in 'common use in the majority of mental hospitals' by the 1940s, and were mentioned as useful in the treatment of schizophrenia, depression, mania, and 'involutional melancholia'.[59] Facilities for physical treatments were introduced to Wormwood Scrubs in 1946, marking the advent of a more somatic approach to mental health medicine in prisons as well. The prison hospital contained equipment for electro-convulsive therapy (ECT), and there were occasional forays to local hospitals for insulin shock therapy. Although insulin therapy was found to be unsuccessful and discontinued, ECT appears to have been used to treat small numbers of prisoners throughout the 1950s and beyond.[60]

The scale of such treatments should not be overestimated. Mackwood and Gould treated a total of 312 offenders between 1943 and 1949, at a time when there were on average about 37,000 receptions into prison each year. Their efforts at Wormwood Scrubs therefore involved less than 0.2% of the prison population.[61] Between 1934 and 1949, with a short hiatus during the war, the three psychological specialists attached to H. M. Prison Service treated a grand total of 526 offenders. The number of adult prisoners referred for psychological treatment per year had risen to 233

[58] John A. S. Beard, 'Dr William Sargant (1907-88) and the Emergence of Physical Treatments in British Psychiatry', *Journal of Medical Biography,* 17 (2009), 23-29 (p.24).
[59] K. E. Hemphill and W. Grey Walter, 'The Treatment of Mental Disorders by Electrically Induced Convulsions', *Journal of Mental Science,* 87 (1941), 256-275 (p.256, p.270).
[60] *Report of Prisons for 1949*, p.92-93. The numbers for these latter treatments were not large: in 1947 Dr Gould treated 41 prisoners, of whom 10 received ECT and 3 insulin. See also *Report of the Commissioners of Prisons for the Year 1958* (London: H. M. Stationery Office, 1959) p.105, p.138; *Report of the Commissioners of Prisons for the Year 1959* (London: H. M. Stationery Office, 1960) p.141.
[61] *Reports of the Commissioners of Prisons*, 1943 to 1949.

by 1959, or 0.6% of all those admitted under sentence.[62] This was still, therefore, a small operation, even though additional psychological units had opened at other institutions and the psychological staff involved in assessing prisoners had expanded. By the end of the 1950s, facilities at Wakefield and Holloway prisons catered to the north of England and to women respectively, while Feltham could provide treatment to adolescent boys. Girls passing through the juvenile courts could be sent to Duncroft School for psychotherapy, although only about 12 could be received there each year.[63] Outside of these small, specialist units, generalist prison doctors were not all equally expert or even equally interested in the field of mental abnormality. The damning Gwynn Report of 1964 characterised the prison medical service as severely lacking in psychiatric expertise, with only 11 out of its 140 doctors possessing the Diploma in Psychological Medicine.[64] It was only for a short time, then, that prison doctors were at the vanguard of a medical approach to crime. In light of this and the small numbers of prisoners undergoing psychiatric treatment, the significance of prison medicine might seem minimal, but its importance rested upon the status of prison doctors as intermediaries between the extreme ideas to be found in both medicine and law. In this role, they could engage closely with the practical possibilities and implications of a more psychological approach to crime.

Innovation within the prison medical service was therefore closely connected to events within the wider medical community. Having lagged behind France and German-speaking nations during the nineteenth century, psychiatry and psychology were beginning to establish themselves on a firmer footing in England. Psychology benefited

[62] *Report of Prisons for 1959*, pp.102-103.
[63] John C. Mackwood, 'Psychotherapy in Prisons and Corrective Institutions', *Proceedings of the Royal Society of Medicine,* 47 (1954), 220-224 (p.222, p.224) and *Report of Prisons for 1959*, p.102. As Chapter 3 will discuss, psychological work amongst female criminals generated precious little official attention.
[64] *The Organisation of the Prison Medical Service*, p.2.

from a rapidly growing Society and the first academic professorships dedicated to the subject, while the enormously significant Maudsley Hospital opened its doors to the general public in 1923. Many more mental health clinics followed suit after the Mental Health Act of 1930 provided for voluntary treatment to be delivered more widely.[65] Two London-based organisations, the Tavistock and the ISTD, were particularly important when it came to crime and delinquency.[66] The Tavistock clinic, founded by Dr Hugh Crichton-Miller as a temporary solution to the needs of the civilian population after the First World War, received its first patient on 27 September 1920. It was unusual at the time, if not unique, for offering out-patient therapy at little or no charge to all-comers, and the extent to which demand continually outstripped supply ensured that it rapidly became a permanent feature of the psychiatric landscape. Numerous doctors joined its ranks, including many eminent specialists, and its volunteers already numbered 90 by 1939.[67] Its first referrals from the courts arrived in 1923, and by the end of the 1920s the clinic could report 'a remarkable increase of probation cases referred by the courts' from 6 in the first year to 68, which represented 10% of its annual intake.[68]

The ISTD, founded in 1931, was in many ways a more specialised branch of the Tavistock, with many of the same personnel and practices but a focus on criminality. A

[65] Mathew Thomson, *Psychological Subjects: Identity, Culture, and Health in Twentieth-Century Britain* (Oxford: Oxford University Press, 2006) p.59, p.191; Rhodri Hayward, 'Germany and the Making of "English" Psychiatry: The Maudsley Hospital, 1908-1939', in *International Relations in Psychiatry,* ed. by Volker Roelcke, Paul J. Weindling, and Louise Westwood (Rochester: University of Rochester Press, 2010), pp. 67-90. The Maudsley had been granted permission to treat mental patients on a voluntary basis by special Act of Parliament.

[66] These clinics and the organisations running them underwent numerous changes of name during the period in question. For simplicity, they will be described here as the Tavistock and the ISTD.

[67] 'H. Crichton-Miller, M.D., F.R.C.P.', *British Medical Journal,* 1 (1959), 116-117 (p.116).

[68] *Report of the Tavistock Square Clinic for Functional Nervous Disorders for April 1929-March 1930* (London: Tavistock Square Clinic, n.d. [c.1931]), p.5, and 'Memorandum: The Tavistock Clinic', in 'Feversham Committee: Memoranda on individual organisations', Wellcome Library (London), SA/MAC/E.2/9.

much greater proportion of its patients were therefore referred by the courts.[69] It also adopted a more proactive stance in the field of criminology than the Tavistock, aiming to carry out research into the causes and prevention of crime, and to educate the wider medico-legal community.[70] It was inter-disciplinary from the outset, making use of the expertise not only of psychiatrists and psychologists, but also social workers, sociologists, and a range of other experts. The ISTD strove to establish close links with the probation service, and emphasised that only wide-ranging social and psychological enquiry could produce meaningful results. Physical illness, domestic problems, dissatisfaction at work, and even endocrinological imbalance were all identified as possible causes of an individual's disturbed mental state and anti-social conduct, and could require remedial measures. This matrix of contributory factors meant that, although a medical approach to crime was spearheaded by the psychological branch of the profession, diagnoses and remedies incorporated many different social and clinical elements.[71] The ISTD's organising committee aspired for its clinical arm to become a national service, and attempted with varying degrees of success to establish branches in Plymouth, Cheltenham, Nottingham, Shrewsbury, Liverpool, Oxford, Wolverhampton, and Brighton.[72] In 1948, the ISTD, like the Tavistock, separated its clinical work from other activities in research, education, training, and campaigning, so that its clinical endeavours could form part of the new NHS. The fact that the prison medical service did not become part of the NHS at this time only served to render it increasingly isolated as the 1950s progressed.

[69] Figures are available in their annual reports, held in the Archives of the Centre for Crime and Justice Studies, London.
[70] The ISTD's objectives can be found on the inside cover of most of their publications.
[71] Diagnoses and remedies for sexual crimes will be discussed in detail in Chapter 4.
[72] Minutes of meetings of 10 May 1934; 7 July 1936; 20 July 1937, in 'Reports and minutes of meetings of the Institute for the Scientific Treatment of Delinquency', Archives of the Centre for Crime and Justice Studies (London), [uncatalogued].

In their first decades, though, both the Tavistock and the ISTD were well known to the prison medical service. Relations between individual representatives of all three bodies were largely cordial. Hamblin Smith was invited to become a member of the ISTD after his retirement, and duly accepted, while Norwood East entered into a positive and supportive exchange with the Director of the Tavistock, Dr J. R. Rees, on the subject of the clinic's reported results.[73] There was, however, some conflict between the underlying assumptions of the work of prison doctors and their counterparts based elsewhere. The two clinics tended to advocate very widely for a medical approach to crime. Dr Grace Pailthorpe, the founder of the ISTD, had concluded that criminals were 'suffering from psychological illness or defects', since all 'serious deviation from [the norm] is an indication of deficient adaption capacity on the part of the individual to his surroundings'.[74] Statistically, she found that even excluding the 'mental defectives and constitutional inferiors', in 55% of her subjects 'mental imbalance is evident' and 'psychological treatment in one form or other is necessary'.[75] Dr Emanuel Miller of the Tavistock spoke out in favour of an exclusively medical approach to crime, saying that 'all convicted offenders ought to be examined psychologically and the appropriate treatment prescribed by experts, instead of sentence'.[76] Glover was even more specific in his insistence that 'the most fundamental approach to crime, pathological or otherwise, is that of psycho-analysis'.[77] These views presented a definitive challenge to the fundamentals of existing medico-legal procedure.

[73] Correspondence between J. R. Rees and Sir Alexander Maxwell, December 1937-January 1938, in The National Archives (London), HO 45/18736, File 438456/33.
[74] Grace Pailthorpe, *Studies in the Psychology of Delinquency* (London: H. M. Stationery Office, 1932) p.99.
[75] Pailthorpe, *Studies in the Psychology of Delinquency*, p.87.
[76] Reported, with some concern, in 'Treatment of Delinquency'.
[77] Edward Glover, *The Roots of Crime* (London: Imago, 1960), p.xiv.

Such claims were controversial, not least because of their connection to psychoanalysis. Historians have charted the reception of Freud and psychoanalysis in Britain, drawing varying conclusions about the extent of awareness and opposition,[78] but psychoanalysis was undoubtedly contentious in medico-legal circles. It had been dismissed as 'pornography' by eminent psychiatrist Charles Mercier, and its scientific basis was questioned by such luminaries as Sir Clifford Allbutt, president of the BMA, who saw it as a ridiculous fad. 'Nay, even pickpockets were now appealing to their judges to regard their cases from the psychological point of view' these days, he remarked in 1922.[79] Although both Tavistock and ISTD were usually keen to play down their associations with psychoanalysis, recognising that any suggestion of a reliance upon psychoanalytic methods 'is likely to do the institution and its appeal for support more harm than good', many of their members were firm advocates for a broadly psychoanalytic approach.[80]

This they shared with Hamblin Smith, who was also committed to the principle of thorough medico-social investigation of all offenders. For the most part, however, he and his colleagues within the prison service adopted a much more pragmatic outlook.

---

[78] Dean Rapp, 'The Early Discovery of Freud by the British General Educated Public, 1912–1919', *Social History of Medicine,* 3 (1990), 217-243; Waters, 'Havelock Ellis, Sigmund Freud and the State'; Shapira, *The War Inside*, especially pp.7-20.

[79] Charles Mercier, 'Psycho-Analysis', *British Medical Journal,* 1 (1914), 172-173; 'Psycho-Analysts' "False Science"', *The Times,* 3 October 1922, p.7. The remarks were made during a lecture at St George's Hospital Medical School, and noted in a Home Office file dedicated to psychoanalysis within 'Psychological Treatment of Crime, 1921-41', The National Archives (London), HO 45/18736.

[80] E. Farquhar Buzzard, 'The Tavistock Clinic: A Correction', *British Medical Journal,* 1 (1928), 287. Upon receipt of a supportive letter from MP Thomas Cassells, the ISTD's governing committee noted that his 'inclination to stress the value of psycho-analysis might be a little dangerous from the Institute's point of view'. Minutes of the ISTD committee meeting of 7 July 1938, in 'Reports and minutes of meetings of the Institute for the Scientific Treatment of Delinquency', Archives of the Centre for Crime and Justice Studies (London), [uncatalogued]. This contradicts somewhat Michal Shapira's view that 'the ISTD did not shy away from publicly identifying itself with psychoanalysis': some of its doctors may have been or become bolder about doing so, but it certainly remained cautious about drawing such connections until the 1950s, at least. Shapira, *The War Inside*, p.146.

Hamblin Smith acknowledged from experience that his preferred solution of psychoanalysis was not always the best answer. 'I fully recognise', he said, that 'there is much in the rival theories which has to be taken into consideration'.[81] Furthermore, in practical terms, lengthy and costly treatment was simply not possible for most offenders, even if it could be agreed that it was the best route to law-abiding conduct. And such agreement was not in evidence. 'Crime is still alleged by some to be a disease', Norwood East was sorry to report, perhaps with one eye to the doctors of the ISTD and Tavistock, but in his view the 'majority of law-breakers are mentally normal'. In such cases, medical treatment would not necessarily be of much help. Punishments could still serve as a useful deterrent, he felt, but the experience of the prison doctor could help to identify those cases of crime in which disease might play a role and treatment could usefully intervene.[82] The psychological approach was important, but no panacea. The Committee on Persistent Offenders, which reported in 1932 and counted Norwood East amongst its members, acknowledged that although some crimes may result from 'an abnormal mental condition', efforts to address such abnormalities 'on the whole have been inconclusive'.[83] 'Sometimes', reflected Landers, 'when I read of the extravagant claims made for certain forms of treatment of crime, I am reminded that it is the "quack" doctor who can cure everything'.[84]

Pointed remarks about 'quacks' could serve a useful purpose for the prison medical service. In his petitions to the Home Office for permission to appoint a prison psychotherapist, Norwood East emphasised that 'many people, some not too well

[81] Hamblin Smith, *The Psychology of the Criminal*, p.9.
[82] William Norwood East, 'Responsibility in Mental Disorder, with Special Reference to Algolagnia', *Journal of Mental Science,* 84 (1938), 203-221 (p.208); William Norwood East, 'The Modern Psychiatric Approach to Crime', *Journal of Mental Science,* 85 (1939), 649-666 (p.254).
[83] *Report of the Departmental Committee on Persistent Offenders* (London: H. M. Stationery Office, 1932) pp.43-46.
[84] Landers, 'Observations on Two Hundred Dartmoor Convicts', p.979.

informed, are clamouring at the present time for... the psychotherapeutic treatment of prisoners'. Even more concerning was the fact that many officials had been approached by 'medical men who have volunteered to treat prisoners'. Such volunteers, Norwood East pointed out, may not be suitably qualified and may not produce reliable evidence of success or failure. 'Unless this work is officially undertaken, controlled, and critically examined in regard to its effects', he concluded, 'the Commissioners will invite further criticism to which there seems to be no satisfactory reply, and unofficial work on the same lines undertaken elsewhere may issue misleading results'.[85] The introduction of psychotherapy for 'selected cases' within prisons reflected a pragmatic and manageable solution to this problem.

The wider medical establishment broadly endorsed a compromise along these lines. Much had also changed since Sir Clifford Allbutt's disparaging comments about the psychological approach to crime in 1922. Following the introduction of the Criminal Justice Bill in 1938, the Medico-Political Committee of the BMA passed a resolution that would have taken Sir Clifford aback: 'that a psychological assessor should be available to assist benches of magistrates in selection of cases… for psychological treatment'.[86] The pickpocket's mental state was worthy of consideration after all. This position was sustained for several decades. Although the Second World War disrupted the provision of forensic psychiatric services as doctors joined the armed forces or were co-opted for military purposes, the contributions of many mental health specialists to the management of military recruitment and casualties elevated the profile and optimism surrounding mental health medicine considerably. Professor of Psychology L. S.

[85] Proposed Appointment of a Medical Psychologist, 1932, and Persistent Offenders Committee meeting of 30 Oct 1933, both in 'Psychological Treatment of Crime', The National Archives (London), PCOM 9/186. The appointment was approved on 20 December 1933.
[86] 'The Medico-Political Committee of the B. M. A.', *British Medical Journal,* 1 (1938), 336-337 (p.337).

Hearnshaw referred in 1951 to 'the exuberance of the immediate post-war period' when psychologists and psychiatrists alike 'imagined or led others to imagine that the solution to all human and social problems by psychological techniques was at least within the bounds of possibility'. This 'culminated in the International Congress of Mental Health held in London in August 1948', he drily remarked, 'where delegates prescribed for the mental sickness of mankind as a whole'.[87] Needless to say, such prescriptions had failed to yield a cure. Post-war optimism proved difficult to sustain.[88] Psychiatry had only recently been adopted onto the teaching programmes of all medical schools, and even by 1960 the country could boast just 400 psychotherapists.[89] Even in situations in which medical evidence could be heard and the judiciary was enthusiastic about treatment, resources remained stretched.

## 2.3 Legal procedures and curing crime

Innovations in responding to crime clearly did not rely solely upon the medical profession. Without a willingness on the part of the judiciary to hear them, and a legal framework that allowed for their use, medical ideas could serve little practical purpose. In the early twentieth century, opportunities for expert evidence regarding mental state were limited, as the case of one Dr Watson from 1901 illustrates. According to *The Times*, after Dr Watson had pleaded guilty to a charge of indecent assault but before sentencing, his lawyer had asked leave to introduce evidence from the medical officer stationed at Holloway prison. The Recorder, Sir Forrest Fulton K.C., dismissed this request with some impatience, protesting that it was quite improper for defendants to

[87] L. S. Hearnshaw, 'Recent Trends in Psychology: Lectures and Pamphlets', Wellcome Library (London), PSY/HEA/4/4, p.1.
[88] Edgar Jones has addressed this with specific reference to psychotherapy: Edgar Jones, 'War and the Practice of Psychotherapy: The UK Experience 1939–1960', *Medical History,* 48 (2004), 493-510.
[89] Thomas Bewley, *From Madness to Mental Illness* (London: Royal College of Psychiatrists, 2008) p.122; Thomson, *Psychological Subjects*, p.252.

try to 'influence the Judge in passing sentence by suggesting that they were not of sound mind'. 'The question whether an accused person was of unsound mind was one for a jury to determine', he maintained. For this Recorder, being of sound mind was a black-and-white matter. A plea of insanity could only be decided by a jury and meant that the defendant was not legally responsible for any crime. Otherwise, he should be punished according to the law, and his mental state was irrelevant. Juries were not involved in a substantial array of legal proceedings, including sentencing decisions, and so Fulton refused to allow evidence regarding mental state. There was no place within this legal environment for a borderland of mental abnormality.[90]

The Recorder may well have been reacting to changes in practice that he felt were already afoot in some corners of the legal establishment. By 1910, the Medical Inspector of Prisons felt confident that 'judges, magistrates, and the public generally are now very much more alive than formerly to the fact that anti-social conduct is frequently dependent on some abnormal mental condition'.[91] Although he did not specify the impact of this awareness, medical involvement in legal proceedings became significantly more prominent towards the end of the 1910s. By 1919, in fact, the Recorder's refusal to consider evidence regarding the state of the accused's mind before sentencing was no longer a tenable position. Although it was still widely believed that only a jury could decide in the event of a defence of insanity,[92] the judiciary accepted that psychiatric evidence might address other forms of mental abnormality, and that the presence of milder forms of disorder could shape individual conduct and should therefore inform

[90] 'Central Criminal Court', *The Times,* 16 December 1901, p.13.
[91] *Report of Prisons for 1910*, p.31.
[92] This belief was still in circulation as recently as 1997. See Tony Ward, 'Magistrates, Insanity and the Common Law', *Criminal Law Review,* (November 1997), 796-804. This refers to insanity as a defence leading to the special findings of 'guilty but insane' or 'insane on arraignment'.

sentencing decisions. Cases of petty fraud, thefts, and – as later chapters will examine – sexual offences came to feature expert medical opinion with some regularity.

In 1919, the magistrates of Birmingham made this explicit in their request to the Prison Commissioners for some further assistance in dealing with mentally unbalanced offenders. The zeal with which the Prison Commissioners responded suggests that this request came not a moment too soon, and the Commissioners quoted the Birmingham Justices at length. The judiciary had expressed in no uncertain terms their mounting concern at 'the futility and inadequacy of the customary methods of dealing with persons charged with crimes, particularly as to the absence of any consideration of the mental condition of such persons'. In their view, in 'many cases some mental instability is the fundamental cause of the commission of the crime, and "treatment" as distinct from "punishment"... is the proper and sane method to adopt'. The Prison Commissioners were only too pleased to send a 'special doctor' to Birmingham prison to assist.[93] This 'special doctor' was, in fact, Hamblin Smith, already in the employment of the prison service at Portland prison. The Commissioners were therefore bringing the psychological expertise of their staff to the fore, and emphasising the extent of medico-legal agreement regarding the importance of mental abnormality.

The Birmingham Justices had situated their plea against the backdrop of the demobilisation of wartime personnel and 'shell shock and other diseases (mental or physical) arising out of war conditions'. In so doing, they were both responding to, and participating in, the significant rise in profile of psychiatry in the immediate aftermath of the First World War.[94] As has often been noted, the 'battlefields of Europe' were vital to the development of mental health medicine, amongst doctors and the wider public

[93] *Report of Prisons for 1919*, pp.16-17.
[94] *Report of Prisons for 1919*, p.16.

alike.[95] Magistrates began to request reports on the mental state of defendants appearing before them with increasing frequency, and at least some of the time they were responsive to the advice they received. In 1920, Norwood East could already relate recent examples of an offender who had received a lighter sentence in recognition of an apparent mental abnormality. Others, he reported, had had their cases 'discharged by the magistrate' after the presentation of medical evidence connecting their crimes to 'war psycho-neuroses', 'neurasthenia', 'hysteria', 'psychasthenic inebriety' and 'mental depression'.[96] Such leniency probably reflected a desire to avoid imposing heavy penalties upon individuals who were cast in a sympathetic light in the courtroom. This is not to say that the courts had not reacted more favourably to some offenders than others in the past. In the 1901 case of Dr Watson, the Recorder had passed an extremely light sentence, equal to time already served, in response to the doctor's hitherto 'unblemished reputation'. Rather, the basis for making such allowances had begun to change. Medical evidence of mental abnormality could now accompany or even take the place of character references and evidence of mitigating circumstances. The extent and nature of such evidence in relation to sexual offences, and the kinds of offender for whom it was successfully deployed, will be explored in greater depth in Chapter 5.

The enthusiasm of the Birmingham magistrates for wider enquiry into the mentally unbalanced man or woman in the dock spilled over into Bradford. In their 1922 survey of the prison system, Stephen Hobhouse and Fenner Brockway identified both

[95] Of the Tavistock Clinic, the 'need which had inspired its founding' in 1921 has been said to have come 'from the battlefields of Europe'. Elizabeth F. Irvine, *A Pioneer of the New Psychology: Hugh Crichton-Miller* (Chatham: W & J Mackay, 1963) p.26. See also M. Stone, 'Shellshock and the Psychologists', in *The Anatomy of Madness: Essays in the History of Psychiatry,* ed. by W. F. Bynum, Roy Porter, and Michael Shepherd (London: Tavistock, 1985), pp. 242-271; and Peter Barham, *Forgotten Lunatics of the Great War* (New Haven: Yale University Press, 2004).
[96] William Norwood East, 'Some Cases of Mental Disorder and Defect Seen in the Criminal Courts', *Journal of Mental Science,* 66 (1920), 422-438, p.437.

cities as centres for experimental efforts in a more psychological approach to crime.[97] In the 1930s, Bradford magistrate F. J. O. Coddington unofficially appointed his own medical advisor in the form of a retired professor of forensic medicine, Dr Eurich. He spoke with considerable enthusiasm about the advantages of this collaborative effort, and presented the Home Office with a detailed account of their achievements.[98] Claud Mullins, a London stipendiary magistrate, was another vocal proponent of careful medical enquiry, as he proudly affirmed in his books and lectures. Greatly influenced by magistrate William Clarke Hall, an advocate for the wider use of probation who had introduced significant changes to juvenile courts in London, Mullins strove for a more imaginative approach to resolving the legal problems that came before him. He engaged closely with the ideas emerging from the ISTD, and enthusiastically sought medical advice in specific cases.[99]

These were far from typical representatives of the judiciary. Edward Glover recalled that in the 1920s, magistrates were 'by nature and training extremely conservative and indeed almost allergic to the idea that any crime could be a manifestation of disorder'.[100] This was borne out by the commentary of magistrate Ratcliffe Cousins, reported in *The Times* in 1925. 'At present', Cousins observed with evident annoyance, 'a number of persons, amateur criminologists... have been discussing the question of crime from the psychological point of view', and would see some crimes as evidence of pathological predisposition. 'That is sheer nonsense', was his unequivocal

[97] Hobhouse and Brockway, *English Prisons To-Day*, p.53. Unfortunately the West Yorkshire Archives do not hold any records that shed light on such activities in Bradford.
[98] Newspaper cuttings and correspondence between the Home Office and Coddington are in 'Psychological Treatment of Crime, 1921-41', The National Archives (London), HO 45/18736.
[99] Claud Mullins, *Crime and Psychology* (London: Methuen, 1943); 'Psychiatry and the Criminal Law: A Maudsley Lecture', *British Medical Journal,* 2 (1948), 951-952; Emma Dally, *Claud Mullins: Rebel, Reformer, Reactionary* (Leicester: Troubadour Publishing, 2010).
[100] Glover, *The Roots of Crime*, p.3.

assessment.[101] Mullins, who held the dubious honour of being described as the first magistrate to apply psychology to his work, was well aware of the rarity of his outlook.[102] When delivering the Maudsley Lecture in 1949, he warned his audience that 'most of the opinions that I shall express will not be at all popular in my own profession: I must not be regarded as typical of either lawyers or metropolitan magistrates'.[103] In 1940, the official organ of the Magistrates' Association had criticised the 'mass of ill-digested thought and partial observation' that had been produced regarding the criminal of late, including 'notions ranging from one which almost makes him a member of a race apart to another which regards him merely as a psychologically sick man. He is usually quite an ordinary person'.[104] Psychological causes and cures remained something of a minority interest. Mullins noted sadly that whenever he attended courses for magistrates run by the ISTD, there were never more than eight of his colleagues present, and the Bradford team of Coddington and Eurich seems to have been unique.[105]

Despite active resistance in some quarters of the judiciary, and apathy in others, a growing proportion of offenders were being remanded for consideration as to their mental health. Although this was instigated by prison doctors on occasion, it was more commonly at the request of the judiciary. The number of these reports increased year on year, from 1,611 in 1920, when records began, to 6,029 in 1960. As a percentage of all prisoners under sentence, the rate of those undergoing mental examination fluctuated but maintained an upward trend. Figure 1 illustrates this change, from 1920 when just over 4% of prisoners were examined, to 1960 when it exceeded 14%. Figure 1 also shows the dramatic change taking place in the early 1960s, when the proportion of

[101] 'Punishment of Crime', *The Times,* 18 August 1925, p.5.
[102] Mullins, *Crime and Psychology*, p.xiv.
[103] Claud Mullins, 'The Twenty-Second Maudsley Lecture: Psychiatry in the Criminal Courts', *Journal of Mental Science,* 95 (1949), 263-274 (p.263).
[104] 'Criminal Science', *The Magistrate,* November (1940), 333-334 (p.334).
[105] Mullins, *Crime and Psychology*, p.218.

prisoners being examined rose extremely rapidly in a short period of time, from around 14% to over 25%. This has been attributed to the Mental Health Act of 1959, which tried to make treatment more accessible and acceptable, and encouraged a process of de-institutionalisation across in-patient facilities.[106] The Act marked a dramatic step-change in the operation of forensic psychiatry. The years between 1919 and 1959, though, saw a steady increase in the inclusion of medical expertise in judicial decision-making.

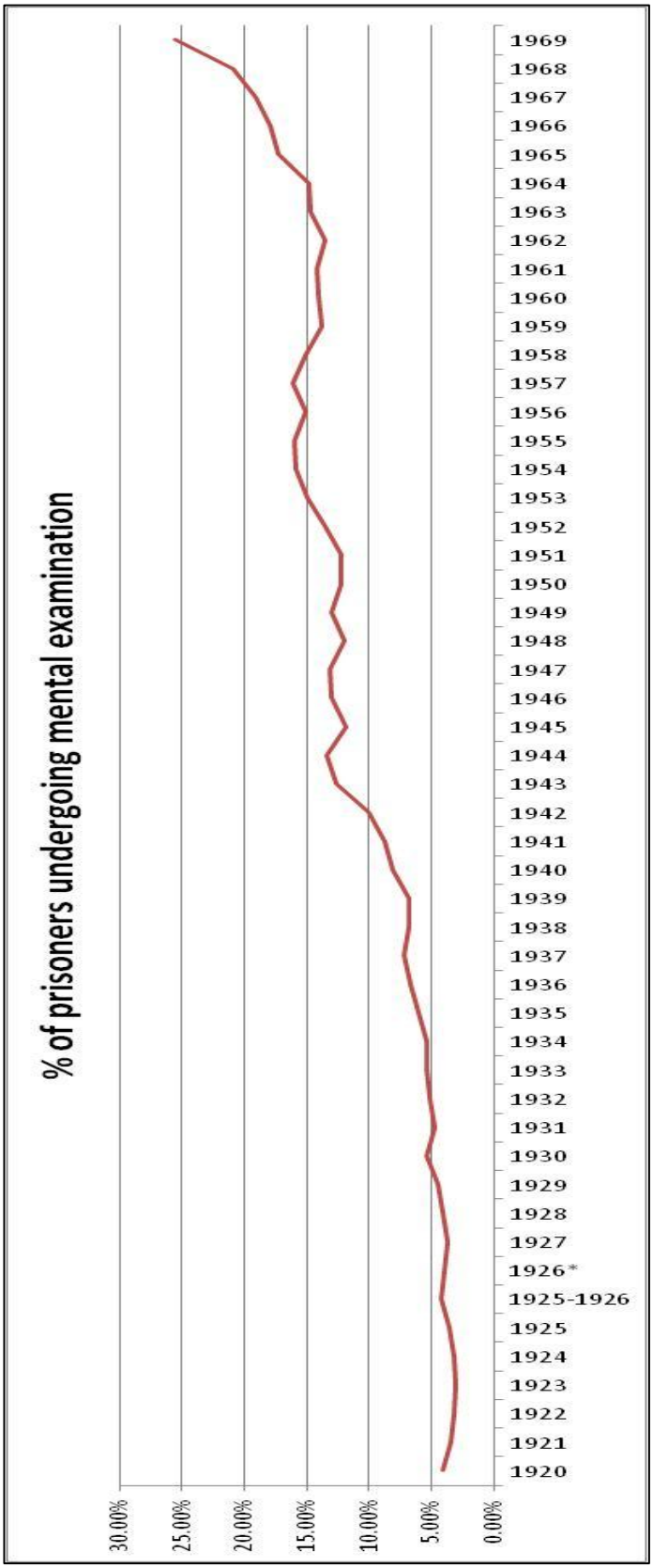
The exact nature and extent of medical involvement were governed by various features of the legal system in England. It lacked a tradition of including medical expertise, in contrast with continental jurisdictions such as France. The medical profession had, therefore, been marginalised. Historians and legal scholars have attributed this to the preference within the common law adversarial system for decisions made by lay people, as symbolised by the jury, rather than experts, whether legal or medical.[107] Added to this is the fact that an expert witness within the English jurisdiction could only be called by either the prosecution or the defence, and not independently by the court. Inevitably, this tended to produce the appearance of bias, as each side would present the evidence supporting their own case, resulting in a lack of coherence or unity within the views on offer.[108] Disagreements between psychiatrists were well publicised in controversial capital cases from the mid-twentieth century, notably those of Ronald True in 1922 and Neville Heath in 1946. Both provoked much discussion, not only about the compatibility of medical and legal concepts of

[106] The impact of the 1959 Act on remands for psychiatric observation is noted in Walker and McCabe, *Crime and Insanity in England*, p.53; on de-institutionalisation, 'Penrose's Law' supposes 'an inverse relationship between mental hospital patient numbers and prisoner numbers'. The precise conclusions that might be drawn from this are much debated: John Gunn, 'Future Directions for Treatment in Forensic Psychiatry', *British Journal of Psychiatry,* 176 (2000), 332-338. Courts may have asked for more medical reports because more defendants had a history of hospitalisation, or may have seen more defendants who appeared mentally ill to the layman's eyes as in-patient facilities were closed down.

[107] Eigen, *Witnessing Insanity*, pp.112-113; Oosterhuis and Loughnan, 'Madness and Crime: Historical Perspectives on Forensic Psychiatry', pp.3-4.

[108] The impact of this is considered in Goold and Kelly, *Lawyers' Medicine*.

**Figure 1: Proportion of prisoners examined as to their mental health, 1920-1969**




* The reported year changed from the twelve months ending on 31 March to the calendar year in 1926, so there is some duplication of data in the figures for 1925-1926 and 1926.

responsibility, but also about the value and apparent malleability of medical expertise. As recent critics of forensic psychiatry have pointed out, this throws into doubt the 'expert' status of the evidence, which begins to look rather more like opinion or speculation.[109] Nor did such experts have to possess any particular qualifications or experience. One doctor with knowledge of international comparisons summarised these difficulties, noting in 1951 that in Scandinavia 'the relative absence of a jury system and the greater development of the psychiatrist as a neutral adviser to the courts... have helped to produce uniform standards' and vastly improved the status of psychiatry in the courts.[110] In England, psychiatry was seen as less reliable, and less useful, than was the case elsewhere.

At the same time, the gradual extension of legal aid over the first half of the twentieth century allowed more defendants the benefit of a professional defence, which arguably increased the use of medical evidence and put pressure on judges to engage with medical interpretations. The Poor Prisoners' Defence Act of 1903 and subsequent legislation made it possible for growing numbers of those accused of crime to receive advice and representation. Between 1903 and 1949, legal aid was available at the discretion of the courts, although only in relation to more serious crimes and rarely if the accused was pleading guilty. The system was far from perfect. In 1931, the Howard League received a letter from 'Mr Llewellyn Jones, MP, reporting a murder case in which he had found it almost impossible to obtain Counsel owing to the low scale of fees laid down'.[111] As well as the matter of fees, not all judges were enthusiastic in their dispensation of legal aid and may have misinterpreted or ignored the letter of the law.

---

[109] Derek Chiswick, 'Use and Abuse of Psychiatric Testimony', *British Medical Journal (Clinical Research Edition),* 290 (1985), 975-977.
[110] T. C. N. Gibbens, 'Recent Trends in the Management of Psychopathic Offenders', *British Journal of Delinquency,* 2 (1951), 103-116 (p.114).
[111] Minutes of the executive committee meeting of 30 January 1931, in 'Howard League Committee Meetings 1927-1931', Modern Records Centre (Warwick), MSS.16B/1/1.

Complaints continued into the 1940s that 'many magistrates did not know what their powers were' and refused to grant legal aid even in the most persuasive cases, and as a result the less wealthy defendant would be unable to put forward a professional defence and associated medical evidence.[112] However, only 756 applications were declined in 1946, with total of 5,151 applications granted and a further 1,714 offered without an application from the defendant.[113] The Legal Aid and Advice Act of 1949 went on to expand and clarify the cases in which legal advice should be provided without charge to those who could not afford it. Surprisingly little research has been conducted into the practice of criminal defence law and the extent of legal aid, but it seems likely that these steps to increase the presence of defence lawyers in court had an impact upon the uses of expert medical evidence. A professional defence argument, drawing attention to mitigating circumstances such as mental illness, would inevitably shape the course of legal proceedings and the role of medical opinion.[114]

These developments indicate some of the interactions of legal, penal, and medical spheres. Also significant was the distinction between responsibility and culpability as constructed by the English legal system. Roger Smith and others have argued that medical and legal approaches to the issue of *responsibility* for criminal acts often appeared to be fundamentally at odds.[115] This was encouraged by the existence of a judicial definition of responsibility, dating from the mid-nineteenth century and often said to ignore advances in medicine, and the absence of a 'diminished responsibility'

[112] Minutes of executive committee meetings of 30 January 1931, 4 July 1938, 7 November 1944, and 13 December 1946, in Howard League Committee Meetings 1927-1947, Modern Records Centre (Warwick), MSS.16B/1/1-4.
[113] Data gathered from *Criminal Statistics for England and Wales, 1946* (London: H. M. Stationery Office, 1947) pp.67-68.
[114] For more on how the various legal aid acts were interpreted and their limitations, see Howard Levenson, 'Legal Aid for Mitigation', *Modern Law Review,* 40 (1977), 523-532.
[115] Smith, *Trial by Medicine*; Bowden, 'William Henry de Bargue Hubert' (p.336); a useful overview is provided in Loughnan and Ward, 'Emergent Authority and Expert Knowledge'.

defence in England until the late 1950s. Since responsibility was absolute, debate tended to be absolutist. Conflict was much less pronounced when *culpability* was at stake. As Norwood East explained, culpability was a matter of degree, and all factors including the moral, mental, and circumstantial could be taken into account. Dr Young, Senior Medical Officer at Wormwood Scrubs and later Medical Director of Prisons, confirmed that the 'culpability of an offender may be reduced by a variety of causes which do not affect his legal responsibility'.[116] As interest in rehabilitation demanded individualised responses to crime, and as medical and legal professionals alike recognised a borderland of mental disorder that did not constitute insanity, medical evidence could be used to inform assessments of culpability without threatening the concepts of responsibility and free will that were so important in law.

In this subtle recognition of the boundaries between legal and medical decisions, and in fact definitions, the prison medical service did much to encourage medico-legal co-operation. Medicine did not acquire the final word on culpability, but could contribute evidence for consideration, while the judiciary had a new method for explaining offenders or offences that seemed unusual or unexpected, potentially reducing the offender's blameworthiness and the severity of his punishment. The judiciary therefore had opportunities to make use of ever-more medical information about the mental state of those appearing before them, without this presenting a fundamental challenge to the principles of the legal system itself.

[116] *Report of the Commissioners of Prisons and the Directors of Convict Prisons for the Years 1942-1944* (London: H.M. Stationery Office, 1946) p.66.

## Conclusion

Writing in 1947, Glover observed that 'in psychiatric clinics the diagnosis and treatment of delinquency is still regarded as rather an esoteric interest'.[117] The psychological approach to crime did not become a mainstream pursuit, even amongst mental specialists, nor did it achieve wholehearted endorsement from the administrators of the law. 'I have never been able to appreciate what this phrase is intended to mean', wrote one civil servant irritably with reference to the title of *The Psychological Treatment of Crime*, 'unless it were suggested, which I am sure it is not, that crime is a disease'.[118] Despite the arguments of some psychoanalytically influenced doctors, the idea of crime as disease did not achieve widespread acceptance. Nor, indeed, did doctors become dominant in the courtroom. However, rehabilitation and individualised responses to crime were prominent between the 1910s and the dawn of the 1960s, and the nature of the legal system allowed for medical ideas to be incorporated up to a point. Degrees of mental abnormality amongst some of the prison population, and amongst some defendants, were acknowledged as potentially relevant to their criminality and their culpability. Medical treatment in prison or while on probation emerged as a useful addition to penal solutions, and the judiciary heard medical evidence on an increasingly regular basis. There was, by the end of the 1950s, significantly more flexibility within the legal system for medical ideas to play a role in sentencing decisions and even to attempt occasional cures.

As Joe Sim has argued, prison doctors 'increasingly set the parameters for debates about crime and criminality'.[119] Prison medicine played a vital role in providing measured opinions and practical solutions that recognised existing legal principles and

[117] Edward Glover, 'The Investigation and Treatment of Delinquency', *British Medical Journal,* 1 (1947), 421.
[118] 'Psychological Treatment of Crime, 1921-41', The National Archives (London), HO 45/18736.
[119] Sim, 'The Prison Medical Service and the Deviant 1895-1948', p.109.

methods as valid. It seems that the briefly rising star of the prison medical service was waning by the 1960s, though. Not all prison doctors were approved as 'experts' in mental health under the terms of the Mental Health Act of 1959, which caused no small amount of embarrassment in court.[120] At the same time, the isolation of prison work from the NHS had made it an unpopular career choice for young doctors.[121] Prison medicine fell behind while forensic psychiatry and psychology within universities and large hospitals continued to advance. Perhaps, too, Norwood East's death in 1953 marked the irreplaceable loss of the medical service's best advocate. This, coupled with the urgent problem of severe overcrowding in prisons in the face of a perceived crime wave and the loss of faith in reform and rehabilitation which is associated with 1960s criminology, provided nails in the coffin for the prison medical service and the psychological approach to crime alike.[122] Nevertheless, as the next section of this thesis goes on to explore, these changes to medico-legal theory and practice provided fertile ground for medical enquiry into the causes and cures of sexual crime.

[120] Dr Smart at Lewes prison was 'not an approved Medical Officer under the Mental Health Act' but was 'very well known at the Court' for all the wrong reasons. One 'could not say any great reliance is placed on his mental reports', the Governor of Lewes reported. Dr Smart was tactfully sidelined for court work. See 'Psychotherapy & Psychiatry in Prisons', The National Archives (London), PCOM 9/2178.

[121] This is clear in the catalogue of reasons given by psychiatrists surveyed in the early 1960s as to why they did not want to join the prison medical service. Evidence of the Institute of Psychiatry for the Gwynn Committee, in 'Papers of Sir Aubrey Lewis: correspondence, reports, copy minutes and papers', Bethlem Royal Hospital Archives & Museum (London), AJL-12.

[122] On the changing approach to crime and punishment of the 1960s, see David Garland and Peter Young, 'Towards a Social Analysis of Penality', in *The Power to Punish: Contemporary Penality and Social Analysis,* ed. by David Garland and Peter Young (London; New Jersey: Heinemann, 1983), pp. 1-36.

# Part One: Medicine in Theory

# Chapter 3: Researching the sexual offender

In 1958, retired Manchester police surgeon Nesta Wells published a detailed study of the hundreds of cases of sexual crime she had encountered during her long career. As the first female police surgeon in the country, one of her objectives was to argue for more women in the police force to interview and examine victims, particularly the very young. However, this was not the only cause she championed. Her article also contained some impressions of the offenders involved in such cases, and considered how they might best be managed to ensure that they did not repeat their crimes. Worthy of special mention were those with 'poor mental faculties', 'mental abnormality, defect, or perversion', and 'the emotionally and sexually uncontrolled man' who fell easily into the commission of sexual crime under the influence of alcohol. 'As many of the accused are mentally slow or suffering from sexual perversion of some kind', she concluded, 'no amount of prison sentence is likely to stop them doing the same thing again on discharge. It is *treatment* of some sort with a view to *prevention* that is needed, rather than punishment'.[1]

This statement echoed the observations of the Birmingham magistrates some forty years earlier, as they anxiously contemplated the flooding of the courts with mentally disabled ex-soldiers. In the intervening years, such a call for treatment for offenders had acquired a new focus. The judiciary had drawn attention to disturbed veterans of war, but doctors quickly refined this concern to emphasise sexual crime as a sign of mental disorder. Wells had joined the police in 1927, just as research into sexual offenders was being introduced as a valid subject for medical study in England, and her

[1] Nesta H. Wells, 'Sexual Offences as Seen by a Woman Police Surgeon', *British Medical Journal,* 2 (1958), 1404-1408 (p.1407). Emphasis in original.

views reflect many of the dominant themes of this process. As the first section of this chapter will show, medical approaches to sexual crime shifted in the early to mid-twentieth century. Doctors began to single out sexual offenders, broadly defined, calling into question their mental state, and insisting that careful study was needed to understand this group and to prevent recidivism, possibly by means of treatment. This was spearheaded by the prison medical service, but was also taken up by psychotherapists and other doctors, as well as campaigners for legal and penal reform. Medical opinion was certainly not in absolute agreement, but those with an interest in sexual crime argued that an understanding of the true motives for seemingly strange offences was key to their prevention.

Not all sexual crime was thought to require equal medical attention. As Wells' language reveals, the study of the sexual offender involved the use of a new diagnosis: 'sexual perversion'. Sometimes a synonym for sexual crime in general, this diagnostic and descriptive category signalled the focus of medical interest on offences that were seen as 'abnormal'. Assessments of mental disorder amongst male sex offenders were grounded in a model of sexual and psychological impulse that conflated sexual instinct with the drive to reproduce. It was, therefore, troubled by all sexual behaviour that did *not* appear to have reproduction as its aim. Medical attention to sexual offenders thus reflected several of the ideologies surrounding sex that have been highlighted by queer theorists such as Gayle Rubin. Rubin has drawn attention to the 'excess of significance' attributed to sexual acts, which is evident here in the medical focus upon male sexual offenders, and the 'hierarchical system of sexual value' in which only some few acts are seen as healthy or normal.[2] Interest from doctors in crimes such as rape or indecent

[2] Gayle S. Rubin, 'Thinking Sex: Notes for a Radical Theory of the Politics of Sexuality', in *Culture, Society and Sexuality: A Reader,* ed. by Peter Aggleton and Richard Parker (Abingdon: Taylor & Francis e-Library, 2002), pp.143-178 (p.151).

assault of women was minimal, with indecent exposure and homosexuality attracting the most attention, and indecencies with young children occupying a slightly uncertain space.

Also distinctive was the absence of medical discussion regarding female sexual offenders. On the rare occasions when they were mentioned, doctors focused almost entirely upon the prevalence and treatment of venereal disease and had little to say about the causes or indeed the cure of women's sexual crime. There were some exceptions to this, but even in the case of offences related to prostitution, which were a persistent social concern, medical interest and interpretation were rare. The final section of this chapter suggests several possible reasons for this. Firstly, crime in general and sexual crime in particular were, with the exception of prostitution, much less common amongst women and were decreasing. Secondly, the sexualisation of all crime committed by women operated in combination with psychiatric views of the minds and bodies of women as being extremely closely connected, such that 'bodily control, the brain, diseased behaviors, and female sex were all intimately interwoven'.[3] Rather than leading to psychological interest in female sexual offenders, this all-encompassing explanation meant that the diversity and flexibility of interpretation and outcome made possible by medical views of male sexual crime were largely unnecessary. By examining the presence, absence, and foundations of medical attention to sexual offences, broadly defined, this chapter will highlight these and other beliefs about crime and sexual conduct that were, by the dawn of the 1960s, firmly embedded within medical thought.

[3] Joel T. Braslow, *Mental Ills and Bodily Cures: Psychiatric Treatment in the First Half of the Twentieth Century* (Berkeley; London: University of California Press, 1997) p.157. The sexualisation of crime committed by women reflected some of the views in Cesare Lombroso, *The Female Offender* (New York: D. Appleton, 1895).

### 3.1 From sexual offender to patient

Greater attention to the individual offender and his rehabilitation, as outlined in Chapter 2, encouraged interest in the mental state of the criminal. Research into the sexual offender as a particularly troubling type of criminal, often requiring expert attention and interpretation, emerged in England in the 1920s as part of this shift towards psychology and rehabilitation. Prior to the 1920s, the medical profession in England had said relatively little about the minds and motivations of those guilty of sexual crime of any kind.[4] The involvement of doctors, as recent scholarship on the role of the expert witness in Victorian and Edwardian trials has suggested, centred upon the body of the accuser rather than the mind of the accused.[5] Alfred Swaine Taylor's best-selling *Principles and Practices of Medical Jurisprudence* addressed the crime of rape, but primarily in relation to the physical examination of the complainant.[6] Discussions of sodomy or the more wide-ranging 'unnatural offences' in such textbooks were brief in the extreme, and also limited to physical examinations.[7] The defendant did not escape entirely without scrutiny, as findings of impotence or paralysis would have obvious bearings on questions of paternity and accusations of sexual assault. So too might injuries upon the body or the presence or absence of venereal disease in either the defendant or the complainant. Beyond this, during the nineteenth century the perpetrator of sexual crime could pass largely unremarked upon by doctors.

---

[4] On the late adoption of a medical model of sexuality in Britain, specifically homosexuality, see Hall, '"The English Have Hot-Water Bottles"; I. D. Crozier, 'Becoming a Sexologist: Norman Haire, the 1929 London World League for Sexual Reform Congress, and Organizing Medical Knowledge about Sex in Interwar England', *History of Science,* 39 (2001), 299-329 (especially p.303, p.323); and Brady, *Masculinity and Male Homosexuality*.

[5] This recent work includes Crozier and Rees, 'Making a Space for Medical Expertise'; Bates, 'Venereal Disease Diagnosis in English Courts, 1850–1914'.

[6] Alfred Swaine Taylor, *The Principles and Practice of Medical Jurisprudence* (London: John Churchill & Sons, 1865), chapters 77 and 78; Alfred Swaine Taylor, *The Principles and Practice of Medical Jurisprudence*, 2nd edn vol. 2 (London: John Churchill & Sons, 1873), chapters 85 and 86. See also a rival textbook, first produced in 1902, which maintained this focus on physical examinations of complainants: John Glaister, *A Text-Book of Medical Jurisprudence, Toxicology, and Public Health* (Edinburgh: E. & S. Livingstone, 1902), chapter 14.

[7] Taylor, *The Principles and Practice of Medical Jurisprudence*, 2nd edn, pp.472-475; Glaister, *Text-Book of Medical Jurisprudence*, 1st edn, pp.341-342.

This is not to say that the medical profession had maintained absolute silence on matters of the mind and sexual behaviour. Indeed, the nineteenth-century formulation of 'masturbatory insanity' has been used as evidence of the perception of a close connection between sexual excess and mental disease during the Victorian era.[8] As Ivan Crozier has shown, nineteenth-century alienists in England connected morbid passions including 'onanism' and 'erotomania' to insanity, whether as symptoms or causes of mental deterioration.[9] Textbooks acknowledged that 'undue sexual passion' might sometimes be a sign of lunacy, while debates over 'insanity of conduct' often took 'perverted sexual feelings' as one example of the type of seemingly baffling behaviours that this diagnosis could explain.[10] From a rather different perspective, Havelock Ellis's publications around the turn of the century also contemplated many and varied sexual impulses and suggested that treatment in some cases might be preferable to punishment, while a handful of doctors involved in organisations such as the British Society for the Scientific Study of Sex Psychology debated sexual matters more widely.[11]

Medical interpretations, and connections between mental state and sexual behaviour, were therefore not without precedent. However, discussion of such subjects amongst doctors remained limited until the 1920s in two important ways. Firstly, the

[8] E. H. Hare, 'Masturbatory Insanity: The History of an Idea', *Journal of Mental Science,* 108 (1962), 1-25; Thomas Laqueur, *Solitary Sex: A Cultural History of Masturbation* (New York: Zone Books, 2003), chapter 5.
[9] Crozier, 'Nineteenth-Century British Psychiatric Writing', pp.71-73.
[10] Fred J. Smith, *Taylor's Principles and Practice of Medical Jurisprudence*, 6th edn (London: J. & A. Churchill, 1910) p.298; George H. Savage and C. Mercier, 'Insanity of Conduct', *Journal of Mental Science,* 42 (1896), 1-17, p.6 and, in more detail, pp.10-12. Savage had also published one earlier study, George Savage, 'Case of Sexual Perversion in a Man', *Journal of Mental Science,* 30 (1884), 390-391. Notably, he was one of the founders of the journal in question, which may have eased the passage of his research into such a controversial subject into print.
[11] The best known of his six-volume work, *Studies in the Psychology of Sex,* is: Havelock Ellis and John Addington Symonds, *Sexual Inversion: A Critical Edition* (Basingstoke: Palgrave Macmillan, 2007 [1897]). Lesley Hall has researched this organisation, and has argued that the doctor-members of the Society were 'somewhat outside the orthodox mainstream of the profession'. Hall, '"Disinterested Enthusiasm for Sexual Misconduct": The British Society for the Study of Sex Psychology, 1913-47' (p.669).

idea of a form of insanity in which disorderly sexual conduct was the sole symptom gained little traction. Only the true 'maniac', textbooks maintained, should have recourse to the defence of insanity. Alleging an 'irresistible impulse' or overwhelming sexual passion was not persuasive for nineteenth-century medical experts, any more than for their judicial counterparts.[12] For the most part, doctors remained reluctant to propose or accept that sexual crime or misconduct might be connected to mental disorders, other than occasionally as one amongst many signs and symptoms of florid lunacy. Secondly, any consideration of possible medical causes of sexual crime was rare. This went hand in hand with the attention paid to physical examinations, primarily of the accuser, to determine the facts of the case. Ellis's wide-ranging subject matter, which offered explanations for a great many aspects of sexual life, set him apart from the medical mainstream, and reviews in medical journals of his multi-volume *Studies in the Psychology of Sex* took brief and often hostile form.[13] After the second volume became the subject of an obscenity trial in England in 1898, Ellis himself chose to direct the majority of his original works to American journals and publishers until the 1930s.[14] 'Unnatural offences', in particular, were swiftly dismissed as a problem for other nations, being supposedly little known amongst the English.[15] Psychoanalysis and continental

[12] Smith, *Taylor's Principles and Practice of Medical Jurisprudence*, 6th edn, p.893.
[13] In the *British Medical Journal*, for example, volumes 1 and 2 of his *Studies in the Psychology of Sex* were characterised as 'disgusting and nauseous' and 'not interesting in themselves, nor are they important in connexion with any scientific principle, hypothesis or doctrine'. 'Sexual Psychology and Pathology', *British Medical Journal,* 1 (1902), 339-341 (p.340). Ivan Crozier has also acknowledged Ellis's limited impact in his home country, in Crozier, 'Medical Construction of Homosexuality', p.64.
[14] Phyllis Grosskurth, *Havelock Ellis* (London: Allen Lane, 1980) p.184, p.290. Ellis did continue to contribute reviews to the *Journal of Mental Science* and was acknowledged from the 1920s as an important influence by many of the doctors mentioned in this thesis. He seems to have retained a discreet but constant presence in English psychiatry.
[15] For example, Glaister's textbook supposed that such crimes were more common overseas. This national distinction was also raised in the 1871 case of *R v. Boulton and Park*, a trial concerned with cross-dressing and suspected homosexual acts which piqued considerable interest both then and now. John Glaister, *A Text-Book of Medical Jurisprudence and Toxicology*, 5th edn (Edinburgh: E. & S. Livingstone, 1931), p.550, and all earlier editions. On Boulton and Park, see Crozier, 'Medical Construction of Homosexuality', particularly pp.68-69 and p.72. The case has

sexology alike were described by doctors as potentially damaging to the 'clean-minded men and pure-minded women' of the nation.[16] In the name of professional and national standards, possibly combined with a fear of falling foul of obscenity legislation, professional respectability demanded silence.

Medical approaches and criminological concerns both underwent significant change in the early twentieth century. Textbooks of forensic medicine began to include 'a few words of comment as to the cause' of sexual crime, acknowledging lunacy as one possible factor but looking more broadly towards education, environment, bodily states, and the very nature of the sexual impulse as well.[17] Sexual immorality and excess were also connected to feeble-mindedness in the 1900s and 1910s, within debates surrounding mental deficiency.[18] Psychoanalysis and broadly psychodynamic medicine gained some ground during the 1910s, allowing for the publication in 1921 of articles from this perspective on the subjects of homosexuality, sadism, and masochism, in the respectable *JMS*.[19] Such articles would have been unimaginable only ten years earlier. As the 1920s dawned, the stage was set for doctors to begin to address the subject of the sexual offender as a specific type of criminal, uniquely disordered and potentially ideal for medical enquiry in the name of crime prevention.

This situation was enhanced not only by an increasingly psychological approach to crime in general, but also a rise in reports of sexual crime. Contemporary

---

also been imaginatively documented recently in Neil McKenna, *Fanny and Stella: The Young Men Who Shocked Victorian England* (London: Faber and Faber, 2013).

[16] Mercier, 'Psycho-Analysis'.

[17] Smith, *Taylor's Principles and Practice of Medical Jurisprudence*, 6th edn, p.297. This was new to the early twentieth-century editions.

[18] Hamblin Smith, 'Notes on 100 Mentally Defective Prisoners at Stafford', p.334; Sturrock, 'The Mentally Defective Criminal', p.318.

[19] C. Stanford Read, 'Homosexuality', *Journal of Mental Science,* 67 (1921), 8-12; and W. Rees-Thomas, 'Sadism and Masochism', *Journal of Mental Science,* 67 (1921), 12-17.

criminologists found that sexual offences known to the police had begun to increase as the First World War ended,[20] and continued to do so at a faster and more consistent rate than many other types of offence.[21] Thanks in large part to the efforts of various women's groups such as the Medical Women's Foundation and the National Council of Women, the profile of sexual offences against children in particular was raised sufficiently in the interwar years to prompt the convening of a Departmental Committee to investigate.[22] As has been documented elsewhere, homosexual offences were identified as an increasingly pressing problem from the interwar years onwards as well, culminating in the Wolfenden Committee, convened in 1954.[23] At the same time, reported sexual assaults of adult women increased dramatically from fewer than 1,000 per year in the 1910s, to more than 4,600 in the immediate aftermath of the Second World War and nearly 10,000 per year by the end of the 1950s.[24] From the 1940s, public concern regarding sexual offences was encouraged, if not instigated, by much more press coverage of sex in general and sexual crimes in particular.[25] Whether sexual offenders were becoming more numerous, as some feared, or whether such crimes were simply reported or policed more comprehensively is impossible to determine, but the sexual offender had become a more high-profile cause for concern.

In 1924, perhaps given confidence by the *JMS*'s bold foray into sexual subjects in 1921, William Norwood East broached the topic. 'Sexual offences', he wrote, 'seldom

[20] Hermann Mannheim, *Social Aspects of Crime in England between the Wars* (London: G. Allen & Unwin, 1940) p.122.
[21] Figures from 1938 to 1959 are collected in *Criminal Statistics for 1959*, p.xli.
[22] *Sexual Offences Against Young Persons*. For some analysis of this Committee and subsequent debate, see Carol Smart, 'Reconsidering the Recent History of Child Sexual Abuse, 1910-1960', *Journal of Social Policy,* 29 (2000), 55-71 (pp.60-64).
[23] See for example Weeks, *Coming Out*; Stephen Jeffery-Poulter, *Peers, Queers, and Commons: The Struggle for Gay Law Reform from 1950 to the Present* (London: Routledge, 1991); Hugh David, *On Queer Street: A Social History of British Homosexuality, 1895-1995* (London: HarperCollins, 1997).
[24] On the policing of homosexual offences, see Houlbrook, *Queer London*. Data here is gathered from HMSO's annual published criminal statistics.
[25] Bingham, *Family Newspapers*, p.12; Waters, 'Disorders of the Mind', pp.139-140.

form the subject of an article in this country', probably thanks to their 'distastefulness'. In his view, this was entirely unsatisfactory. He professed concern that doctors were expected to provide advice to the courts on the basis of little or no knowledge, since 'textbooks on insanity usually either dismiss the subject in a few lines or fail to mention it at all'.[26] This gap in medical expertise was precisely that which he sought to remedy, outlining in his publications the many different types of sexual crime that he had encountered and their possible causes and classifications.[27] These articles were intended for a wide readership of generalist medical practitioners who might be summoned to shed light on the conduct of one of their patients, as well as those with a particular interest in the relationship between crime and mental disorder. This presentation of research into indecent exposure, sexual assaults, fetishes, and homosexual offences began to transform hitherto ignored or unmentionable criminals into subjects of useful and important medical enquiry.

The 1920s and 1930s saw a handful of doctors researching the sexual offender, both inside and outside the prison. Prison doctors published on the subject in well-respected journals, including the *BMJ*, *The Lancet*, and the *JMS*, and commentary within the annual reports of the Prison Commissioners made increasingly regular reference to sexual offenders as a particular problem.[28] Psychiatrist Bernard Hollander, in his 1922 book on *The Psychology of Misconduct, Vice, and Crime,* included a chapter on the subject of 'Sexual Perverseness' which ranged from marital problems to indecencies

[26] Norwood East, 'Observations on Exhibitionism', p.371.
[27] Norwood East, 'Observations on Exhibitionism'; Norwood East, 'The Interpretation of Some Sexual Offences'.
[28] Articles were published by Hamblin Smith and Dr H. T. P. Young, as well as Norwood East. Within the Prison Commissioners' annual reports, in 1925 for example the medical officer of Brixton prison drew attention to those in his prison who were mentally abnormal but not insane or mentally defective, including 'the cases of sexual perverts' who 'apparently cannot resist their disordered impulses'. *Report of the Commissioners of Prisons and the Directors of Convict Prisons for the Years 1924-1925* (London: H. M. Stationery Office, 1926) p.35.

with children, exhibitionism, and masochism and sadism.[29] Departmental Committees addressing crime in the 1920s and 1930s heard from assorted medical witnesses and explicitly associated sexual crime of various types with mental disorder.[30] Drs J. A. Hadfield, E. A. Bennet, and Rees, all senior specialists affiliated with either the Tavistock or the ISTD, reflected from their psychoanalytic perspectives upon the 'sexual perversions' in the pages of respectable journals, and their colleague Dr Clifford Allen published a textbook entitled *The Sexual Perversions and Abnormalities* in 1940.[31] This was followed by ever more research, commentary, and debate, culminating in a two-day conference devoted to the 'Psychopathology and Treatment of Sexual Deviation' to mark World Mental Health Year in 1960.[32] Papers at this conference, later published as an edited collection and reprinted in a third edition as recently as 1998, covered the subjects of homosexuality, exhibitionism, sexual murder, sexual aggression, aetiology and treatment, psychoanalytic theories, and even the sexual habits of birds.[33] Sexual perversions or crimes and their underlying causes were now discussed at length.

---

[29] Bernard Hollander, *The Psychology of Misconduct, Vice, and Crime* (London: George Allen & Unwin, 1928 [1922]) p.145.

[30] *Sexual Offences Against Young Persons,* p.56; *Report of the Departmental Committee on Persistent Offenders*, p.43.

[31] J. A. Hadfield, 'Some Aspects of the Psychopathology of Sex Perversions', *Proceedings of the Royal Society of Medicine,* 29 (1933), 1021-1030; Hadfield, 'Some Aspects of the Psychopathology of Sex Perversions'; J. R. Rees, 'Sexual Perversions', *The Practitioner,* 137 (1936), 98-107; Clifford Edward Allen, *The Sexual Perversions and Abnormalities* (London: Oxford University Press, 1940).

[32] Some further articles and discussion include Desmond Curran, 'Sexual Perversions and Their Treatment', *The Practitioner,* 158 (1947), 343-348; Edward Glover, *The Social and Legal Aspects of Sexual Abnormality* (London: Institute for the Scientific Treatment of Delinquency, 1947); F. L. Golla and R. Sessions Hodge, 'Hormone Treatment of the Sexual Offender', *The Lancet,* 253 (1949), 1006-1007; Humphry Osmond, G. W. Fleming, Harold Burrows, W. W. Horton, and G. Orissa Taylor, 'Penalties for Sexual Offences', *British Medical Journal,* 2 (1951), 672-673; W. Calder, 'The Sexual Offender: A Prison Medical Officer's Viewpoint', *British Journal of Delinquency,* 6 (1955), 26-40; Leon Radzinowicz, *Sexual Offences: A Report of the Cambridge Department of Criminal Science* (London: Macmillan, 1957).

[33] 'Psychopathology and Treatment of Sexual Deviation', *British Medical Journal,* 2 (1960), 1303-1304; Ismond Rosen's papers include copies of most of the talks, in 'Archives of Ismond Rosen: Sexual Deviation: 'The Pathology and Treatment of Sexual Deviation' two-day conference, Royal Society of Medicine, Oct 1960', Wellcome Library (London), PP/ROS/D/1; Ismond Rosen (ed.), *The Pathology and Treatment of Sexual Deviation: A Methodological Approach* (London: Oxford University Press, 1964).

This interest was accompanied by calls for more regular and thorough medical examinations of sexual offenders. In the 1920s, Hamblin Smith was a particularly vocal proponent of psychological assessments of *all* those accused of a sexual offence, as a matter of course. In 1924, apparently repeating earlier statements, he reported to the local judiciary that he 'would again urge the eminent desirability of the careful investigation of the mentality of all persons charged with offences of a sexual character'.[34] A modified version of this position was adopted by the prison medical service as a whole, with the Prison Commissioners recording in 1926 that many individuals were placed under special observation as to their mental state while in prison on remand, either because of a troubling 'mental characteristic' in evidence, or because of 'the nature of the offence, *e.g.*, some sexual offences, arson and such like'.[35] In some prisons, at least, this was extended to all sexual offences, with the doctor of Leeds prison confirming in 1937 that it 'is our practice to examine as to his mental condition every offender charged with an offence of a sexual nature'.[36] This was echoed in other corners of the medical world. Dr Letitia Fairfield, chief medical officer for London County Council and a significant figure in public health, had been sufficiently convinced to argue in 1938 that with 'certain offences such a large proportion of the offenders turned out to be mentally abnormal' that psychiatric examination should unfailingly take place. 'The chief of these offences', she was sure, 'were the sex category'.[37] Even in the mid-1950s, this broad-brush approach was still being advocated,

[34] These comments are in a report of the General Purposes Committee presented to the Birmingham Justices, for 1924, in 'Psychological Treatment of Crime, 1921-41', The National Archives (London), HO 45/18736. He reiterated the point in his book, saying that 'A very strong case exists for the routine investigation of all persons charged with "sex" offences'. Hamblin Smith, *The Psychology of the Criminal*, p.178.
[35] *Report of Prisons for 1925*, p.42.
[36] *Report of Prisons for 1937*, p.64.
[37] 'Reports of Societies', *British Medical Journal,* 2 (1938), 1167-1171 (p.1169).

with Dr Jack Hobson telling the Wolfenden Committee that he would extend a blanket policy of compulsory psychiatric examination 'to all sexual offences'.[38]

The provision of treatment for sexual offenders, and the types of offender that were singled out to receive it, will be considered more fully in Chapter 6. It is, however, worth drawing attention to the fact that sexual offenders were also seen as likely candidates for psychotherapy. Over half of those who received treatment with Dr Hubert in Wormwood Scrubs in the 1930s were classed as sexual offenders. Indeed, the request for candidates for this experimental programme of treatment had specifically mentioned sexual offenders as particularly worthy of consideration.[39] This was echoed in 1950 by another prison doctor, Dr Young, who reported that good cases for psychotherapy 'may be found among persons convicted of indecent exposure, homosexuality, sadism and other forms of sexual perversion'.[40] Again, this view was reiterated by doctors elsewhere. In 1933, a *BMJ* editorial expressed grave doubts regarding psychological remedies for crime in general, but conceded that when it came to 'pathological thieves and sexual offenders', some could indeed be helped by this method.[41] Another editorial agreed that sexual offenders were 'usually not criminals at all, but victims of psychological disorder which may be amenable to treatment', and Edward Glover stated emphatically that '*every sexual offender without exception should be psychologically examined and given the opportunity of receiving psychological treatment*'.[42] Sexual offenders not only demanded careful medical examination, but might be particularly responsive to psychotherapy.

[38] Committee meeting of 31 October 1955 in 'Transcripts of evidence hearings: Committee on Homosexual Offences and Prostitution', The National Archives (London), HO 345/14.
[39] Circular from Prison Commission to all Men's Prisons dated 1 March 1934, in The National Archives (London), PCOM 9/186.
[40] *Report of Prisons for 1950*, p.85.
[41] 'Treatment of Delinquency'.
[42] 'Probation at Mental Hospital: A Legal Experiment', *British Medical Journal,* 1 (1938), 260; Glover, *Sexual Abnormality*, p.13, emphasis in original.

The idea of the sexual offender as a potential patient was far from uncontroversial. Giving evidence to the Departmental Committee considering sexual offences against children, Sir Chartres Biron, the Chief Magistrate of the London Metropolitan area, complained that some people saw sexual crimes as 'a sign of lunacy'. In his view, the perpetrators 'are not mad the least bit in the world, and I think that punishment is a very good deterrent'.[43] Frequent protests from interested doctors that magistrates and judges ignored or, worse yet, did not even ask for medical evidence in cases of sexual crime suggest that he was not alone amongst his fellow Benchers in taking this stance.[44] Nor was the civil service always supportive. When *The Psychological Treatment of Crime* was submitted for approval and publication, an unnamed Home Office official expressed concern that the 'references to the various perversions' might lead to this plain Home Office publication being presented in the 'shop fronts in Villiers Street along with the History of the Rod and the works of Krafft-Ebing'.[45] Fears of breaching obscenity laws may not have been at the forefront of medical minds by this time, but the value and content of their work remained questionable to some.

Medical opinion itself was divided. Reviews of Allen's book, for example, were not enthusiastic.[46] In 1935, psychiatrists Desmond Curran and Eliot Slater complained that general practitioners now tended to attach too much importance to sexual

[43] 'Evidence to the Departmental Committee on Assaults of Young Persons', The National Archives (London), HO 45/25434. Biron was perhaps most famous for his 1927 ruling that Radclyffe Hall's novel *The Well of Loneliness* was obscene.
[44] Glover, *The Roots of Crime*, p.31; see also Hamblin Smith's pleas to the judiciary, quoted above.
[45] Memoranda in 'Psychological Treatment of Crime, 1921-41', The National Archives (London), HO 45/18736. 'History of the Rod' refers to William M. Cooper, *Flagellation & The Flagellants: A History of the Rod in all countries from the earlist period to the present time* (London: John Camden Hotten, 1869), sometimes viewed suspiciously as potential pornography. Richard von Krafft-Ebing's *Psychopathia Sexualis* was a textbook by a German psychiatrist in which many hundreds of case studies of sexual deviance were detailed. Although it was not at any point entangled in any obscenity prosecutions in England, the fact that it enjoyed a wide readership was also viewed with suspicion in some quarters.
[46] S. M. Coleman, 'The Sexual Perversions and Abnormalities', *Journal of Mental Science,* 86 (1940), 1020-1021.

abnormalities and referred too many such cases for specialist psychiatric treatment as a result, while a paper by Dr Denis Carroll to the Medico-Legal Society prompted some discussion and polite disagreement from Norwood East.[47] More impassioned conflicts of opinion were stirred up in the *BMJ* by correspondence from a Dr Stanley-Jones of Cornwall, published in February 1946, on the subject of the recent sentencing of a scoutmaster to 14 years' imprisonment for 'immoral conduct with boys'. Stanley-Jones wrote with considerable confidence that it was 'now generally conceded that the majority of cases of homosexuality yield to treatment by psychotherapeutic measures', but this was certainly not accepted by subsequent correspondents.[48] One called it an 'astounding assertion', and an extremely wide variety of opinions were ventilated.[49] A few years later, a report prepared by the Joint Committee of the BMA and the Magistrates' Association entitled 'The Criminal Law and Sexual Offenders' was critiqued in the *BMJ* and characterised in part as 'highly controversial', signalling that agreement surrounding sexual offenders had not yet been achieved.[50]

By contrast, a connection between sexual crime and mental illness was enthusiastically embraced by those campaigning for change to the legal and penal systems. As other historians have explored in detail, medical models of sexual behaviour were adopted and used in a variety of ways by campaigners, particularly from the 1950s, within debate surrounding homosexual law reform.[51] This was not the only arena in which they were deployed. In campaigns calling for rehabilitation rather than

[47] Desmond Curran and Eliot Slater, 'Mental Disorder in General Practice: A Plea for Clinical Psychiatry', *The Lancet,* 225 (1935), 69-71 (p.71); Denis Carroll, 'Observations on the Psychiatric Handling of Delinquents', *The Medico-Legal and Criminological Review,* 8 (1940), 182-198.
[48] D. Stanley-Jones, 'Homosexuality', *British Medical Journal,* 1 (1946), 179.
[49] S. K. McKee, 'Homosexuality', *British Medical Journal,* 1 (1946), 503; for some of the extremes, see W. Lumley, 'Homosexuality', *British Medical Journal,* 1 (1946), 369; E. A. Bennet, 'Homosexuality', *British Medical Journal,* 1 (1946), 450; Kathleen A. H. Sykes, 'Homosexuality', *British Medical Journal,* 1 (1946), 409-410.
[50] 'Sexual Offenders', *British Medical Journal,* 1 (1949), 446-447.
[51] Weeks, *Coming Out*, p.30, p.156; Waters, 'Disorders of the Mind', pp.141-143; Houlbrook, *Queer London*, pp.247-257.

punishment, *all* sexual offenders were included. Roy and Theodora Calvert, members of the Howard League, vigorously protested in their lengthy book *The Lawbreaker* that many of those in prison for sexual offences 'require neither punishment nor training but medical treatment' for 'various kinds of mental disease', and the League firmly supported unsuccessful legislation to make a psychiatric report compulsory in cases of sexual crime.[52] Former prisoners, in their critiques of the system, also made use of the same message. 'Sex crimes', ex-convict Wilfred Macartney observed, were 'undoubtedly pathological'.[53] Richmond Harvey, another former prisoner, was reportedly horrified to encounter in prison a clergyman with convictions for 'offences against boys', who, 'despite Counsel's plea that the accused was prepared to enter a home and undergo any form of treatment that medical science might prescribe', was despatched to jail 'to live the life of an ordinary prisoner, and to return to the world with his impulses unchecked'.[54] Such complaints attacked the failure of the judicial world to make good its promise to pay more attention to the causes of each offender's crime, and to take action to prevent the offence's repetition.

Doctors themselves were sometimes equally outspoken, but usually took care to justify their interest in the sexual offender by other means.[55] Historian Angus McLaren

[52] E. Roy Calvert and Theodora Calvert, *The Lawbreaker: A Critical Study of the Modern Treatment of Crime* (London: Lund Humphries, 1933), p.133; Minutes of the Policy Sub-Committee meeting of 7 June 1934, in 'Howard League Committee Meetings 1932-1937', Modern Records Centre (Warwick), MSS.16B/1/2.

[53] Wilfred Macartney and Compton Mackenzie, *Walls Have Mouths* (London: Victor Gollancz, 1936) p.320. Macartney served ten years' penal servitude for various offences under the Official Secrets Act.

[54] Richmond Harvey, *Prison from Within* (London: George Allen & Unwin, 1937) p.261. Harvey did not reveal the nature of his own offence.

[55] Notably, in the 1950s, Neustatter and Glover both argued that sexual crime should be conceptualised around the issue of consent, rather than any idea of 'perversion'. W. Lindesay Neustatter, *Psychological Disorder and Crime* (London: Christopher Johnson, 1953) p.161, and Edward Glover, *The Problem of Homosexuality: Being a Memorandum Presented to the Departmental Committee on Homosexual Offences and Prostitution by a Joint Committee Representing the Institute for the Scientific Treatment of Delinquency and the Portman Clinic* (London: Institute for the Scientific Treatment of Delinquency, n.d. [c.1955]), p.5.

has suggested that the medical profession became involved in the creation of 'taxonomies of deviance' because of demand from the courts for their advice, and this was certainly given on occasion as an explanation for research into sexual crime, including by Norwood East.[56] More common, though, was a claim that medical interest was inspired by a 'general agreement' or 'general feeling that we are dealing with something abnormal' or that 'the incidence of mental abnormality in offenders of this class is very high'.[57] The Departmental Committee on Sexual Offences against Young Persons was reportedly convened in an atmosphere of 'general belief' that those who committed such offences were 'often mentally abnormal'.[58] When the chapter dedicated to sexual offenders in *The Psychological Treatment of Crime* came under threat of excision, Norwood East called upon this general belief to maintain that it should remain, insisting that

> the chief value of the report would be lost if the chapter about sexual offences is omitted. Sexual offences are those which the general public frequently regard as symptoms of mental abnormality requiring psychotherapeutic treatment rather than punishment.[59]

In fact, only 500 copies of this report were printed, of which most were dispatched to prison governors, doctors, and specialist journals, and it was expressly not sent to the mainstream press.[60] References to the 'general public' and their beliefs about sexual offenders might have been particularly useful to put pressure on the administrators of the law, and were difficult to rebut, but may have been exaggerated.

---

[56] Angus McLaren, *Twentieth-Century Sexuality: A History* (Oxford: Blackwell, 1999) p.90; Norwood East, 'Observations on Exhibitionism', p.371.
[57] Hamblin Smith, 'The Mental Conditions Found in Certain Sexual Offenders', p.644; Hamblin Smith, *The Psychology of the Criminal*, p.178.
[58] *Sexual Offences Against Young Persons*, p.5.
[59] 'Psychological Treatment of Crime, 1921-41', The National Archives (London), HO 45/18736.
[60] Perhaps the anxiety of the civil servant had some sway in this decision. A list of publications receiving a copy, and those to be excluded from the mailing list, is in 'Psychological Treatment of Crime, 1921-41', The National Archives (London), HO 45/18736.

Nevertheless, the assumptions upon which many doctors based their work did reflect widely held beliefs about what constituted a logical or acceptable motive for crime. The absence of intelligible motive was key to the identification of mental disorder amongst criminals during this period. Taylor's textbook had for decades affirmed that 'the crime of a lunatic is frequently without motive, or rather it is in opposition to anything that could be called a sane motive'.[61] Doctors from the 1920s made it clear that, although sexual offenders were not necessarily lunatics, their motives were often obscure at first glance and demanded expert interpretation. Indecent exposure, for one, often appeared to be a 'nonsensical and meaningless' act, as a doctor at Brixton prison put it, and so medical enquiry should attempt to uncover its cause.[62] Furthermore, the true motive for a sexual crime demanded significant expertise to establish, since the same act might, in different situations, be 'the result of depraved brutality, selfish indulgence or sublime emotion'.[63] The study of sexual offenders therefore centred upon uncovering underlying motives, which were thought to be particularly complex and varied. However, not all types of sexual offence presented equal difficulty. As the next two sections of this chapter will illustrate, crimes committed by men and designated 'abnormal' demanded far more attention from medicine than both the 'normal' offence and the female offender.

### 3.2 'Normal' and 'abnormal': The sexual perversions

Sexual offences were not all equal in the eyes of the doctor. Nor did they correspond with legal definitions. Home Office statistics divided offences against the person into

[61] Smith, *Taylor's Principles and Practice of Medical Jurisprudence*, 6th edn, p.878.
[62] F. H. Taylor, 'Observations on Some Cases of Exhibitionism', *Journal of Mental Science,* 93 (1947), 631-638 (p.631).
[63] William Norwood East, *Sexual Offenders* (London: Delisle, 1955), p.14. See also Norwood East, 'Some Cases of Mental Disorder'; William Norwood East, *An Introduction to Forensic Psychiatry in the Criminal Courts* (London: J & A Churchill, 1927) p.7.

two categories: 'crimes of violence' and 'sexual offences', with the latter including indecent offences between men, rape, indecent assault, 'defilement' of girls under the age of consent, incest, procuration and abduction for the purposes of prostitution, and bigamy. Indecent exposure was counted separately, as it could only be tried in the lower courts of summary jurisdiction, as could crimes such as brothel keeping, living off immoral earnings, and indecencies pursued under vagrancy laws. These classifications remained almost unchanged over the following four decades, with only minor adjustments in terminology.[64] The medical definition of a sexual offence, in contrast, was far less static or clear-cut.

In his 1922 book, *The Psychology of the Criminal*, Hamblin Smith framed the subject of sexual deviance as an important element in understanding mental disorder and crime as a whole. He provided a thorough grounding in psychoanalytic ideas and used this theoretical foundation to suggest that, although some offences should be seen as self-evidently sexually motivated, in fact 'many other and widely different forms of delinquency may result from such a sex complex'.[65] Understanding sexual disorder was therefore of primary importance, in his view, to tackling criminality in general. This was something of an extreme position, but it was not uncommon for doctors to extend their understanding of sexual crime to include offences which were thought to have sexual gratification as their motive. In rather specific terms, these were catalogued by one doctor as 'the fetishists who snip girls' hair in crowds or steal their underwear from clothes lines, the peeping-toms who peer through lighted windows by night', and 'the men who slit girls' raincoats in crowded tube trains with safety razor blades'.[66] Sexual crimes might include 'thefts, housebreaking, burglary, common assault and murder if

[64] *Criminal Statistics for 1919* p.5, p.11, p.14; *Criminal Statistics for 1959*, p.liv.
[65] Hamblin Smith, *The Psychology of the Criminal*, p.99.
[66] Calder, 'The Sexual Offender', p.28.

the offence has for its purpose the immediate or delayed gratification of normal or abnormal sexuality'.[67] The important issue for medical enquiry was motive, and crimes without logical or 'sane' motive could sometimes be traced back to unexpected sexual desires. Classification based upon the exact nature of the crime was therefore not entirely satisfactory from the medical perspective. Dr Mackwood of Wormwood Scrubs emphasised that, in his reporting, 'it is the really important psychological factor that is classified in the tables, and not the recorded offence'.[68] Glover concurred that legal classifications were not always useful to the medical enquirer, who would prefer to focus on that which had caused the crime, rather than the form the crime itself took.[69] Medical and legal definitions were not aligned, and in medical terms the sexual offence was a broader category.

And yet, despite this apparently broad definition, doctors were generally interested only in offences relating to 'abnormal' sexual crime. By virtue of their 'abnormality', they were associated with abnormal mental states. This was not a fixed and unchanging category, but it did commonly exclude rape, indecent assaults or 'defilements', and incest.[70] *The Psychological Treatment of Crime* divided its sexual offenders into abnormal and normal, and explained that those 'guilty of assaults on women and girls, belong to the normal group of offender'.[71] Elsewhere, Norwood East

[67] Norwood East, *Sexual Offenders*, p.14.
[68] Norwood East, 'The Interpretation of Some Sexual Offences', p.416; *Report of Prisons for 1949*, p.76, p.78.
[69] Edward Glover, *The Diagnosis and Treatment of Delinquency, Being a Clinical Report on the Work of the Institute during the Five Years 1937 to 1941* (London: Institute for the Scientific Treatment of Delinquency, 1944), p.14. This principle was even extended by some affiliated to the ISTD to argue that all prisoners should be classified and organised by personality type, so that each type could receive appropriate treatment as a group. Hermann Mannheim and John C. Spencer, *Problems of Classification in the English Penal and Reformatory System* (London: Institute for the Scientific Treatment of Delinquency, n.d.) pp.2-3.
[70] Elise Chenier has noted that the same was true of Canadian 'sexual psychopath' legislation, which usually excluded crimes of rape or assault of adult women. Chenier, 'The Criminal Sexual Psychopath in Canada: Sex, Psychiatry and the Law at Mid-Century' (p.79).
[71] Norwood East and Hubert, *The Psychological Treatment of Crime*, p.149.

specified that the 'crime of incest in this country does not usually present any complex psychological problem for investigation', being simply 'the result of propinquity and opportunity'. In a contribution to one of the first criminology textbooks to come out of England he confirmed that 'the manner and circumstance of a sexual offence against women and girls requires no detailed presentation here, since the criminal behaviour is often no more than the transference of normal thought into criminal activity'.[72] If the offence appeared 'sane', or normal, it was unlikely to signify mental disorder or to present a puzzle that required medical expertise to explain.

Distinctions along these lines were called up to emphasise that medicine could not 'cure' *every* instance of sexual crime. Efforts to clarify and define the type of sexual offender who could be cured will be explored in more detail in Chapter 6, and did not rely solely upon the nature of the offence. Nevertheless, prison medical officer Dr Calder considered that cases of incest, rape, indecent assault, and carnal knowledge of a minor 'might almost be regarded as signs of normality' rather than disorder. In seeking to address the 'assumption which even in very well informed circles is held to be self-evident – that a proven sexual charge irrespective of its nature is clear evidence of some perversion, or at least of some abnormal urge of psychiatric significance', he contrasted these crimes with 'the tremendous problem of homosexuality', 'the fetishists', 'the peeping-toms' and the 'exposeurs'.[73] Calder's list closely matched the specific sexual crimes that were commonly described as the perversions and associated with mental disorder.

---

[72] On the subject of incest, see Norwood East, *Medical Aspects of Crime*, p.344, and on violent rapes as sadism, Norwood East, 'The Interpretation of Some Sexual Offences', p.420. On sexual offences against women and girls, see William Norwood East, 'Sexual Offenders', in *Mental Abnormality and Crime: Introductory Essays,* ed. by L. Radzinowicz and J. W. C. Turner (London: Macmillan, 1944), pp.177-207, p.190.

[73] Calder, 'The Sexual Offender', pp.28-29. Those found suitable for treatment or susceptible to cure will be discussed in more detail in Chapter 6.

Norwood East defined the sexual perversions in strikingly similar terms to Richard von Krafft-Ebing's explanation of 'perversion of the sexual instinct', or 'paraesthesia'. Krafft-Ebing, whose textbook *Psychopathia Sexualis* had been published in English in 1893 but had received little attention until the 1920s, had argued that when there was 'opportunity for the natural satisfaction of the sexual instinct, every expression of it that does not correspond with the purpose of nature – i.e., propagation – must be regarded as perverse'.[74] Norwood East endorsed the same conclusion, stating that a true perversion was

> sexual activity in which complete satisfaction is sought and obtained without the necessity of heterosexual intercourse. It... must not be merely a substitute for a preferred heterosexual activity which, for some environmental reason, is difficult to obtain.[75]

Both definitions placed a premium on the 'natural satisfaction' of potentially reproductive intercourse. Havelock Ellis preferred the term 'deviation' to 'perversion', and this became increasingly popular from the 1950s, but tended nonetheless to retain the same definition of abnormality.[76]

The perversions were, in summary, 'fetishism, sado-masochism, transvestism, exhibitionism and homosexuality'.[77] This ordering did not reflect the frequency with which they had a bearing upon sexual offences; Norwood East explained that 'exhibitionism is the most frequent perversion seen in the criminal courts', with homosexuality and sadism less frequently, fetishism and transvestism rarely, and masochism almost never.[78] They were all, however, linked to mental disorder. This was spelled out in Norwood East's classification of criminals, which first appeared in the

[74] R. von Krafft-Ebing, *Psychopathia Sexualis: With Especial Reference to the Antipathic Sexual Instinct*, trans. Franklin S. Klaf (New York: Arcade Publishing, 1998 [1965, 1902]) pp.52-53.
[75] Norwood East, 'Sexual Offenders', p.186.
[76] Havelock Ellis, *Psychology of Sex: A Manual for Students* (London: Heinemann, 1933), pp.126-127.
[77] 'The Court and the Sexual Offender', *British Medical Journal,* 2 (1951), 1459-1460 (p.1459).
[78] William Norwood East, 'Psychopathic Personality and Crime', *Journal of Mental Science,* 91 (1945), 426-446 (p.443).

*Report of the Prison Commissioners and Directors of Convict Prisons for the Year 1935* and was reproduced and referenced on later occasions. It featured six top-level categories of mental state: normal, subnormal, mentally defective, mentally inefficient, psychoneurotic, and psychotic. The sub-group of 'Perverts', shown in Figure 2, demonstrated a variety of 'mental inefficiency' and included the various sexual offences that were considered to be signs of abnormality.[79] Norwood East maintained this emphasis on the 'Perverts' as mentally disordered in one of his last publications, in which he confirmed that 'sexual perverts are included in this group of mentally abnormal persons here and in many classifications'. He argued that psychiatrists should always examine 'perverts' in the dock, since prison only worked as a deterrent 'when the offence is the result of normal impulses'.[80] Crimes prompted by abnormal impulses demanded expert analysis.

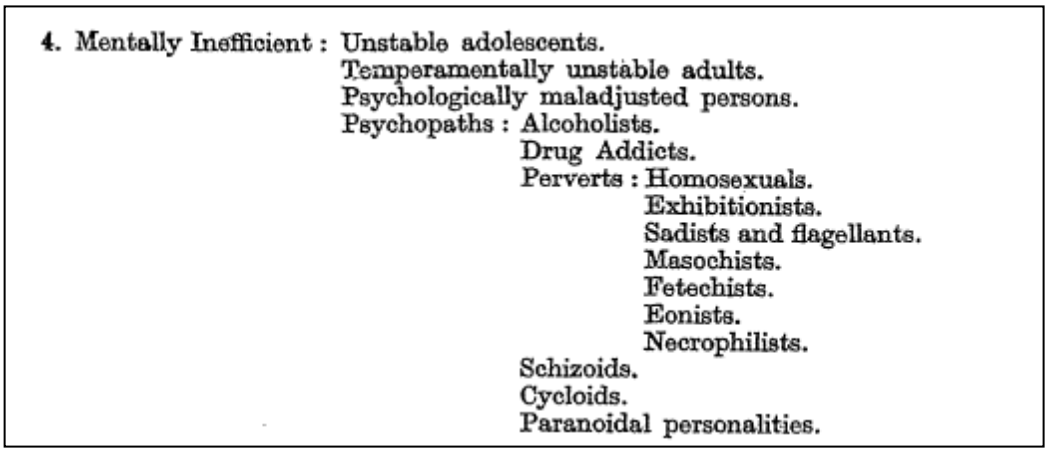

4. Mentally Inefficient : Unstable adolescents.
Temperamentally unstable adults.
Psychologically maladjusted persons.
Psychopaths : Alcoholists.
Drug Addicts.
Perverts : Homosexuals.
Exhibitionists.
Sadists and flagellants.
Masochists.
Fetechists.
Eonists.
Necrophilists.
Schizoids.
Cycloids.
Paranoidal personalities.

**Figure 2: Extract from William Norwood East's 'Mental Classification of Criminals'**

[79] *Report of the Commissioners of Prisons and the Directors of Convict Prisons for the year 1933* (London: H. M. Stationery Office, 1935) p.56. The table also appeared in Norwood East and Hubert, *The Psychological Treatment of Crime*, and Norwood East, 'Responsibility in Mental Disorder', and its pattern is replicated in, for example, Landers, 'Observations on Two Hundred Dartmoor Convicts', pp.961-968.

[80] William Norwood East, *Society and the Criminal* (London: H. M. Stationery Office, 1949) p.104, p.121. Ideas about psychopathic personalities and their relation to sexual crime will be discussed in more detail in Chapter 4.

This focus upon the 'perversions' was upheld and nuanced by others. The Medical Inspector of Prisons in 1950 affirmed that cases suitable for medical treatment 'may be found among persons convicted of indecent exposure, homosexuality, sadism and other forms of sexual perversion'.[81] An element of expertise was still required, however, in order to determine the true cause of any such crime. Indecent exposure, for example, was viewed as an offence that might occur in an attempt at 'sexual invitation', with the seduction of a woman as its aim. This was entirely different from indecent exposure for its own sake.[82] Equally, a particularly violent rape or murder might suggest sadism, if the violence itself produced gratification, and was therefore perceived entirely differently from most sexual assaults by specialists.[83] Broadly speaking, however, offences such as rape or indecent assault were held as intrinsically different, in medical terms, from the 'perversions'.

Although a line had been drawn between the normal and abnormal sexual offences, with the 'perversions' firmly situated on the abnormal side, particular perversions received more attention at different times. In the 1920s and 1930s, indecent exposure was commonly highlighted as a very strong indicator of mental disorder that demanded medical attention. The 1925 report of the committee convened to consider sexual offences against children recorded that 'cases of indecent exposure... showed a comparatively large proportion of mental trouble' and recommended that 'in all cases of indecent exposure... the offender should be examined as to his mental condition'.[84] This chimed with the evidence received from the Medical Women's Federation. Their notes dwelt upon the problem of indecent exposure, and concluded that 'all persons convicted

[81] *Report of Prisons for 1950*, p.85.
[82] Circular from the Prison Commission of 1 March 1934, 'Psychological Treatment of Crime', The National Archives (London), PCOM 9/186.
[83] Kenneth Walker and Eric B. Strauss, *Sexual Disorders in the Male* (London: Hamish Hamilton Medical Books, 1939) pp.164-165.
[84] *Sexual Offences Against Young Persons*, p.56, p.58.

of exhibitionism should be subjected to medical examination by the Special Board' and, leaping perhaps unintentionally to the inevitability of mental abnormality, should be 'certified as of unsound mind'.[85] Indecent exposure received dedicated attention from Norwood East and Hamblin Smith, and in later years from their successor prison medical officer F. H. Taylor and psychiatrist David T. Maclay.[86] Early on in its life, the board of the ISTD had proposed further study into 'the treatment of sex offenders' generally but 'the aetiology of exhibitionism' in particular, and this sexual crime continued to receive attention from psychoanalysts.[87]

This is perhaps not surprising. Angus McLaren has suggested that indecent exposure was heavily penalised due to the threat it posed to models of masculinity.[88] Whether or not punishments were in any sense disproportionate, indecent exposure was amongst the most frequently reported sexual offence, with thousands of cases each year.[89] The motive was also often in doubt, with the act regularly viewed as 'nonsensical and meaningless', and repeated frequently irrespective of punishment.[90] Concern regarding the mental state of the exhibitionist was evident in the legal and penal fields as well as within medicine. Those stalwarts of prison reform, Roy and Theodora Calvert, complained emphatically that '*439 were sent to prison for indecent exposure'* in one

[85] 'Medical Women's Federation: Home Office Committee to Enquire into Sexual Offences against Young Persons', Wellcome Library (London), SA/MWF/D.7.
[86] Hamblin Smith, 'The Mental Conditions Found in Certain Sexual Offenders; Norwood East, 'Observations on Exhibitionism; Taylor, 'Observations on Some Cases of Exhibitionism; David Maclay, 'The Diagnosis and Treatment of Compensatory Types of Indecent Exposure', *British Journal of Delinquency,* 3 (1952), 34-43.
[87] 'Scientific Treatment of Delinquency', *British Medical Journal,* 1 (1939), 1192-1193 (p.1192); Hans Christoffel, 'Exhibitionism and Exhibitionists', *International Journal of Psychoanalysis,* 17 (1936), 321-345.
[88] Angus McLaren, 'Exhibitionism and Deviance', in *Sexuality,* ed. by Robert A. Nye (Oxford: Oxford University Press, 1999), pp. 180-183 (p.182).
[89] This was recognised in Glover, *Sexual Abnormality*, p.10; a useful overview of annual averages for different crimes, divided into five-year blocks, can be found in *Criminal Statistics for 1959*, p.13 for indecent exposure and p.2, p.6, and p.9 for other sexual offences. The rapid increase in reports of indecent assault is notable here, rising from under 2,000 per year in 1930-1934 to over 9,600 in 1959.
[90] Maclay, 'The Diagnosis and Treatment of Compensatory Types of Indecent Exposure', p.631.

recent year, despite a growing conviction that it was 'pathological in origin'. Magistrate Claud Mullins took a similar view, and often cited indecent exposure as the typical offence that was suitable for medical assessment and treatment.[91] Perhaps more surprisingly, so did the official organ of the Magistrates' Association in 1940. In an editorial, it asserted that in such cases 'there ought, where no reasonable explanation of the misbehaviour can be found, to be a remand for medical and psychological examination'. Reasonable explanations might include forgetfulness in dressing or being caught in the act of urination, but if no such explanation could be found, pathology presented itself as a likely answer.[92]

Dr Ismond Rosen, a psychiatrist affiliated to the ISTD, was undertaking research on this particular type of offender in the 1950s, examining the effects of group therapy on desistance from crime. By this point, though, indecent exposure had been somewhat eclipsed by a greater source of anxiety during the post-war years: homosexuality.[93] Homosexual offences had certainly not been overlooked in earlier years, but did not occupy any more or less space than discussions of other sexual perversions. In 1938, though, Dr Desmond Curran provided a full-length article dedicated to homosexuality for *The Practitioner*, and in the following year *The Psychological Treatment of Crime* featured a full chapter on homosexuality alongside one on exhibitionism, signalling an increasing parity of status in medico-legal minds. By the mid-1940s, parity was a distant memory. In pamphlets from the Prison Medical Reform Council, correspondence in the *BMJ*, papers presented by prison medical officers, and articles in the medical press,

[91] Calvert and Calvert, *The Lawbreaker* p.144, emphasis in original; Mullins, *Crime and Psychology* p.66.
[92] 'Indecent Exposure', *The Magistrate,* November-December (1940), 336-337 (p.337).
[93] Radzinowicz, *Sexual Offences*, pp.246-248; 'Archives of Ismond Rosen: Exhibitionism: Group therapy', Wellcome Library (London), PP/ROS/E/2.

anxious discussion of homosexuality was everywhere.[94] The ISTD had reportedly treated equal numbers of cases defined as 'homosexual' and 'heterosexual' in the early 1940s, but a decade later, the number of homosexual cases had jumped into the lead.[95]

This largely reflected the vigour of debate elsewhere, about which much has been written.[96] Lurid newspaper reporting gave newly elevated profile to the 'problem' of the homosexual.[97] Even the Prison Commission was forced to acknowledge the presence of homosexuals in prisons, and to respond to calls for their segregation from other prisoners and each other.[98] Talk of legislative change, and then the appointment of the Wolfenden Committee, galvanised numerous medical, legal, religious, and other organisations into gathering information, canvassing opinion, and setting out their views.[99] From 1949, cases of homosexuality that were treated in the Psychological Unit at Wormwood Scrubs were enumerated separately and often discussed in some detail, and it was noted upon the opening of Grendon psychiatric prison that a

---

[94] Desmond Curran, 'Homosexuality', *The Practitioner,* 141 (1938), 280-287; Norwood East and Hubert, *The Psychological Treatment of Crime*, chapters 6 and 7; R. D. Reid, *The Case of the Homosexual* (Chiselhurst: Prison Medical Reform Council, 1944); Stanley-Jones, 'Homosexuality'; L. I. Hardy, 'Homosexuality', *British Medical Journal,* 1 (1946), 291; Clifford Allen, 'Homosexuality', *British Medical Journal,* 1 (1946), 449-450; *Report of the Commissioners of Prisons and the Directors of Convict Prisons for the Year 1947* (London: H. M. Stationery Office, 1947) p.67; John C. Mackwood, 'Male Homosexuality', *The Medico-Legal Journal,* 15 (1947), 14-18; 'Anomaly', *The Invert*, and so on.

[95] Glover, *Sexual Abnormality*, p.11; Glover, *The Problem of Homosexuality*, p.3.

[96] Jeffery-Poulter, *Peers, Queers, and Commons*; Bingham, *Family Newspapers*; Chris Waters, 'The Homosexual as a Social Being in Britain, 1945–1968', *Journal of British Studies,* 51 (2012), 685-710.

[97] See Bingham, *Family Newspapers*, and Justin Bengry, 'Profit (f)or the Public Good?', *Media History,* 20 (2014), 146-166.

[98] At a meeting of the Prison Commissioners in 1947, the Chairman asked 'whether it was desirable to segregate homosexuals', leading to much discussion. 'Minutes of the meetings of the Prison Commissioners 1929-1947', The National Archives (London), PCOM 14/8.

[99] The ISTD had suggested research on homosexuality to the Howard League in 1943, but it was not followed up until the 1950s. See executive committee meeting minutes of 14 October 1943, Modern Records Centre (Warwick), MSS.16B/1/3. Its written evidence to the Committee was published in the late 1950s: Glover, *The Problem of Homosexuality*, and Mary Woodward, 'The Diagnosis and Treatment of Homosexual Offenders', *British Journal of Delinquency,* 9 (1958), 44-59. See also the evidence of the Royal Medico-Psychological Society and other psychiatrists in 'Transcripts of evidence hearings: Committee on Homosexual Offences and Prostitution', The National Archives (London), HO 345/14.

disproportionate number of offenders classed as homosexual seemed to be amongst its first residents.[100] The question of understanding, analysing, and even curing the homosexual offender dominated medical discourse surrounding sexual crime in the 1950s.

Although indecent exposure and homosexuality received the bulk of medical attention, with other perversions appearing in the form of curious or unusual case studies, this is not to say that other sexual crimes were ignored entirely. Doctors may have sought to emphasise that those who committed incest or assaulted girls under the age of consent were not necessarily to be considered abnormal, but in so doing there seems to have been an unspoken assumption that this did not apply in the case of the very young child. An unspoken assumption is, inevitably, difficult to identify, but many of those who encountered criminals of all stripes as part of their daily life displayed a particularly strong antipathy towards those who assaulted small children, and doctors can be included in this.[101] Walker and Strauss maintained that men who repeatedly assaulted children, whether girls or boys, 'should be permanently segregated in a protected environment', although whether this was because they were incurable, incorrigible, or simply too dangerous to be left to roam freely was unspecified.[102] Assaults of small children were also singled out as connected to senility or brain disease in many cases, and more will be said about the particular ailments associated with elderly men in Chapter 4. However, this connection signalled that something was amiss;

[100] *Report of Prisons for 1949*, pp.78-91; *Report of the Commissioners of Prison for the Year 1954* (London: H. M. Stationery Office, 1955) p.138, p.142; *Report of the Commissioners of Prisons for the Year 1962* (London: H.M. Stationery Office, 1962) p.60.
[101] Such abhorrence is evident in C. E. F. Rich, *Recollections of a Prison Governor* (London: Hurst and Blackett, 1932) p.214; Harvey, *Prison from Within*, pp.259-260; Evidence of Sir Chartres Biron to the Departmental Committee on Assaults of Young Persons in 'Evidence to the Departmental Committee on Assaults of Young Persons', The National Archives (London), HO 45/25434.
[102] Walker and Strauss, *Sexual Disorders in the Male*, p.184.

indecency or assault involving young children was frequently seen as a sign of illness, whether physical or mental.

The appearance of the diagnosis of 'paedophilia' in medical literature in the 1940s, with very little further comment or explanation, also suggests that it described something that was already well understood. Norwood East adopted the term at around this time, and simply included it alongside such perversions as sadism, fetishism, and exhibitionism without additional comment.[103] By the 1960s, it was often included in the pantheons of perversions. However, a lack of definition or explanation in earlier texts, alongside insistence that sexual crimes such as incest and the 'defilement' of girls in their teenage years were not necessarily evidence of mental abnormality, leaves a lack of clarity as to exactly what was meant by the term. Determinations of abnormality may have focused upon the age of the child, the age of the offender, the age difference between them, or the precise nature or frequency of the assault itself. The use of the diagnosis of paedophilia in the 1940s may have been a response to heightened anxiety surrounding homosexuality, in which the 'corruption' of boys by older men came to dominate discussion of the abuse of children. Doctors often tried to provide a careful distinction between the homosexual attracted to men, and those attracted to young boys. This was emphasised in *The Psychological Approach to Crime*, and in much evidence to the Wolfenden Committee, although some letter-writers to the *BMJ* remained convinced that homosexuality inevitably equated to the corruption of boys.[104] The 'abnormal' sexual crime, therefore, was not a static category nor easily and

[103] William Norwood East, 'Crime, Senescence and Senility', *Journal of Mental Science,* 90 (1944), 835-850 (p.838); Norwood East, 'Psychopathic Personality and Crime', p.443. Earlier uses of the term, with variations of spelling, can be found in Ellis, *Psychology of Sex*, p.129; August Forel, *The Sexual Question: A Scientific, Psychological, Hygienic and Sociological Study*, trans. C. F. Marshall (Brooklyn, NY: Physicians and Surgeons Book Co., 1931 [1906]) p.254.
[104] Norwood East and Hubert, *The Psychological Treatment of Crime*, p.86.

uniformly defined, even if certain types of offence were more likely to pique medical interest than others.

### 3.3 The female sexual offender

The medical study of female sexual offenders was rather different. Even though the annual criminal statistics demonstrated that women were convicted of offences relating to prostitution, incest, and even occasionally indecent assault, 'unnatural offences', and 'defilement' of children under 16, they were all but entirely absent from studies and discussions surrounding the sexual offender. The 'sexual offender' as discussed by prison doctors and other researchers was almost always exclusively male, while the topic of interest regarding women was the number and treatment of those with venereal disease. Describing a situation reminiscent of the Contagious Diseases Acts of the late nineteenth century, prison reformers pointed out that the judiciary often made inappropriate use of its powers of remand, detaining 'common prostitutes' in prison for long enough to receive treatment for venereal disease even before their trial.[105] Although this particular concern appears to have died away, the issue of treatment for venereal disease remained. In 1950, Holloway prison, occupied since 1903 by female prisoners only, acquired a 'venereal disease social worker', and in 1952, a new 'V.D. Clinic' and second specialist social worker. By 1954, a doctor at a Borstal institution for girls studied, amongst other things, the rates of venereal disease, pregnancy, and virginity amongst those who were re-convicted after their release from Borstal. Although she recommended psychotherapy for the 'unstable and those showing neurotic symptoms', and there was also a psychotherapist attached to Holloway women's prison from the late 1940s, the absence of any further discussion is notable. This silence is in marked contrast with the space devoted to dealing with bodily disease,

[105] Hobhouse and Brockway, *English Prisons To-Day*, p.359.

moral training, and, indeed, the psychological treatment of male offenders in Wormwood Scrubs.[106] Reports of psychological endeavours within prisons mentioned only men. For women, penicillin rather than psychotherapy became the doctor's best line of attack.

The state of mind of the female offender was not entirely overlooked. Over the course of his long career, Norwood East gave a total of three case studies of female sexual offenders. The first two related to charges of libel, and were therefore presented as examples of crimes that were not self-evidently sexual in nature, but should be understood by the well-informed doctor as indicative of underlying sexual problems. In the first, the offender had believed herself to be married to a clergyman and had written to 'bishops and other dignitaries of the Church, as well as to relations, announcing the marriage', while the second case concerned letters alleging a seduction and pregnancy which were 'grossly obscene'. Norwood East's explanation of both cases was that their 'sexual desires were intolerable to their own moral training and peace of mind' so they 'projected their wishes onto others'. His elaboration of the character of the second offender belies an unspoken opinion that her sexual desires were, in fact, excessive due to flaws in her upbringing and even her very personality. He described her as 'a sensual-looking girl of 22, vain, suggestible, idle, and spoilt'.[107] The third case study, published in 1951, was of a woman who reportedly stole for sexual excitement.[108] Excessive sexual desire in women was given here as an explanation for otherwise baffling crimes. However, Norwood East had nothing further to say. He had observed that 'the whole

[106] P. Epps, 'A Further Study of Female Delinquents Undergoing Borstal Training', *British Journal of Delinquency,* 4 (1953-1954), 265-271 (p.270); *Report of Prisons for 1950*, p.75; and *Report of the Commissioners of Prisons for the Year 1952* (London: H. M. Stationery Office, 1953) p.103.
[107] Norwood East, 'The Interpretation of Some Sexual Offences', pp.422-423.
[108] 'The Court and the Sexual Offender', p.1459.

realm of female criminality needs much scientific study', but demonstrated very little personal interest in taking up this challenge.[109]

Indeed, there was only one significant piece of research into mental abnormalities in female offenders. This was conducted by Dr Grace Pailthorpe, one of a very small number of women doctors working in the field of crime or mental health during the period under examination.[110] She provided 'invaluable voluntary services' to Hamblin Smith in the 1920s by 'making investigations among the female prisoners'.[111] A later study under the auspices of the Medical Research Council of 100 women in Holloway prison and 100 women in 'rescue homes' was designed to assess 'what treatment – using the term in the most elastic sense – would lead to the restoration of these cases to the ranks of normal people'. Although she was adamant that medical treatment would help, she did not single out any particular type of offence or offender.[112] Reports as to mental state were, presumably, sought in some cases of crime committed by women, but except in cases of murder or infanticide, they generally went unremarked.

Small numbers of female offenders received medical attention at the Tavistock and the ISTD, and with Eurich in Bradford. Eurich attributed a great deal of petty crime amongst women to 'sexual maladjustments'. By this, he like Norwood East meant an excess of sexual feeling. The solution, in his mind, was to encourage more 'feminine' thoughts and pastimes. In one case study of a 'strongly sexed' woman, his

[109] Norwood East, 'Responsibility in Mental Disorder', p.204.
[110] Perhaps the best-known female mental health doctor was Dr Helen Boyle of Brighton: Louise Westwood, 'A Quiet Revolution in Brighton: Dr Helen Boyle's Pioneering Approach to Mental Health Care, 1899–1939', *Social History of Medicine,* 14 (2001), 439-457. Doctors in women's prisons were men, although a few women did work with the Tavistock and the ISTD.
[111] *Report of Prisons for 1923*, p.53.
[112] Pailthorpe, *Studies in the Psychology of Delinquency*, p.8.

recommendation for cure was to join the local Mother's Union and spend time looking after needy children. 'This is not the only case where delinquent women have recovered balance by charitable work among children or others less fortunate than themselves', he reported.[113] Of the 196 adult sexual offenders seen in the Tavistock's first fifteen years of operation, 34 were women. 'Female homosexual cases' were in this number, despite the fact that this was not technically an offence, as well as some few cases of prostitution.[114] No further details were given, and the Tavistock doctors do not seem to have published on these subjects.

In a striking departure from widespread medical apathy regarding prostitution and its causes, to Glover it was undoubtedly a matter for psychotherapeutic treatment. He acknowledged that 'prostitution is not generally regarded as a sexual abnormality', but was adamant that there was 'conclusive evidence that a large number of prostitutes, both young and experienced, not only suffer from emotional and intellectual backwardness, but exhibit many signs of unconscious mental conflict'. Furthermore, and uniquely, he argued that both prostitute and client shared the same pattern of mental disturbances and developmental disorders.[115] Norwood East also published on the subject of prostitution towards the end of his career, and agreed that medical examination might be advisable to determine whether retarded sexual development or other mental disorder was a causal factor. He hinted that observation of the mental state of prostitutes was taking place in some quarters, although it was not reported by

[113] The National Archives (London), HO 45/18736, File 438456/37.
[114] 'Psychological Treatment of Crime 1933-1939', The National Archives (London), HO 45/18736, file 438456/33.
[115] Glover, *Sexual Abnormality*, p.10; Edward Glover, *The Psycho-Pathology of Prostitution* (London: Institute for the Scientific Treatment of Delinquency, n.d.) p.5. The only other reference I have found within medical literature to the prostitute's client is in an article by Norwood East from 1947, in which he observed that 'the chief cause of the prostitution of women is the demand made and maintained by men'. William Norwood East, 'Prostitution', *The Practitioner,* 158 (1947), 335-342 (p.342).

the Prison Commissioners or published during the period under examination.[116] One of his colleagues had noted that young women convicted of prostitution-related crimes could not be given 'a sentence of imprisonment sufficiently long either to treat adequately their physical condition or to investigate their mental state', suggesting a willingness to conduct such investigations if time permitted.[117]

Sexual crime amongst women was, therefore, not entirely absent within medical literature, and some psychotherapeutic attempts may have been taking place. However, Glover's view that prostitution was just as likely to indicate mental disorder as the misconduct of men was not widely shared. It was telling that, in covering the 1929 meeting of the World League for Sexual Reform, the *BMJ* highlighted 'marriage, divorce, and prostitution' as topics of discussion that pertained only 'indirectly' to medicine, and although medical witnesses to the Wolfenden Committee were pressed for information about prostitution by committee members Dr Desmond Curran and Mrs Mary Cohen of the Girl Guides Association, they rarely had anything to say on the subject.[118] Dr Noel Harris opened his evidence on behalf of the Royal Medico-Psychological Society by confirming that 'we did not feel that prostitution was a matter that really concerned us from a psychiatric angle', and Dr Sessions Hodge emphasised that prostitutes were 'another problem altogether'. Although Dr Eustace Chesser offered the tantalising possibility that he had 'a fair experience of [treating] them', he had nothing to add to Sessions Hodge's view that they required 'a period of training in an institution'. The nature of this training remained unspecified, but was probably similar to the training of the Borstal or approved school, in which firm discipline and practical skills of a suitably feminine nature were intended to induce self-control and a capacity for acceptable

[116] Norwood East, 'Prostitution', p.341, p.388.
[117] *Report of Prisons for 1933*, p.40.
[118] 'The Scientific Study of Sex Problems', *British Medical Journal,* 2 (1929), 508.

forms of work. Aside from Glover, only Mary Hamilton, a probation officer, seemed to feel that mental disorder truly was a serious problem amongst prostitutes.[119] As Julia Laite has observed, study into the mind or psychological state of women working as prostitutes was 'very limited', even by the 1950s.[120]

At first glance, this may seem to contradict much historical research into women and deviance. A common argument has been, in the words of Shani D'Cruze and Louise Jackson, that women 'actively engaged in criminality tended to be pigeon-holed as irreconcilably "bad" or, with the growth of a gendered psychiatric discourse that linked mental illness to reproductive function, as "mad"'.[121] Women committing crime were supposedly more commonly pathologised than their male counterparts. Given this tendency to associate female criminality with mental disorder, and at a time in which interest in sexual disorder and psychological explanations was growing, why were female sexual offenders so widely ignored?

One possible explanation is that the female sexual offender was not seen as a problem on the same scale as the male. Norwood East noted 'the intriguing, well established, and, as far as I know, unexplained fact that women commit crime less frequently than men'.[122] The number of women serving prison sentences was declining steadily and significantly over the period in question, from an average of 9,437 per year in 1920 to 3,370 in 1959. Over this same period, the number of men imprisoned each year rose from 24,842 to 42,637. As a percentage of the overall prison population,

[119] Meetings of 31 October 1955 and 29 April 1955, in 'Transcripts of evidence hearings: Committee on Homosexual Offences and Prostitution', The National Archives (London), HO 345/14 and HO 345/13.
[120] Julia Laite, *Common Prostitutes and Ordinary Citizens: Commercial Sex in London, 1885-1960* (Basingstoke: Palgrave Macmillan, 2012) p.197.
[121] D'Cruze and Jackson, *Women, Crime and Justice in England since 1660*, p.2.
[122] Norwood East, 'Responsibility in Mental Disorder', p.204.

women went from 28% to just 7%. This decline in visibility within one particular setting may have been important, given the role played by prison doctors in researching the sexual offender.[123] The numbers of women convicted of sexual offences *other than* those overtly related to prostitution were also declining. This may have reflected changing methods of policing, regulating, and categorising indecent acts committed by women, rather than a reduced rate of the crimes themselves or even of their detection. However, and unlike offences related to prostitution, the number of women arrested for incest, indecent exposure, or indecent assault was always extremely low. Set against the thousands of male sexual offenders passing through the courts each year, the hundred or so women convicted of sexual offences other than prostitution may have seemed insignificant.[124]

Offences related to prostitution were by far the most common sexual crime for which women were arrested, and generated more medical interest as a result. However, they were increasingly dealt with by means of non-custodial sentences such as fines, which restricted opportunity for medical examination or attempts at rehabilitation. This is not to say that the matter of prostitution no longer seemed important. Although the number of arrests for prostitution-related offences was decreasing until the 1950s, as Julia Laite has argued, this was not the full picture. The growing complexity of the 'legislative and administrative patchwork' that dealt with prostitution and other forms of commercial or public sex quite probably concealed the visibility of prostitution within official statistics.[125] As she and others have discussed, concern about prostitution did not disappear, and became particularly acute during and immediately after the Second

[123] *Report of the Commissioners of Prisons and the Directors of Convict Prisons, with Appendices, for the Year ended 31st March, 1920* (London: H. M. Stationery Office, 1920) p.48; *Report of Prisons for 1959*, p.13.
[124] Data gathered from HMSO's annual criminal statistics.
[125] Laite, *Common Prostitutes and Ordinary Citizens*, p.214.

World War.[126] It was in this context that Norwood East, Glover, and one or two witnesses giving evidence to the Wolfenden Committee conceptualised prostitution as a potentially psychological problem, worthy of further study. Heightened public interest did perhaps generate more medical discussion that went beyond VD, but it remained marginal.

The frequency with which women were arrested for sexual crimes is not on its own a useful explanation for the presence or lack of medical interest. Broader attitudes towards women, crime, and sex are far more revealing. Many historians have discussed the ways in which criminality in women has often been sexualised, irrespective of the nature of the crime itself and in contrast to the conceptualisation or presentation of criminality in men.[127] This was undoubtedly a persistent perception throughout the period under examination, and is evident in the case studies offered by Norwood East and Eurich. A Home Office circular of 1933 affirmed that sexual impropriety and its corollary of VD should be assumed not only in cases of sexual crime, but also 'sleeping-out, wandering, begging and insulting behaviour' amongst women.[128] This connection between a range of crimes committed by women and likely sexual misconduct leading to infection was made more explicit in a project funded by the Rockefeller Institute in the mid-1940s, to investigate the 'social background of convicted women at Holloway Prison infected with venereal disease'. It confirmed that any offence committed by women 'may be considered offences essentially sexual in nature'. Here, there was an echo of the expansion of male sexual offences to include anything with a sexual motivation, but without delving into the unconscious or psyche. The conclusion was quite simply that

[126] Laite, *Common Prostitutes and Ordinary Citizens*, chapter 10.
[127] Lisa Downing, 'Murder in the Feminine: Marie Lafarge and the Sexualization of the Nineteenth-Century Criminal Woman', *Journal of the History of Sexuality,* 18 (2009), 121-137; D'Cruze and Jackson, *Women, Crime and Justice in England since 1660*.
[128] 'Circular to all local prisons: 'Venereal Disease – Women Prisoners'', The National Archives (London), PCOM 9/413.

crime amongst women was always prompted by sexual excess. 'Wandering or lodging out was associated with sexual promiscuity and soliciting', while many cases of trespass involved women 'suspected of hanging round military or air force camps for immoral purposes. In one case a woman had actually spent the night in barracks'. Theft was also 'invariably connected with irregular modes of life', being Absent Without Leave involved 'a man met casually', and the 'undesirable cafes' and 'doubtful companions of the West End' were a bottomless pit of crime and immorality. Simply put, 'in these women it is impossible to separate sexual from non-sexual delinquency: one may lead to the other'.[129]

The same was true of delinquent girls. Studies into delinquent girls and the ways in which they were managed have argued that girls 'were institutionalised for sexual conduct that was not so treated in boys', and that their sexual practices were fundamental to their demarcation as delinquent.[130] Concerns about youthful promiscuity amongst girls, and the conflation of criminality with precocious sexuality, are evident in medical writings about young female offenders. A report about child guidance work in Oxford contemplated the differences between boys and girls, and observed that 'sexual immoral tendencies are not combined to a very great extent with stealing' in boys, whereas in the sample of girls, sexual immorality was often combined with theft. Criminality and sexual misconduct were therefore part and parcel of the same problem for girls, but not for boys.[131] A decade later, the connection between sexual delinquency in young girls and crime remained strong. With specific reference to

[129] K. Edkins, ''Enquiry into the social background of convicted women at Holloway Prison infected with venereal disease'', The National Archives (London), PCOM 9/413.
[130] Shani D'Cruze, 'Crime', in *Women in Twentieth-Century Britain: Social, Cultural and Political Change,* ed. by Ina Zweiniger-Bargielowska (Harlow: Longman, 2001), pp. 198-213 (p.205); Linda Mahood and Barbara Littlewood, 'The "Vicious" Girl and the "Street-Corner" Boy: Sexuality and the Gendered Delinquent in the Scottish Child-Saving Movement, 1850-1940', *Journal of the History of Sexuality,* 4 (1994), 549-578 (p.557).
[131] Good, 'The Danger in our Midst', p.60.

girls in Borstal institutions, a Governor stated in 1955 that 'all have been sexually promiscuous', and an unnamed prison doctor commented that the young age of many female offenders 'makes one realize how difficult it must be to rehabilitate girls who have had sexual experience from such an early age'.[132] The female offender was, therefore, seen by doctors as invariably sexually delinquent, often from a young age.

In women, then, crime of all stripes was associated with lax morals, sexual misconduct, and venereal disease. Sexual offences amongst women therefore fell into the same category for medical purposes as 'normal' sexual offences amongst men: socially undesirable, certainly, but not immediately suggestive of mental disorder and not demanding the consideration of a psychological cure or other rehabilitative treatment instead of prison. In some rare cases, such as those examples cited by Norwood East or Eurich, wayward sexuality in otherwise respectable women might overflow into seemingly unrelated criminality like petty theft or libellous letter-writing, and in such situations medical expertise could shed some light. For the most part, though, the fact that women's criminality was intrinsically linked to sexual deviance meant that it required little further comment. The primary interests of prison doctors in women's prisons were curing venereal disease and, more ambitiously, with preventing re-infection and re-offending through education and the encouragement of a more wholesome and typically feminine lifestyle. This did not require psychological research, nor experiments in individualised cure.

## Conclusion

Over the early to mid-twentieth century, medical interest in sexual abnormalities, broadly defined, and sexual offenders in particular gained a firm foothold. Research and

[132] *Report of Prisons for 1950*, p.75; *Report of Prisons for 1954*, p.124; *Report of Prisons, 1955*, p.147.

books dedicated to the subject were published and discussed, amidst some agreement that sexual offenders demanded careful medical attention and, quite possibly, medical treatment. This did not achieve universal acceptance, but medical enquiry was justified on the basis of a need to uncover the true underlying motives in such cases so that rehabilitation could be attempted. 'Abnormal' sexual crime, in contrast to rape or indecent assault of women, was depicted as requiring particular attention, analysis, and explanation. The female criminal, by contrast, was expected to be sexually wayward, and so sexual offences committed by women, like 'normal' sexual crime committed by men, held less interest for doctors. Causes or motives in these cases rarely seemed to demand medical expertise, and such offences could simply be punished in the traditional manner rather than considered from the perspective of rehabilitation and 'cure'.

Medical interest in explaining sexual deviance proved durable, even if the project of rehabilitation or cure of the sexual offender was to stumble and fall in the 1960s. Textbooks from the 1960s and 1970s addressing sexual deviations did not always acknowledge the tradition of which they formed part, but their preoccupations revealed their debts. Although some attention to the issue of consent began to appear, there remained a focus upon the 'perversions' amongst men, a lack of interest in sexual deviance amongst women, and a paucity of comment on rape or sexual assaults of children, which stands in sharp relief against contemporary anxieties. Within forensic medicine, the language of 'perversion' largely fell away, but 'paraphilia' took its place. Theories about the cause and possible treatment of sexual crime, as the next chapter will explore, remained remarkably diverse.

# Chapter 4: Causes and treatments

Harry Mills was by any measure a serial sexual offender. He was interviewed in the 1960s, by which time he had 112 convictions for indecent exposure, and was still only 47 years old. He recounted the explanation for his conduct that his psychiatrists had provided, that it was 'something to do with my feelings about my birth and my upbringing, my sense of inferiority, my resentment towards my mother and all the rest of it'. This psychological explanation was, Mills thought, 'probably right', but he instinctively reverted to an alternative. He believed that he had been the product of an incestuous relationship between siblings, and was therefore not 'normal'. In his mind, he carried a terrible 'hereditary taint', made manifest in his persistent offending.[1] This was a seemingly insurmountable problem, and myriad medical treatments had, so far, failed to have any effect. In the meantime, he had found a promising solution in the unlikely form of the local police station, to which he would despatch himself in times of temptation. Staff would let him spend some time there, and would provide tea, cigarettes, and moral support, and 'then one of them will walk me to the bus-stop and see me on the right bus home'.[2] He found this more helpful than anything else.

Harry Mills brings together some of the many explanations that were offered by medical science to account for abnormal sexual crimes. He was also the recipient of many of its best efforts at cure. As this chapter will show, the causes and possible treatments that were explored by doctors were numerous. It was widely agreed that a variety of causes could operate singly or together, and only skilful and thorough medical enquiry could reveal the true balance of their influence in causing any one sexual crime.

[1] Parker, *The Twisting Lane*, p.160.
[2] Parker, *The Twisting Lane*, p.156.

Of some interest were the offender's personal circumstances and environment. Harry Mills had found a way to manage his sexual offending by changing his immediate surroundings, using his local police station as a sanctuary. The morbid influence of particular situations or circumstances was recognised by medical thought, although doctors tended to focus closely on the home and the opportunities for 'normal' sexual activities. The age of the offender was also a consideration, with both youth and old age bringing particular problems that needed recognition. Psychological causes, often drawing heavily upon psychoanalysis, were popular during the 1920s and 1930s, frequently using the language of maturity and civilisation to characterise a healthy sexual impulse. Psychological treatments, known loosely as 'psychotherapy', were energetically advocated. The idea of an inherited disposition did not disappear in the face of this psychological enthusiasm, though, as Mills' self-diagnosis suggested. 'Hereditary taint' as a description was in many respects subsumed within diagnoses of 'constitutional perversion' and psychopathic personality. The eventual popularity, albeit controversial, of diagnoses of sexual psychopathy *and* assertions of innate homosexuality in the 1950s therefore represented a resurgence of long-held medical belief. Physiological causes, attributed to the glands or the brain, could also co-exist with all of these possible explanations for crime, and treatment was equally diverse.

The medical profession, like the probation service and other social forces brought to bear on offenders in the name of rehabilitation, tended to conceptualise crime 'within a framework of faulty and maladjusted individuals rather than the wider social structure'.[3] With specific reference to homosexuality, Chris Waters has argued that after the Second World War the social aspect of sexuality rose in prominence, and

[3] Whitehead and Statham, *The History of Probation*, p.17.

the homosexual became a social being rather than a pathological individual.[4] This chapter will argue that, although a wider social picture was beginning to encroach on the field of sexual pathology by the late 1950s, for the most part it retained a focus upon unhappy homes, flawed sexual development, innate tendencies, and occasional disease. The offender in a broader social context was, with a handful of exceptions, not considered. The many possible causes that could explain sexual crime were to be found by studying the individual, and they could explain any kind of sexual crime, occurring in any circumstance, and committed by anyone at all. Whether treatment operated by reducing sexual impulses or by fortifying will-power, by resolving lingering childhood conflicts or identifying environmental stressors, psychiatric contributions could claim to reduce crime by means that did not require any one single underlying cause or cure.[5]

### 4.1 The network of causes

Sexual crime was usually seen as the product of a poisonous combination of causes. This ready acceptance of plurality reflected the fragmented nature of English psychiatry as a whole. As historians of psychiatry have pointed out, the boundaries between psychiatry and neurology were unclear in the early twentieth century.[6] Attempts to explain immorality in medical terms often relied upon a vague but all-encompassing 'nervous system' or 'organization' that could be disrupted, throwing the smooth functioning of the human organism off balance.[7] Debates surrounding mental defect had emphasised questions of heredity, while at the same time, the First World War saw growing interest

[4] Waters, 'The Homosexual as a Social Being', p.688.
[5] Walker and Strauss, *Sexual Disorders in the Male*, p.180; Neustatter, *Psychological Disorder and Crime*, p.158.
[6] Angel *et al.* (ed.), *European Psychiatry on the Eve of War: Aubrey Lewis, the Maudsley Hospital, and the Rockefeller Foundation in the 1930s*, especially pp.40-42.
[7] Felix Schirmann, 'Badness, Madness and the Brain – the Late 19th-Century Controversy on Immoral Persons and Their Malfunctioning Brains', *History of the Human Sciences,* 26 (2013), 33-50. An example is Savage and Mercier, 'Insanity of Conduct'.

in Freudian theories and psychodynamic approaches to mental disorder. Gradually, too, the harsh dividing line separating the mad and the sane, represented by certification of insanity and compulsory institutionalisation, was being blurred in medical and legal circles. This had begun in the nineteenth century, but had suffered from the absence of university or hospital-based psychiatry in England to provide alternatives to the asylum. In the first decades of the twentieth century, however, new types of hospital for observation and early treatment were beginning to appear, alongside academic Chairs in psychology and psychiatry. Notably, these developments did not usurp pre-existing approaches, but were able to co-exist.

By the eve of the Second World War, psychiatry had therefore expanded its horizons. Avenues of enquiry could proceed in any number of directions, as the Clinical Director of the Maudsley Hospital, Dr Aubrey Lewis, made clear: consider, he wrote, 'the enormous field psychiatry now straddles over or touches; from social legislation, psychotherapy, or statistics, to neurology, internal medicine, and the minutiae of laboratory research'.[8] Physiological, social, and psychological issues were all worthy of examination. At the Maudsley Hospital, the preferred approach of Dr Lewis's predecessor Dr Edward Mapother has been characterised as an 'eclectic therapeutic', and many other psychiatrists were equally open to variety. In this climate, doctors were prepared to accept that the causes of sexual deviance could be multitudinous. Although some doctors preferred one explanation over others, most were prepared to keep an open mind.[9] Dr Clifford Allen, for example, felt that the 'true factor' behind sexual perversion tended to come down to 'the home circumstances', but was still prepared to

[8] Aubrey Lewis's report is reproduced in Angel *et al.* (ed.), *European Psychiatry on the Eve of War: Aubrey Lewis, the Maudsley Hospital, and the Rockefeller Foundation in the 1930s*. This quotation is from his Introduction, p.57.

[9] Hayward, *Germany and the Making of "English" Psychiatry*, p.72. Roger Davidson's research into the Scottish case has suggested a similar picture, with psychiatrists of the 1950s tending not to adhere closely to any one theory. Davidson, 'Psychiatry and Homosexuality'.

devote much time to researching endocrinological disturbances. Indeed, in his view these elements were often inextricably linked.[10]

In the 1920s and 1930s, as doctors sought explanations for the full gamut of abnormal sexual crime, emphasis upon the breadth of medical enquiry that was necessary was particularly pronounced. This emphasis was, in part, an effort to persuade those who were suspicious of psychological medicine that the treatment of the delinquent was most certainly *not* just about psychoanalysis. 'For some', the Tavistock clinic could report, 'a great deal is most usefully done by the adjustment of environment and circumstance'.[11] Official reports about the work of the ISTD were keen to point out that initial examination usually included not only an interview with a psychological specialist, but also a social history, a physical examination including eyes and teeth, investigation of possible hormone disorders, an intelligence test, and an interview with a vocational guidance expert.[12] Meanwhile, in Bradford, Eurich followed a similar pattern. He conducted a physical investigation, gathered a wide-ranging 'social history', and only then conducted a 'psychological exam'. Although Eurich and his judicial colleagues believed that their approach to offenders was 'really <u>different</u> from the London clinic work' because it considered not only mental and physical problems, but also 'diet, finances, social and religious relations' and more, in fact, metropolitan operatives were maintaining an equally broad perspective. Desmond Curran and Eliot

[10] Allen, 'Homosexuality', and Allen, *The Sexual Perversions and Abnormalities*, especially p.viii; Clifford Allen, 'Virilism with Mental Symptoms', *British Medical Journal,* 2 (1956), 604.
[11] *Tavistock Square Clinic for Functional Nervous Disorders: Report for the Years 1920-1927* (London: Tavistock Square Clinic, n.d. [c.1928]), p.19.
[12] Glover, *The Diagnosis and Treatment of Delinquency*, p.17; Glover, *The Problem of Homosexuality*, p.18.

Slater as well as Edward Glover were at pains to emphasise that a wide range of causes should always be explored.[13]

This signalled that each sexual offender was a unique and remarkably complex problem. The prevailing mood of the period may have dictated that criminals in general needed more tailored measures in order to be rehabilitated, but any signs of sexual perversion required personalised and expert attention, in no uncertain terms. 'Numerous factors, constitutional and environmental, are involved; each case must be judged on its own merits', concluded a study from 1947.[14] A dazzling array of causal factors were propounded, from nasal obstruction to undescended testes, from the death of a parent to fear of venereal disease, from dissatisfaction at work to the secretions of an enlarged prostate.[15] At the ISTD, treatment could involve referrals to surgeons or experts in endocrinology, for example, as well as changes to the patient's living or working environment, drug prescriptions, or psychotherapy at the clinic itself.[16] In Bradford, Eurich's recommendations sometimes included hospitalisation, but also changes to hobbies or employment.[17] However, uncovering the immediate, precipitating cause of sexual deviance was an important first step. As one doctor observed, 'in many cases of sex offenders, sociological aspects are so interwoven with psychological

[13] Report of Dr Coddington sent to the Home Office and his letter to Sir Alexander Maxwell dated 1 July 1938, in The National Archives (London), HO 45/18736, file 438456/37, emphasis in original; Curran and Slater, 'Mental Disorder in General Practice: A Plea for Clinical Psychiatry'; Glover, *The Diagnosis and Treatment of Delinquency*, pp.14-17; Glover, *The Problem of Homosexuality*, p.18.
[14] Taylor, 'Observations on Some Cases of Exhibitionism', p.638.
[15] Norwood East and Hubert, *The Psychological Treatment of Crime*, p.112, p.106; 'Archives of Ismond Rosen: Exhibitionism: Group therapy', Wellcome Library (London), PP/ROS/E/2; Norwood East and Hubert, *The Psychological Treatment of Crime*, p.132; Radzinowicz, *Sexual Offences*, p.248, Norwood East, 'The Interpretation of Some Sexual Offences' (p.421); Mullins, *Crime and Psychology*, p.82, p.92; Morley Roberts, 'Indirect Results of Prostatectomy', *British Medical Journal,* 2 (1922), 1048.
[16] Glover, *The Diagnosis and Treatment of Delinquency*, p.17; Glover, *The Problem of Homosexuality*, p.18.
[17] 'Correspondence with Dr Coddington, Bradford Stipendiary magistrate', The National Archives (London), HO 45/18736, File 438456/37.

aspects, that one realises any attempt to remedy the latter with the former remaining constant can but do more harm than good'.[18]

If underlying problems were present, something as apparently unconnected to sexual crime as a surgical operation could trigger an offence.[19] Often, however, precipitating causes were found in the offender's domestic situation. The most common environmental cause was an unhappy home. Rees of the Tavistock was quite certain that 'social conditions are inevitably linked with all these problems of sex', giving an example of the 'unsympathetic or very demanding or querulous' wife. Such an unsatisfactory domestic situation could have an impact even if only temporary, as in the case of an offence found to be 'partly precipitated by the stress of living alone while his wife was in hospital to have their first child'.[20] Wives, in their overbearing presence or exceptional absence, could disrupt the sexual equilibrium of their husbands. This attention to domestic relationships was consistent throughout the period, with a survey from the 1950s finding that a significant number of sexual offenders had been 'required to have psychiatric treatment in connection with matrimonial difficulties'.[21]

On occasion, doctors were more specific about the nature of the matrimonial difficulty. Sexual crimes were often attributed to 'unsatisfactory sexual relations between man and wife', as Mullins put it. Methods of birth control, leading to just such a lack of satisfaction for the male offender, were one cause of sexual crime identified by the doctors advising Mullins.[22] Hamblin Smith agreed that the absence of a successful

[18] *Report of Prisons for 1949*, p.121.
[19] A surgical operation was held to be to blame in 'General Messervy Bound Over', *The Times,* 11 September 1956, p.4.
[20] J. R. Rees, 'Prognosis in the Sexual Neuroses', *The Lancet,* 225 (1935), 948-949; Radzinowicz, *Sexual Offences*, p.248.
[21] Radzinowicz, *Sexual Offences*, p.247.
[22] Mullins, *Crime and Psychology*, pp.90-92. The method in question was the withdrawal method.

sexual relationship at home could contribute to sexual crime, and Norwood East provided a case study of a recently widowed man who had 'sent his daughter on the streets' to then 'view her relations with the men she took home'. 'His normal sexual energy found an obstacle to its consummation' following the death of his wife, Norwood East maintained, which led to the adoption of this unsavoury sexual outlet.[23] Such studies ignored the sexual and emotional lives of the women involved, lending weight to the argument that medical interest in women's wayward sexuality did not seek to delve into causes and cures in the same way as they did for men.

It is notable, here, that doctors envisaged male sexual energy or impulse as constantly present. A certain quantity of sexual impulse existed within each man, and if the proper outlets were not available for it to be kept at a healthy level, then perversion could strike as it overflowed into improper channels. Sexual crime could therefore indicate the absence of opportunity for healthy, 'normal' sexual activity. This was most evident in the many caveats surrounding definitions of 'true' sexual perversion, in which it was acknowledged that an otherwise healthy and law-abiding man might indulge in abnormal activity if, 'for some environmental reason', heterosexual activity was 'difficult to obtain'.[24] This assumed that it was quite normal for sexual behaviour to take an unusual turn in straitened circumstances; sexual continence may have been preferable from the moral standpoint, but from the medical view it was to be expected that indiscriminate sexual practices might ensue.

This presented a particular problem for older men as well as those with absent wives. Indeed, age was an important consideration when interpreting sexual crime. In

[23] Hamblin Smith, 'The Mental Conditions Found in Certain Sexual Offenders', p.645; Norwood East, 'The Interpretation of Some Sexual Offences', p.421.
[24] Norwood East, 'Sexual Offenders', p.186.

1893, the reviewer of *Psychopathia Sexualis* had said with apparent confidence that 'we all recognise the forms of sexual vice which occur especially in youth and those which occur in senility'.[25] Although it was some twenty years before a doctor in England would provide any further description of these vices, the particular problems of youth and old age were elaborated as discussions of sexual crime became more common. The older man was frequently seen to be unable to direct his sexual appetites towards the proper heterosexual goal, whether because of impotence, bereavement, or lack of willing partners. The 'relative frequency of indecency with males committed by men over 60 may indicate their unattractiveness for the average woman', reflected Norwood East. Or, they might be 'due to the fact that phantasy and desire have outlived potency', so that strange substitutes were sought.[26] In Eurich's view, elderly sexual offenders were 'quite or nearly impotent'. 'They are bored', expounded the magistrate with whom Eurich worked, 'they brood, and they want to recover, if only for a moment, the sexual excitement of their youth'.[27] Whether out of boredom or desperation, the sexual crimes of old men reflected the troublesome presence of sexual energies even when healthful marital relations were impossible.

The inability to pursue proper channels for sexual desire was equally a challenge for adolescents, who, it was theorised, may not fully understand new sexual impulses or have the opportunity to indulge them. Dr W. Lindesay Neustatter, who was by the 1950s well on the way to becoming the 'doyen of forensic psychiatry', posited that indecent exposure was 'especially apt to occur in young persons, sometimes due to a failure of

[25] 'Review: Psychopathia Sexualis with Special Reference to Contrary Sexual Instinct by R. von Krafft-Ebing', *British Medical Journal,* 1 (1893), 1325-1326 (p.1325).
[26] Norwood East, 'Crime, Senescence and Senility', p.838.
[27] 'Correspondence with Dr Coddington, Bradford Stipendiary magistrate', The National Archives (London), HO 45/18736, File 438456/37.

sexual outlet, sometimes in lieu thereof'.[28] Radzinowicz referred to the 'difficulties usually associated with adolescence' which, as he had learned in the course of researching the problem of the sexual offender, could lead to such crimes but simply required suitable management to return the youth to the correct path towards adulthood. This was exemplified by one boy of 15 whose assault of a 7-year-old girl was reportedly 'precipitated by curiosity aroused from descriptions of sexual adventures he had heard from other boys', and did not signify any serious or permanent abnormality. Indeed, Radzinowicz's research revealed that younger sexual offenders were often sent to child guidance clinics 'because it was felt that they were in need of instruction in sexual matters'.[29] Dr Maclay of Uffculme Clinic in Birmingham received numerous referrals of adolescents who had committed 'some form of indecent assault' in the later 1950s, and reported that 'bewilderment about sexual matters' was a frequent cause.[30]

For younger offenders, then, a common theme was the need for better sex education and less anxiety in the home about youthful sexual impulses. Glover strongly encouraged the provision of information about sexual matters to children in an atmosphere of 'polite and friendly understanding', without giving it undue weight.[31] As sexual misconduct could be caused by parents handling childish sexual curiosity 'too strictly', as Neustatter put it, a more relaxed approach with adequate sexual education might prevent youthful misconduct. This emphasis upon information and understanding for children, rather than 'threats, warnings and punishments', was echoed elsewhere.[32]

---

[28] 'W. L. Neustatter, BSc, MD, FRCP, FRCPsych', *British Medical Journal,* 2 (1979), 278; Neustatter, *Psychological Disorder and Crime*, p.153.
[29] Radzinowicz, *Sexual Offences*, pp.247-248.
[30] David Maclay, 'Boys Who Commit Sexual Misdemeanours', *British Medical Journal,* 1 (1960), 186-190 (p.187, p.190).
[31] Glover, *Sexual Abnormality*, pp.3-4.
[32] Neustatter, *Psychological Disorder and Crime*, p.148; Walker and Strauss, *Sexual Disorders in the Male*, pp.160-162; Glover, *The Problem of Homosexuality*, p.22; Glover, *Sexual Abnormality*, p.3. Calls for better sex education were also issued in Robert Sutherland, 'Sexual Delinquency:

In this sense, psychiatrists endeavoured to promote a route to preventing the emergence of new sexual offenders, as well as the cure of those already identified.

Notably, such calls for attention to the sex education of the nation's youth rarely paid much heed to the gender of the teacher. In the interwar years, the National Union of Teachers conducted vigorous campaigns to ensure that boys over the age of seven had *male* teachers, and these were often inflected with concern that an excessively feminine environment might produce an unmanly generation who would not develop healthy sexual impulses. Clifford Allen addressed this specifically, suggesting that education 'in an entirely feminine environment' led to men within 'feminine traits' who were homosexual.[33] However, a more masculine environment or more male teachers were not advocated with any frequency by doctors as a means of preventing future sexual crime. Sensible guidance might come from any source. As the next section will explore, though, the role of the mother took on particular significance as part of the psychological approach to sexual crime.

## 4.2 The psychological approach

In the aftermath of the First World War, psychological factors began to appear as explanations for sexual crime. Most medical perspectives were profoundly influenced by psychoanalytic thought, although its impact often went unacknowledged. As one astute observer suspected, 'English people do not readily accept new theories, but we are masters in the subtle art of working new theories in practice without admitting them, or even realizing that changes have taken place'.[34] Incorporation of Freud's theory of

---

Address to the 36th National Conference', *Probation Journal,* 5 (1948), 222-224 (p.224); Maclay, 'Boys Who Commit Sexual Misdemeanours', p.187, p.190.

[33] Allen, 'Homosexuality'.

[34] Mullins, *Crime and Psychology*, p.160.

childhood sexual development occurred along these lines, as it was absorbed into a broader interest in all matters juvenile. Childhood had already been established as significant in determining mental defect, which had to be present from a young age in order to meet the statutory definition set out in the Mental Deficiency Act of 1913. Fears over juvenile delinquency during the interwar period also supported close attention to the problems of youth, and the child guidance movement flourished. The arrival of child psychiatry as a new specialism was signalled by its inclusion in the third edition of a leading textbook of psychiatry, published in 1932.[35] Sexual precocity, in the form of that troublesome habit amongst children of masturbation, already had a long-standing association with insanity.[36] It was, therefore, relatively easy to continue to look into the life of the child to explain sexual perversion in the adult, albeit with a slight adjustment to the explanatory mechanisms at work.

At one extreme, Pailthorpe argued that the 'abnormality of behaviour and psychic instability' of every criminal or delinquent 'can be traced back to childhood', a view that Hamblin Smith would have endorsed. Others addressed the sexual perversions more specifically, interpreting them as the method by which adults attempted to resolve the conflicts and disturbances of infancy. Tavistock psychiatrists Hadfield and Rees agreed that 'infantile experiences', often from the earliest years of life, were often the underlying causes of perversion.[37] Bennett, in giving evidence in a case of indecent exposure in 1956, confirmed that 'the roots of the defendant's offence went back to his

[35] D. K. Henderson and R. D. Gillespie, *A Text-Book of Psychiatry for Students and Practitioners*, 3rd edn (Oxford: Oxford Medical Press, 1932).
[36] Edwin Stephen Pasmore, 'Observations on the Classification of Insanity', *Journal of Mental Science,* 45 (1899), 70-78 (p.76); Hare, 'Masturbatory Insanity: The History of an Idea'; R. P. Neuman, 'Masturbation, Madness, and the Modern Concepts of Childhood and Adolescence', *Journal of Social History,* 8 (1975), 1-27.
[37] Pailthorpe, *Studies in the Psychology of Delinquency*, p.44; Hadfield, 'Some Aspects of the Psychopathology of Sex Perversions', pp.1022-1023; Rees, 'Prognosis in the Sexual Neuroses'.

childhood', and this was of course what Harry Mills had been told as well.[38] The importance of steady progression through the phases and fantasies of childhood was often emphasised. Norwood East explained Freudian theories of child sexual development at some length in earlier publications, albeit without drawing too much attention to his source. He saw some sexual crime as evidence of 'fixation' at, or 'regression' to, an earlier stage of the developmental process through which everyone passed. Although he later diluted the Freudian component of his work somewhat, he continued to recognise the importance of childhood development in forming adult sexual tendencies throughout his career.[39] Similar explanations, emphasising disruptions to the psychosexual development of the child as described by Freud, were also put forward by Walker and Strauss in 1939, and by David Maclay in 1952.[40]

By viewing all sexual perversions as, in the words of Glover, 'regressions to earlier systems', sexual disorder was often seen as a symptom of a failure to achieve or maintain successful adulthood.[41] As historian Stephen Robertson has observed, with reference to American discussions of sexual crime over the mid-twentieth century, psychiatrists 'identified the sexual psychopath as sexually and emotionally immature'.[42] This immaturity was not only childish, but also primitive, or even animalistic. Ellis, who had published in 1933 a well-received summary of his earlier work, was in agreement with Norwood East that indecent exposure in particular reflected a return to the

[38] 'General Messervy Bound Over'.
[39] Norwood East, 'The Interpretation of Some Sexual Offences'; William Norwood East, Percy Stocks, and H. T. P. Young, *The Adolescent Criminal* (London: J & A Churchill, 1942), p.16; Norwood East, 'Sexual Offenders', p.185, p.187.
[40] Walker and Strauss, *Sexual Disorders in the Male*, p.160; Maclay, 'The Diagnosis and Treatment of Compensatory Types of Indecent Exposure', pp.34-35.
[41] Glover, *Sexual Abnormality*, pp.3-4, p.6.
[42] Stephen Robertson, 'Separating the Men from the Boys: Masculinity, Psychosexual Development, and Sex Crime in the United States, 1930s-1960s', *Journal of the History of Medicine and Allied Sciences,* 56 (2001), 3-35 (p.4).

'courtships of the farmyard'.[43] To Ellis, this was 'a pseudo-atavism': not a 'true emergence of an ancestrally inherited instinct', as such, but rather a loss of some of the finer feelings demanded by contemporary civilisation. By returning to the behaviour of the animal kingdom, 'the exhibitionist is placed on the same mental level as the man of a more primitive age', he concluded.[44]

The civilising forces of the modern age were also credited with the reduction of sadistic impulses. These were, in medical eyes, natural and normal up to a point. Dr Grierson explained that sadism was 'an abnormal exaggeration of a normal instinct, or of the instinctive reactions in the animal world, including the human race'.[45] However, this instinct was kept in check by the influence of civilised societies, which induced self-control, although the lurking danger of excessive sexual instinct remained. Historian Alison Moore has identified this as a particular concern of the interwar period. At this time, sadism in men was seen as 'both primitive and natural' and therefore demanded the striking of a delicate balance.[46] To Dr Hollander, an overpowering base instinct was evident in the 'child, the savage, and persons of little culture', all of whom were 'little able to restrain their inclinations'.[47] It was even suggested by Dr Matheson of the prison service when giving evidence in a murder trial in 1955 that the sexual sadism of the defendant, part of the 'normal innate sadistic traits of the male', had 'become exaggerated' because his first sexual experiences had taken place 'with natives' while serving in the RAF in India.[48] Although he did not expand on this, it seemed to imply that

[43] Ellis quotes from Norwood East, 'Observations on Exhibitionism' in Ellis, *Psychology of Sex*, p.167.
[44] Ellis, *Psychology of Sex*, p.167.
[45] The National Archives (London), PCOM 9/742; The National Archives (London), HO 144/22872.
[46] Moore, 'Rethinking Gendered Perversion', p.141.
[47] Hollander, *The Psychology of Misconduct, Vice, and Crime*, p.22.
[48] 'CLARKE, Sydney Joseph', The National Archives (London), DPP 2/2405.

a reversion to childish or animal instincts could be induced by the absence of English civilisation, and perhaps also the proximity of Hollander's 'savage'.

Indeed, from the 1940s, this immaturity or reversion to primitive habits was increasingly overtly associated with both the effeminate and the foreign. Whereas supposed national differences in sexual conduct had not been mentioned with much regularity in preceding decades, sexual perversion became, once again, something to be associated with other nations and a dearth of masculinity. A case study appearing in *The Lancet* found that the patient's 'passive effeminate personality', which accompanied his safety-pin fetish, was typical of 'the immaturity of his psychological development'. In a posthumous publication, which was mainly a reworking of previous articles, Norwood East repeated his comparison of some sexual crimes to the behaviour of animals, but tagged on the further example of 'primitive peoples like the central Australian native and Somalis'.[49] English manliness in a period of post-war anxiety about the state of the nation demanded both active sexuality, but also mature and civilised self-control. As one civil service witness to the Wolfenden Committee stated, in a neat summation of these views, sexual perversion was the very 'negation of decent manhood'.[50]

Such explanations demanded psychologically-informed treatment in the form of psychotherapy. This term did not refer to any very specific type of treatment, but rather covered a full range of what we might understand as 'talking cures'. 'Psychological treatment, or psychotherapy, is the name applied to any method of treatment in which an attempt is made to influence behaviour through the medium of the mind', explained

[49] William Mitchell, Murray A. Falconer, and Denis Hill, 'Epilepsy with Fetishism Relieved by Temporal Lobectomy', *The Lancet,* 264 (1957), 626-630 (p.629); Norwood East, *Sexual Offenders*, p.20.

[50] Evidence of Sir Theobold Mathew, Director of Public Prosecutions, on 7 December 1954, in 'Transcripts of evidence hearings: Committee on Homosexual Offences and Prostitution', The National Archives (London), HO 345/12.

Denis Carroll.[51] Rees agreed that psychotherapy 'means literally the treatment of any condition by mental means'.[52] However, doctors commonly made a distinction between psychologically informed interviews of varying intensity on the one hand, and the time-consuming and complex process of psychoanalysis on the other. Although some insisted that only full psychoanalysis could offer any hope of cure, especially in the most 'complex' cases of sexual neurosis, doctors were usually far more flexible in their approach. It was widely acknowledged that psychoanalysis was neither suitable nor possible for every offender. Most practitioners were careful to maintain an inclusive outlook, perhaps reflecting ongoing suspicion regarding psychoanalysis and a recognition of the practical problems of intensive treatment of any kind.[53] Psychotherapy at Wormwood Scrubs, it was emphasised, did not attempt to follow 'any particular psychological frame-work' or 'the tenets of any particular school'.[54] Reporting on his own method of psychotherapy, Neustatter described four different types of treatment, which he would adopt as seemed appropriate to each case. For some patients, he would prescribe a sedative such as potassium bromide or a placebo and enter into conversation, while for 'suggestion', he explained that 'a slightly hypnoidal state was induced' to enhance his suggestions for recovery. Psychological talks required more in-depth discussion of personal history and symptoms, while analysis involved 'Free association, with or without the use of dream material', and transference.[55]

---

[51] Denis Carroll, 'Psychological Treatment of Delinquents and Some of Its Problems', *The Howard Journal of Criminal Justice,* 4 (1935), 162-166 (p.162).
[52] J. R. Rees, *Mental Health and the Offender* (London: The Clarke Hall Fellowship, 1947) p.4.
[53] Dr Rees of the Tavistock maintained that for the most complex cases 'nothing but reductive mental analysis, of which Freudian psycho-analysis is the best known technique, will be adequate'. Rees, 'Prognosis in the Sexual Neuroses', p.948. However, the Tavistock acknowledged that even amongst those who were responsive to psychotherapy, sometimes 'the difficulties of their environment were too great'. Draft Report of the Tavistock Clinic, sent by J. R. Rees to Sir Alexander Maxwell on 8 December 1937, in 'Psychological Treatment of Crime', The National Archives (London), HO 45/18736, File 438456/33, p.3.
[54] Norwood East and Hubert, *The Psychological Treatment of Crime*, p.21.
[55] W. Lindesay Neustatter, 'The Results of Fifty Cases Treated by Psychotherapy', *The Lancet,* 225 (1935), 796-799 (p.796).

The length of psychotherapy could vary dramatically, depending upon the exact nature of the case. This last option was the most labour-intensive of Neustatter's brands of treatment, requiring a minimum of two interviews a week, often for a prolonged period. In other cases, one meeting with a psychotherapist might be sufficient. At the Tavistock in the 1920s, adult patients required an average of 16 hour-long sessions, but the 'record' was 149 interviews for one particularly tricky case.[56] Norwood East, in correspondence with the Tavistock, was pleased to note that they agreed that 'the best results appear to be obtained by frequent short interviews' and that 'in many cases deep analysis and prolonged psychological interviews are unnecessary'.[57] However, intensive psychotherapy, and longer-term psychoanalysis, was available for those with the time, money, and inclination. After his sixth conviction for indecent assault, one man saw a Harley Street psychiatrist almost every day for a year at his own expense, rather than taking the option of NHS treatment that would, he was told, take longer.[58] Another man interviewed in the early 1990s, whose attraction to other men led him to seek psychoanalysis in the 1930s, recollected that he 'had two years of analysis and then after I was ordained I still used to go'. His treatment was only brought to an end by the Second World War, when his therapist was killed by a bomb.[59]

The Second World War did not only disrupt treatment by removing therapists, whether permanently or temporarily when they joined the armed forces. New methods of psychotherapy emerged, in the form of group therapy and early experiments in creating therapeutic communities. These were a cost-effective and productive form of

[56] *Tavistock Clinic Report for 1920-1927*, p.19, p.6. Unfortunately, no further information was given about the particularly drawn-out case.
[57] Correspondence between William Norwood East and J. R. Rees, 1938-1939, in The National Archives (London), HO 45/18736, File 438456/33.
[58] Parker, *The Twisting Lane*, p.40.
[59] Jeffrey Weeks and Kevin Porter, *Between the Acts: Lives of Homosexual Men 1885-1967* (London: Rivers Oram Press, 1998) p.65.

treatment for larger numbers of people in situations in which individual sessions with a therapist were not logistically possible. They also reflected a shift towards slightly more social, and less individual, approaches, and a focus on the practical goal of enabling patients to return to military service, even 'at the expense of a full recovery'.[60] Their potential for prisons – and indeed, for overstretched hospitals – was quickly recognised. A separate ward was constructed within Wormwood Scrubs for group therapy and other post-war innovations, with the benefits of group therapy greatly appreciated by medical staff since 'many offenders who would be assessed as unsuitable for individual psychotherapy can be treated in a group'.[61] By 1954, the prison doctor at Wormwood Scrubs could report that although 'most forms of psychiatric treatment were available' on site if necessary, the emphasis was very much on group therapy.[62] Mackwood saw this as particularly useful for sexual offenders, remarking upon 'the effect of this social group in starting moral (social) values in amoral offenders'.[63] Group therapy alongside individual sessions became the norm, with Harry Mills participating in 'therapy sessions... either in a group or on your own, where you're encouraged to talk about yourself and your problems'.[64] Group therapy, and early efforts to create therapeutic communities, reflected some attempt to understand and to treat the sexual offender as, in Chris Waters' phrase, a 'social being'.

Notwithstanding this recognition of the importance of social interactions and good sex education, there were few proposals for social change. Psychiatrists interested

[60] Tom Harrison, *Bion, Rickman, Foulkes, and the Northfield Experiments: Advancing on a Different Front* (London: Jessica Kingsley, 2000) p.16. As this account of what became known as the Northfield Experiments makes clear, the roots of group psychotherapy in England are very closely connected to the military psychiatry of the Second World War.
[61] *Report of Prisons for 1949*, p.73, p.80.
[62] 'Reports of Societies: The Criminal and the Doctor', *British Medical Journal,* 1 (1954), 980-981 (p.981).
[63] Mackwood, 'Psychotherapy in Prisons and Corrective Institutions', p.221.
[64] Parker, *The Twisting Lane*, p.154.

in sexual deviance rarely concerned themselves with wider social issues or challenged the criminal code itself. As discussed in Chapter 3, many were themselves guilty of deeply moralistic assessments about 'normal' and 'abnormal' sexual behaviour. Roger Davidson has found in his research into a post-war Scottish hospital that the psychiatric mindset was 'heavily rooted in taxonomies of deviance shaped by established notions of sexual pathology rather than in more progressive ideas of sexual expression and inclusion'.[65] However, it is important not to overlook hints that some doctors found their contemporary situation, with its emphasis upon the punishment of sexual acts that deviated from the norm, unsatisfactory. Neustatter mildly observed towards the end of his textbook for the legal practitioner that 'where consenting adults are involved, punishment hardly seems just', and it was not unusual for psychiatrists to explain that criminal codes regarding sexual behaviour could appear somewhat arbitrary, even illogical, to the medical observer. In the evidence of the ISTD to the Wolfenden Committee, Glover was far more strident. 'To the psychiatrist the problem of homosexuality raises no question of criminality unless the sexual deviation is associated with acts of violence, assault or seduction of minors', he stated. 'It is regarded quite simply as one of a number of deviations from the biological aims of heterosexuality', and he emphasised that '*there is no answer to homosexuality save tolerance on the part of the intolerant anti-homosexual groups in the community*'.[66]

For the most part, though, psychiatrists endeavoured to accommodate social mores and structures, and legal codes, as they found them. Prison doctors, as employees of the state, were in a delicate position and could not criticise the laws they helped to enforce. For many other psychiatrists, their primary concern was the unique

[65] Davidson, 'Psychiatry and Homosexuality', p.417.
[66] Neustatter, *Psychological Disorder and Crime*, p.161; Glover, *The Problem of Homosexuality*, p.5, p.15, emphasis in original.

difficulties faced by the patient before them. From this starting point, many doctors freely admitted that their best efforts at cure were, in fact, simply attempts to reduce the disordered mental states that were produced in unhappy individuals by the knowledge and experience of their socially unacceptable desires. Statements along these lines became particularly evident from the 1940s, as debate surrounding homosexuality attained prominence. Drs Chesser and Stungo explained that treatment could 'remove or relieve concomitant neurotic features. In other words, treatment may convert an unhappy homosexual into a happy or less unhappy one'.[67] This view was shared by Curran and Guttman, Walker and Strauss, and Neustatter, some of whom maintained that medical intervention was almost *only* of value in the treatment of sexual abnormalities for its capacity to alleviate any associated depression, neurosis, or anxiety, rather than the removal of sexual deviance itself.[68] However, concealed within this therapeutic endeavour lay a persistent belief that some people were, simply, born to deviance.

### 4.3 From hereditary taint to sexual psychopath

Amongst the continental sexologists of the late nineteenth and early twentieth centuries, sexual crime had often been attributed to heredity. Some commentators insisted that the inherited or constitutional aspect of sexual abnormality rendered criminalising legislation cruel and unfair, but many more paid anxious attention to that scourge of the turn of the century: widespread degeneration.[69] Krafft-Ebing associated the moral decline of his own and other eras with sexual excess and depravity, and both

[67] Ellis Stungo and Eustace Chesser, 'Homosexuality', *British Medical Journal,* 1 (1946), 450-451.
[68] Allen, 'Homosexuality'; Desmond Curran and Eric Guttmann, *Psychological Medicine* (Edinburgh: Livingstone, 1943), p.58; Walker and Strauss, *Sexual Disorders in the Male*, p.180, p.185; Neustatter, 'The Results of Fifty Cases Treated by Psychotherapy', p.797; Meeting of 31 October 1955 in 'Transcripts of evidence hearings: Committee on Homosexual Offences and Prostitution', The National Archives (London), HO 345/14.
[69] Magnus Hirschfeld was perhaps the best-known proponent of this former case.

he and August Forel, to name but two, saw most sexual crime as the result of inherited taint or 'hereditary dispositions'.[70] A review in the *BMJ* had agreed that 'there is no position, no education, no surroundings which will prevent certain men from falling into the sexual vices, if there be a certain amount of nervous heredity'.[71] Although it faded from view somewhat in the 1920s and 1930s, the question of an innate disposition or constitutional tendency toward sexual perversion was not forgotten. This constitutional tendency was not quite an exact replica of hereditary taint. In theory, it could emerge, fully formed, from the most spotless family line. It was, however, commonly associated with inherited weaknesses and disorders. Slowly during the 1930s and 1940s, then rapidly during the 1950s, this constitutional tendency merged with the psychopathic personality.

Given the lack of clarity around terminology, these trends are difficult to trace. For one, the term 'psychopathic' did not carry the same meaning in the early twentieth century as it later acquired. Until the 1930s, it commonly referred in general terms to the borderland between sanity and psychosis, or a generic illness of the mind. Norwood East described most exhibitionists as 'psychopathic', but then listed the many forms of mental disorder that this might include and contrasted these cases with the 'depraved' who were mentally normal.[72] To him, the term seemed to signify mental illness in general. However, 'psychopathic' gradually came to signify a specific variety of mental disorder, and acquired a noun – the psychopath. There are signs that this evolution in England was influenced by developments in classification of mental disease within

[70] Krafft-Ebing, *Psychopathia Sexualis*, particularly p.3, p.145, p.229, p.333; Forel, *The Sexual Question: A Scientific, Psychological, Hygienic and Sociological Study*, p.208.
[71] 'Review: Psychopathia Sexualis with Special Reference to Contrary Sexual Instinct by R. von Krafft-Ebing'.
[72] This meaning was still in use in the 1930s: see, for example, Alexander Walk's reference to 'the psycho-pathology of the manic depressive psychosis'. A. Walk, 'Review: A Text-Book of Psychiatry', *Journal of Mental Science,* 79 (1933), 173-174 (p.174); Norwood East, 'Observations on Exhibitionism', p.372.

American medicine. Hamblin Smith, in an address to the Chief Constables' Association in 1923, spoke approvingly of the American term 'psychopathic state', used to describe those who did not fit within any existing category of mental disorder, but were nonetheless 'not normal mentally'.[73] This was given further nuance by David Henderson and his student Robert Gillespie, two Scottish psychiatrists who had worked in America with Adolf Meyer and whose impact upon psychiatric thought across Britain was considerable. In several talks and publications in the late 1920s and early 1930s, Gillespie provided descriptive accounts of psychopathic personalities, and their co-authored textbook, through its many editions, continued to popularise their ideas. These works paint a picture of the psychopathic sufferer as one who was emotionally volatile, selfish, disinclined to shoulder responsibility, and lacking judgement or foresight, and often engaging in antisocial – although not necessarily criminal – behaviour.[74]

Importantly, though, the psychopathic personality was not unanimously thought to be the product of heredity. Gillespie was clear that although sometimes it might be caused by 'inherited causes' or even head injury, 'the majority of psychopathic personalities acquire important parts of their unstable disposition as the consequence of faulty training and environment'. This view was endorsed and maintained in later years by David Henderson. It was absolutely not, they were clear, a matter of 'degeneracy', nor was it innate in some persons and not in others.[75] Despite their best efforts, though,

[73] Address by Maurice Hamblin Smith to the Chief Constables' Association's AGM on 1 June 1923, in The National Archives (London), HO 45/18736.
[74] *National Council for Mental Hygiene: Report of the Proceedings of the Conference on Mental Health Convened by the Joint Committee of the National Council for Mental Hygiene and the Tavistock Square Clinic* (London: Adlard & Son, 1929); R. D. Gillespie, *The Service of Psychiatry in the Prevention and Treatment of Crime* (London: Howard League for Penal Reform, 1930); David Kennedy Henderson and R. D. Gillespie, *A Text-Book of Psychiatry for Students and Practitioners* (London: Humphrey Milford, 1927), and subsequent editions.
[75] Gillespie, *The Service of Psychiatry in the Prevention and Treatment of Crime*, p.5; Henderson and Gillespie, *Text-Book of Psychiatry, 1st edn.* p.36.

psychopathic personality remained tied to something hereditary and constitutional. Desmond Curran and Paul Mallinson, in their survey of the field, concluded that although the aetiology was contested, perhaps the most commonly held view was that inherited traits, or a 'constitutional origin', were key to the definition of psychopathic personality.[76]

The psychopath and the disorder of psychopathic personality were frequently associated with sexual crime. In Gillespie's advice to the Association for Moral and Social Hygiene of 1936, he distinguished between sexual offenders suffering from 'a compulsion' and 'those suffering from lesser degrees of mental instability' than certifiable insanity who were, nonetheless, not quite normal. These were, in his words, the 'psychopathic personalities'.[77] 'Psychopathic personalities often commit sexual offences', Norwood East concluded in 1949. He had, after all, designated the sexual perverts as a variety of psychopath some ten years earlier.[78] In the post-war years, however, the term 'psychopath' and particularly the sexual psychopath who indulged in murderous sexual sadism achieved prominence.

This was in all likelihood exacerbated by the post-war anxiety around crime, both in general terms and especially regarding violence amongst demobilised personnel; the social and personal disruptions caused by the Second World War had been accepted as persuasive mitigating factors for violence in some trials, to much consternation. The *News Chronicle*, for one, reported anxiously that 'it would seem from some recent murder trials that the unfaithful wife of a serviceman is an outlaw with no benefit of law

[76] Curran and Mallinson, 'Psychopathic Personality', p.271.
[77] 'Children's Moral Welfare', *British Medical Journal,* 1 (1936), 1261-1262, with the memorandum available in full in 'Collection of Napsbury Mental Hospital, St Albans: General neurology and psychiatry', Wellcome Library (London), GC/135/B.3/2. See also Neustatter, *Psychological Disorder and Crime*, p.156.
[78] Norwood East, *Society and the Criminal*, p.131; Figure 2 in Chapter 3 of this thesis.

whatsoever. She may be murdered with impunity'.[79] As had been the case during the First World War, the role of psychiatry within the military also drew attention to apparent mental disorder amongst servicemen. Military hospitals experimented with new treatments under the guidance of eminent figures such as Dr Rees, who was appointed Director of the Army Psychiatric Services, and arguably elevated the profile of psychiatry enormously. They also enhanced awareness of the psychopathic state as a diagnosis. 'During the war', the Medical Commissioner for Prisons noted in 1947, 'a large number of men were discharged from the armed forces labelled as psychopathic personalities', and the proliferation of this vague diagnosis had become problematic for those involved in the administration of justice.[80] Although this potentially related to offenders of all types, the language of medical evidence brought the psychopathic sexual offender under close scrutiny in the courtroom.

The medical evidence in two trials, from 1946 and 1955, illustrates the contested meaning of psychopathic personality in relation to sexual sadism. 'Doctors Clash on Sanity of Heath' ran one headline, and many column inches were devoted to a detailed account of the medico-legal debate in the trial of Neville Heath for murder in September 1946.[81] Hubert, who had collaborated with Norwood East on *The Psychological Approach to Crime* in the 1930s, gave evidence that Heath's generalised life-long delinquency, in the form of fraud, deception, and military misconduct, in combination with his sexual sadism, suggested that he had been 'born with a deficient moral sense'. This meant that he was 'not an ordinary sexual pervert, but he is suffering

[79] Quoted in Duncan Campbell, 'Murder Most British', *Guardian,* 15 September 2013 <http://www.theguardian.com/uk-news/2013/sep/15/murder-neville-heath-fred-west> [accessed 15 September 2013].
[80] *Report of the Commissioners of Prisons and Directors of Convict Prisons for the Year 1946* (London: H. M. Stationery Office, 1947) p.64.
[81] Ronald Camp, 'Doctors Clash on Sanity of Heath', *News Chronicle,* 26 September 1946,

from moral insanity and at times is quite unaware that what he is doing is wrong'.[82] Dr Young and Dr Grierson, both of the prison medical service, stated clearly and simply that although Heath was indeed a sadist and a psychopath, he suffered from no clearly defined disease of the mind and 'knew what he was doing' at the time of the murders.[83] The judge was thoroughly unimpressed by Hubert's efforts, and Heath was executed a month later.

As the neurologist Macdonald Critchley noted some years later, the word 'psychopath' was 'introduced almost casually by defending counsel' during this trial, was then accepted by all medical witnesses, 'and then dropped' without further ado.[84] In 1946, 'sexual psychopath' operated more as a descriptive term than a psychiatric diagnosis, and the medical evidence hinged upon moral defect as a diagnosis defined in the Mental Deficiency Acts. Just nine years later, the same debates were underway in a similar trial, but the meaning of psychopathy itself was now under examination. In the trial of Sydney Clarke, Neustatter described the defendant as a sadist and a psychopath, explaining the latter as a person 'suffering from a constitutional abnormality in which they are unable to control impulses and are abnormal emotionally'. He went on to confirm that this was, in his view, a 'disease of the mind', but that other psychiatrists saw it as 'a character deficiency' rather than a disease. Dr Matheson of the prison service was one such psychiatrist, insisting that he was 'not prepared to accept psychopathy as a well defined disease'.[85] Cross-examination of the medical witnesses

[82] Gerald Byrne, *Borstal Boy: The Uncensored Story of Neville Heath* (London: John Hill Productions, 1954) p.126. Also reported in Camp, 'Doctors Clash on Sanity of Heath' and discussed in Macdonald Critchley, 'Neville George Clevely Heath', in *Famous Trials 5,* ed. by James H. Hodge (London: Penguin, 1955), pp.55-106.
[83] There is no full trial transcript, but the doctors are quoted at length in Byrne, *Borstal Boy* pp.124-138; Camp, 'Doctors Clash on Sanity of Heath'; 'Defence of "Partial Insanity" in Heath Trial: Killing of Two Women Admitted', *Manchester Guardian,* 26 September 1946, p.4. Written reports are also on file in 'HEATH, Neville', The National Archives (London), HO 144/22872.
[84] Critchley, 'Neville George Clevely Heath', p.89.
[85] 'CLARKE, Sydney Joseph', The National Archives (London), DPP 2/2405.

was lengthy and detailed, but in the end the acknowledged uncertainty over the status of psychopathy as a disease meant that Clarke's insanity plea failed.

Despite this lack of medical agreement surrounding constitutional abnormality, whether described as hereditary taint or psychopathic personality, its resurgence was durable. Although the sexual psychopath did not achieve the same infamous (and monstrous) status in England during this period as was the case in North America, the use of the diagnosis of psychopathic personality in relation to sexual crime played a key role in the introduction, much contested, of the term 'psychopath' to mental health legislation in 1959. Furthermore, the rhetorical power of the matter of constitution, which had been so useful to late nineteenth-century campaigners overseas, did not go unnoticed. Whereas Edward Glover had previously emphasised regression as the cause of sexual abnormalities, in the early 1950s he included 'constitutional or innate factors' in evidence to the Wolfenden Committee. Following Freud, he did not see homosexuality as a disease, but this was perhaps an easier case to make if he allowed that homosexuality could be a naturally occurring, innate, and blameless condition.[86] In so doing, he and other doctors of the 1950s borrowed from Magnus Hirschfeld earlier in the century, and provided medical ammunition for campaigners. In likening homosexuality to 'having a glass eye or a hare-lip' or 'being colour-blind', Peter Wildeblood, a journalist who attained considerable notoriety following his conviction along with Lord Montagu of Beaulieu and Michael Pitt-Rivers for homosexual offences in

[86] This was perhaps simply a reflection of the wider views held by ISTD members who contributed to this written evidence, rather than a change of heart on the part of Edward Glover. However, Chris Waters has suggested that Glover did not seek to cure homosexuality as such in the post-war years, so this may have reflected a shift in his stance, presenting the 'innate' case as neither criminal nor diseased. Glover, *The Problem of Homosexuality*, p.5, p.6, p.21. Chris Waters, 'Edward Glover and the Politics of Homosexual Law Reform', paper given at the Institute of Historical Research, January 2013.

1954, portrayed it as a 'tragic disability', most likely constitutional, that could not logically be criminalised.[87]

Thus, traces remained of earlier confidence that the blame for sexual perversion could be laid exclusively at the feet of 'hereditary taint', even into the 1960s. This was reiterated by offenders themselves, including Harry Mills. The impact of this for the cure of sexual deviance will be discussed in Chapter 6. However, most doctors saw the innate, the constitutional, or the psychopathic as a feature that would combine with other factors in the production of any specific sexual crime. Neustatter had faith in 'psychological explanations' as well as 'a certain constitutional predisposition', and Rosen speculated that constitutional disposition, indicated by the existence of, for example, a father who had committed the same crime, might reinforce the impact of particular environmental stressors leading to sexual offending.[88] The combination of causes remained key, and might include physical ailments too.

### 4.4 Physical causes and physical cures

In the early 1950s, psychiatrist Dr Eric Strauss contemplated the recent 'drift away from individual psychotherapy' and 'a shift of the focus of interest from purely psychological to physical methods of treatment' as part of regular 'swings of the pendulum in between the psychic and the somatic poles'.[89] The rise of physical treatments was certainly reproduced within medical responses to the sexual offender in the years after the Second World War, although many such innovations could trace their roots to the interwar period. In 1918, Viennese surgeon Eugen Steinach claimed to have discovered a

[87] Wildeblood, *Against the Law*, p.8, p.13.
[88] 'Archives of Ismond Rosen: Exhibitionism: Group therapy', Wellcome Library (London), PP/ROS/E/2.
[89] E. B. Strauss, *Reason and Unreason in Psychological Medicine* (London: H. K. Lewis, 1953) p.16.

cure for homosexuality in the form of testicle transplantation, and this enjoyed a brief but celebratory phase of popularity in Austria and Germany.[90] It appears to have been stoically ignored in England at first, with no coverage at all in the leading medical journals, in line with widespread silence on matters of sexual abnormality as a whole. In 1922, however, word had begun to spread. 'It is impossible even to sketch Professor Steinach's further experiments', noted the *BMJ* prudishly after describing one such operation, but went on to outline Steinach's theories that sexual orientation might be the product of the balance of secretions from the gonads.[91] In the very next edition, one Dr Morley Roberts discreetly suggested in the Letters pages that prostate trouble, causing morbid glandular secretions, may lead to the kind of 'sexual irritability' that would result in social disaster, and that surgery may offer a happy solution.[92] Although he did not mention Steinach by name, his reference to the rejuvenating possibilities of this surgery reflected Steinach's other obsession and implied familiarity with his research into glandular surgery.

The matter then went quiet, although experimentation continued with the uses of endocrine therapy for diabetes and growth disorders, amongst other problems. Occasional connections were made between mental illness, sexual abnormalities, and the glands. Lennox Broster, a surgeon at Charing Cross Hospital specialising in the study of the adrenal gland, referred some 52 patients to Clifford Allen in the 1930s because they 'suffered from virilism and... seemed to him to be mentally queer'. The doctors

[90] For more on Steinach and his various operations, see Chandak Sengoopta, *The Most Secret Quintessence of Life: Sex, Glands, and Hormones, 1850-1950* (Chicago; London: University of Chicago Press, 2006), especially pp.75-94.
[91] 'Vienna: Some Recent Medical Work', *British Medical Journal,* 2 (1922), 988-989. Earlier that year, one Dr Williams had made a similar claim, without reference to Steinach, but was shot down in furious correspondence straight away. Leonard Williams, 'The Interstitial Gland', *British Medical Journal,* 1 (1922), 833-835; and C. Marsh Beadnell, 'The Interstitial Gland and Sex Problems', *British Medical Journal,* 1 (1922), 973.
[92] Roberts, 'Indirect Results of Prostatectomy'.

sought to understand connections between psychosis, the adrenal gland, and virilism, in which girls or women began to display secondary male sex characteristics such as increased body hair. For Allen, mental disorder in these patients was connected to sexual disorder, and both perhaps stemmed from their glandular problem. 'In those cases in which a psychosis appeared', he wrote, 'it was clear that there was a strong homosexual element present in their minds before the onset of the virilism'. Removing the adrenal gland was found to be of benefit not only for their psychosis, but also for their sexual impulse.[93] Endocrinological explanations were also upheld by Dr Kenneth Walker, who had long been engaged in surgical treatments of genito-urinary conditions and had explored the potential of glandular grafts back in the 1920s. The 1939 edition of his textbook, co-authored with Eric Strauss, maintained that '[o]nly if the endocrine system of the individual is properly balanced can normal sexual desires arise', and that hormonal balance, along with environmental and psychological factors, contributed to the nature and strength of sexual impulses.[94]

Walker also had faith in the existence of the male 'critical age' during which 'temporary endocrine imbalance' could occur. This was an idea enjoying a resurgence of popularity in the 1930s, as Chandak Sengoopta has argued.[95] In Walker's view, it 'accounts for many of the so-called "park offences", which so often result in eminent and elderly gentlemen being charged with indecent behaviour in a public place'. A crime of this type, he went on to explain, 'suddenly occurring in a respectable man of sixty, is no more vicious in origin than is the absurd infatuation often shown by a woman in her forties for a youth of half her age. Both are the result of a transient neuro-endocrine

[93] Allen, 'Virilism with Mental Symptoms'.
[94] Walker and Strauss, *Sexual Disorders in the Male*, p.4, p.21.
[95] Sengoopta, *The Most Secret Quintessence of Life*, pp.177-186.

maladjustment'.[96] Dr Roberts' suggestion that troublesome hormonal imbalance could be triggered by an enlarged prostate gland was also reiterated and endorsed in the case of the elderly. 'Prostatic enlargement', stated Michael Dillon, 'in old age produces an increased sexual desire and a hitherto decent married man may go off suddenly with a chorus girl or be found guilty of indecent exposure or assault'.[97] 'When practising at the Bar', Bradford magistrate Coddington agreed, 'I saw many elderly men sent to substantial terms of imprisonment for “gross indecency”, the vast majority of whom were suffering from enlarged prostate'.[98] Presumably, as Roberts had suggested, simple surgery was the ready answer.

Despite the fact that others including Neustatter argued that the root cause of sexual abnormality might in some instances be a 'fundamental glandular disturbance',[99] there was little interest in England in other endocrinological methods of altering the nature of the sexual impulses of offenders. Instead, endocrinology's most significant contribution lay in the power of hormonal injections to remove sexual impulse entirely. This shift from alteration or correction to suppression may have been inspired by research from the USA. There, the use of testosterone by injection had been tested in the treatment of homosexuality in men in the very early 1940s but was found to be unsuccessful, whereas androgens appeared to reduce libido.[100] The first published research into this in England emerged from the Burden Neurological Institute in Bristol, where doctors had been treating the growth disorder acromegaly with large doses of synthetic oestrogen. After observing that one of the side effects amongst male patients

[96] Walker and Strauss, *Sexual Disorders in the Male*, p.28.
[97] Michael Dillon, *Self: A Study in Ethics and Endocrinology* (London: William Heinemann Medical Books, 1946), p.29. Dillon was a medical student at the time of writing, and was reportedly the first person in Britain to undergo phaloplasty.
[98] 'Psychological Treatment of Crime, 1921-41', The National Archives (London), HO 45/18736.
[99] Neustatter, *Psychological Disorder and Crime*, p.147.
[100] Sengoopta, *The Most Secret Quintessence of Life*, pp.188-189; Andrew Hodges, *Alan Turing: The Enigma* (London: Vintage, 1992), pp.469-470.

was a 'complete absence of sexual feeling', Dr R. Sessions Hodge tested this same treatment on 15 sexual offenders in the late 1940s.[101] Most famously, perhaps, mathematician and celebrated wartime code-breaker Alan Turing was prescribed this 'organo-therapy' as an out-patient of the Manchester Royal Infirmary in 1952.[102]

It is worth reiterating here that despite some enthusiasm for what came to be known as chemical castration, permanent castration or sterilisation was not seriously entertained in England as a medical solution to sexual crime.[103] The view that sexual desire existed independently of potency and even opportunity lay behind much of the resistance towards sterilising or surgically castrating sexual offenders in England. Walker and Strauss maintained that these interventions did not necessarily have an impact on desire, as did Norwood East, and medical reaction to policies of castration elsewhere was, with a few exceptions, muted at best.[104] The correspondence pages of the *BMJ* occasionally featured suggestions along such lines, but responses tended to insist that this was not a proven solution. The idea of surgical castration therefore generated little support. Given its irreversible nature, modest interest in the castration of sexual offenders overseas was always tempered with distinct unease at the prospect of anything similar on home turf. An editorial in 1955 concluded that in 'Britain there are

[101] Golla and Sessions Hodge, 'Hormone Treatment of the Sexual Offender'; R. Sessions Hodge, 'Medico-Legal Aspects of the Treatment of the Sexual Offender, with Discussion of a Method of Treatment by Gland Extracts', *Medico-Legal Journal,* 18 (1950), 130-144.
[102] Hodges, *Alan Turing*, p.xxiii.
[103] This is not to say that it was never performed. Three such examples from the Poor Law Hospital in Gateshead are cited in Bourke, *Rape*, p.147. Rather, as was the case in Gateshead, such procedures were controversial, infrequent, and only rarely proposed as a wholesale solution. The only reference I have found to such a procedure is from the late 1930s, when Dr Eurich in Bradford treated one elderly man guilty of offences against small children by sterilising him with X-rays. 'Correspondence with Dr Coddington, Bradford Stipendiary magistrate', The National Archives (London), HO 45/18736, File 438456/37.
[104] Walker and Strauss, *Sexual Disorders in the Male*, p.5; 'The Court and the Sexual Offender', p.1459; William Norwood East, 'Memorandum to the Board of Control on Sterilization of Mental Defectives', The National Archives (London), PCOM 9/123; Golla and Sessions Hodge, 'Hormone Treatment of the Sexual Offender'.

probably few advocates for the castration of sex offenders', and that current preference inclined instead towards longer sentences, perhaps with hormone therapy.[105]

It is significant, perhaps, that surgical castration was commonly undertaken in the same locations that made use of indeterminate sentences for the delivery of psychiatric treatment to offenders, particularly Scandinavia and some states of the USA. Indeterminate sentences in general were strongly resisted in England, where a long tradition of fixed maximum penalties prevailed. Provision for something approaching indeterminate sentencing for habitual criminals had been introduced in 1908 in the form of preventive detention, but even then the indeterminate part of a sentence could not exceed ten years; in practice it was rarely used and was abolished in 1948.[106] The use of indeterminate sentences has been seen as part and parcel of the focus on rehabilitation during this period, allowing for greater discretionary powers to tailor responses to crime to the individual.[107] In England, though, whether regarding sentence or surgery, treatment in the name of rehabilitation could go so far but no further.

Surgery on the brain for the sexual offender, by contrast, was beginning to appear by the 1950s. Brain disease had been seen as a possible cause of sexual misconduct, particularly when it occurred in old age. 'When an elderly married man of good character with grown-up children of his own assaults juveniles of either sex', wrote psychiatrist Humphrey Osmond in 1951, 'the chances are that change of personality due to organic disease of the brain, probably arteriosclerosis, caused the crime'. A 'certain amount of arterial disease of the brain' was credited as the cause of a 69-year-old man's

[105] Harold Burrows, 'Homosexuality', *British Medical Journal,* 1 (1946), 368; Osmond *et al.*, 'Penalties for Sexual Offences', p.673; 'Castration of Sex Offenders', *British Medical Journal,* 1 (1955), 897-898.
[106] This is described in Roland Burrows, 'Criminal Law and Procedure', *The Law Quarterly Review,* 51 (1935), 36-57 (p.54).
[107] Rothman, *Conscience and Convenience*.

obscene letter-writing in 1924, which had demanded nursing-home care rather than imprisonment.[108] Neustatter agreed with this, confirming that exhibitionism often 'occurs in elderly men in association with hardening of the arteries of the brain'.[109] However, psycho-surgery was based upon a different assumption: that the balance of brain function was disturbed and that the destruction of some parts of the brain could remove violent impulses.[110] Such treatments as this and ECT may have been used as a treatment for sexual deviance only rarely in England during this period, but it was certainly not unheard of. A man with what was described as epilepsy with fetishism was treated in the 1950s with psychotherapy at first, and then with a 'left lateral craniotomy' which reportedly resolved his ills completely.[111] April Ashley, raised as a boy, received extensive treatment in the Ormskirk Mental Hospital in the 1950s including 'a course of male hormones' and 'Electro-Convulsive Therapy', and Harry Howard, an extremely violent and persistent sexual offender, was lobotomised while under prison sentence in the late 1940s.[112]

A rather different programme of treatment was adopted in the later 1950s in the form of aversion therapy, or behavioural conditioning. This attempted to use physical stimulation to alter psychological processes. Originally developed for the treatment of alcoholism, it operated by combining deeply unpleasant physical sensations with the unacceptable objects of sexual interest in order to 'condition' the patient to reject his undesirable sexual impulses. The Maudsley was reportedly engaged

[108] 'Obscene Libel Charge', *The Times,* 28 March 1924, p.11.
[109] Osmond *et al.*, 'Penalties for Sexual Offences', p.672. Osmond would go on to achieve fame for his work exploring medicinal uses of psychedelic drugs. Neustatter, *Psychological Disorder and Crime*, p.153.
[110] This was particularly popular in the USA, where it seems to have been used much more extensively in the treatment of offenders against boys, and enjoyed a resurgence in the 1970s as well. See Bourke, *Rape*, pp.167-170.
[111] Mitchell *et al.*, 'Epilepsy with Fetishism Relieved by Temporal Lobectomy', p.629.
[112] Duncan Fallowell and April Ashley, *April Ashley's Odyssey* (London: Arena, 1983); Ronald Lloyd and Stanley Williamson, *Born to Trouble: Portrait of a Psychopath* (Plymouth: Cassirer, 1968) pp.144-145.

in researching 'conditionability' in the mid-1950s, but one of the first case studies emerged from St George's Hospital in 1956. In it, Dr Michael Raymond described a typical procedure: a patient with 'erotic fetishism' was injected with a drug to induce vomiting, and then presented with the objects with which he was obsessed. 'The treatment was given two-hourly, day and night, no food was allowed, and at night amphetamine was used to keep him awake' for a week at a time, the study reported. Notably, it was hoped that this approach might use the cause of the patient's fetish in its cure, based upon the theory that the fetishist was born with 'an unusual capacity to form conditioned responses'. An innate capacity to respond quickly to conditioning, the researchers speculated, could become an advantage to the doctor using the same method to reverse the process. What had once been induced through positive associations could in theory be removed with negative ones.[113]

Many patients certainly retained negative associations, albeit not those the doctors had sought to achieve. This is conveyed extremely strongly in the memories of treatment in recently collected accounts. One individual likened aversion therapy to a 'barbaric torture scene by the Gestapo in Nazi Germany trying to extract information from me – I thought I was going to die'.[114] Another recalled the 'excruciating pain of the initial shock; nothing could have prepared me for it'.[115] A young Pete Price, who had volunteered for treatment for homosexuality under pressure from his mother, remembered days of endless 'injections, the vomiting and excrement; drink, injections, vomiting, excrement – hour after hour after hour', without food or sleep.[116] Although

[113] M. J. Raymond, 'Case of Fetishism Treated by Aversion Therapy', *British Medical Journal,* 2 (1956), 854-857; see also Cyril M. Franks, 'Case of Fetishism Treated by Aversion Therapy', *British Medical Journal,* 2 (1956), 1174.
[114] Dickinson *et al.*, '"Queer" Treatments', p.1349.
[115] Dickinson *et al.*, '"Queer" Treatments', p.1349.
[116] Pete Price and Adrian Butler, *Pete Price: Namedropper* (Liverpool: Trinity Mirror NW, 2007) pp.85-86.

these are the reflections of a small and specific group, treated for homosexuality and willing to discuss their experiences some fifty years later, they offer some insight into how such treatment has been remembered. Psychotherapy and psychoanalysis tended to provoke less visceral reactions, although their practitioners were also sometimes viewed with hostility.[117]

While psychiatrists agreed that aversion therapy and hormone treatments could make a useful contribution to the treatment of sexual offenders, many psychiatrists maintained that they should be considered a 'last resort' and an adjunct to psychotherapy only. Psychoanalysis, one doctor argued, had not only already 'helped us to arrive at a comparatively profound understanding of the aetiology and symbolism of fetishism but has also evolved a technique of treatment that can usually be relied on to achieve a partial or complete "cure"'.[118] Alan Turing underwent psychoanalysis alongside hormone injections, and witnesses to the Wolfenden Committee emphasised that the use of oestrogens was no permanent remedy.[119] However, although early proponents of aversion therapies had acknowledged the role of earlier psychotherapy or psychoanalysis in helping to understand sexual offending, later reports of aversion treatments did not mention psychotherapy at all.[120]

The variety of treatments to which some offenders were subjected in the 1950s might demonstrate an unbridled enthusiasm for new technologies, or perhaps a hint of

[117] Weeks and Porter, *Between the Acts*, p.85.
[118] John W. Fisher, 'Correspondence: Fetishism Treated by Aversion Therapy', *British Medical Journal,* 2 (1956), 1302 (p.1301).
[119] Hodges, *Alan Turing*, p. xxiii; evidence of Sessions Hodge and Pearce on 31 October 1955, in 'Transcripts of evidence hearings: Committee on Homosexual Offences and Prostitution', The National Archives (London), HO 345/14.
[120] Raymond, 'Case of Fetishism Treated by Aversion Therapy', p.855; M. J. Raymond, 'Aversion Therapy for Sexual Deviation', *British Journal of Psychiatry,* 115 (1969), 979-980; Basil James, 'Case of Homosexuality Treated by Aversion Therapy', *British Medical Journal,* 1 (1962), 768-770.

desperation in the face of sexual offenders who appeared utterly unresponsive to attempt after attempt to alter their behaviour. The logic behind a broad-brush approach was rarely spelled out, but since the causes of sexual deviance remained uncertain, presumably different types of treatment could be attempted in the hope of eventually discovering the right one for each individual. Where facilities permitted in mental hospitals, doctors could begin with psychotherapy, with or without drugs, and, if this was unsuccessful, progress to insulin, lobotomies, ECT, and aversion methods. Harry Mills had been in and out of prisons and hospitals throughout his adult life without any apparent effect. He recalled that, since his first conviction in 1942, 'I think I've had every possible treatment that there is: imprisonment, drugs, aversion therapy, group therapy, psycho-therapy – whatever you can think of, you name it and I've had it'.[121] Perhaps each new treatment offered Mills and his doctors a brief revival of therapeutic optimism.

There are signs that hormones and other drugs were used more freely from the end of the 1950s onwards. Hormone treatment had been attempted perhaps once or twice within prisons in the early 1950s, but had then been prohibited by the Home Office.[122] In 1958, the Prison Commissioners reported that the 'use of oestrogens' had been authorised once again 'in the treatment of selected sexual cases... following the recommendation of the Wolfenden Committee'.[123] Ritalin and tranquillisers were also reported as useful elements of the prison doctor's armoury, reflecting the remarkable growth in pharmacological medicine which has been well documented elsewhere.[124]

---

[121] Harry Mills in Parker, *The Twisting Lane*, p.154.

[122] Its use was reported in Wildeblood, *Against the Law*, pp.144-145, and confirmed in *Report of Prisons for 1954*, p.138. The prohibition was confirmed by Dr Snell of the prison medical service in a meeting on 1 November 1955, 'Transcripts of evidence hearings: Committee on Homosexual Offences and Prostitution', The National Archives (London), HO 345/14.

[123] *Report of Prisons for 1958*, p.105.

[124] Edward Shorter, *A History of Psychiatry: From the Era of the Asylum to the Age of Prozac* (New York; Chichester: Wiley, 1997); Joanna Moncrieff, *The Myth of the Chemical Cure: A Critique of Psychiatric Drug Treatment* (London: Palgrave Macmillan, 2009).

However, there was reportedly a growing reluctance on the part of sexual offenders to participate in treatment. From Wakefield Prison, the medical officer reported in 1960 that 'an effort is made to see that all morbid sex and other pathological cases are treated if they are treatable, but the number of favourable cases is dropping... it is now somewhat uncommon to find a man who has a real eagerness to be changed'.[125] Whether innovations in physical treatment were rendering it increasingly unappealing, or changing attitudes towards some sexual offences were reducing the numbers of prisoners willing to entertain the notion that they were ill, or whether doctors were becoming more suspicious – or discerning – about potential patients, earlier enthusiasm and optimism regarding the treatment of sexual offenders were on the wane.

## Conclusion

Psychiatrists did not establish one single explanation for the causes of sexual crime; nor, it seems, did they want to. Although, as shown in Chapter 3, sexual offences were frequently singled out, this was not an entirely satisfactory grouping from the medical perspective. There could be many possible causes, acting alone or in combination, for any single act, and addressing any one offender's situation required a study of innate, circumstantial, and psychological factors. Even physiological disease might have a role to play. This profusion of explanations meant that treatments did not structure medical views of what constituted disorder, as has been suggested in relation to mental illness more generally.[126] Rather, the need to explain such a wide range of behaviour, amongst so many different people and in so many different circumstances, ensured that psychiatric theories and treatments both remained diverse. In this wide-ranging aetiology of sexual crime, psychiatry was united. Medical flexibility also allowed

[125] *Report of the Commissioners of Prisons for the Year 1960* (London: H. M. Stationery Office, 1960) p.74.
[126] Braslow, *Mental Ills and Bodily Cures*, p.43.

interpretations to go beyond the potential limitations of pathologisation. As various clinicians and historians have observed, the adoption of mental illness as an explanation for criminal acts, from military desertion to murder, offers the possibility of redemption alongside cure: it allows individuals to be absolved of their sins and returned to society without becoming permanently defined or excluded by their crimes. At the same time, the focus often remains entirely upon the individual, whose difficulties or crimes are personal and unique and bear no relationship to wider social problems.[127] In the case of finding a cure for sexual deviance, however, these restrictions were not always satisfactory. By identifying myriad diagnostic considerations and possible combinations of cause, doctors retained a medical model of sexual perversion that was broad enough to allow for some social considerations, the fully redeemable case, and the incurable pervert as well.

Peter Wildeblood skilfully reflected the eclecticism of medical thought in his presentation of his own homosexuality. He firstly offered a psychoanalytically inflected explanation of childhood sexual development in which 'the normal pattern' can be 'arrested or reversed', meaning that the 'man remains as the child was, failing to discriminate between the sexes; or he develops in the abnormal direction of being attracted only towards his own sex'.[128] He then touched upon events and circumstances from his own life, wondering whether the fact that his mother 'was many years younger' than his father 'was one of the factors which influenced my later development'. He was critical of the single-sex educational environment, reflecting the idea that 'strong sexual

[127] See Shulamit Ramon, *Psychiatry in Britain: Meaning and Policy* (London: Croom Helm, 1985), especially pp.61-62; Elizabeth Fee, 'Psychology, Sexuality, and Social Control in Victorian England', *Social Science Quarterly,* 58 (1978), 632-646 (pp.642-643). Lisa Downing has written about the identification of an exceptional 'essence', whether of evil or of illness, within some criminals as a process of 'individualization and normalization' of their crimes that makes social or political analysis impossible. Downing, *The Subject of Murder: Gender, Exceptionality, and the Modern Killer*.

[128] Wildeblood, *Against the Law*, p.10.

feelings which not only have no possible physical outlet, but no objective to which they may be directed' might lead to sexual abnormality.[129] At the same time, he stated that 'I must always have known that I was different from other children', as though it had been present in him from birth.[130] This plurality was not only useful for campaigners. As the next section will show, it provided some justification for the variety of outcomes that medical approaches to sexual crime could achieve, within legal and clinical settings alike.

[129] Wildeblood, *Against the Law*, p.14, p.22.
[130] Wildeblood, *Against the Law*, p.16.

# Part Two: Medicine in Practice

# Chapter 5: Working with(in) the law

In the summer of 1920, a 39-year-old cotton merchant from New York found himself in trouble during a holiday in Eastbourne. A housemaid and a girl of 14 had both accused Frank Prestwick of indecent exposure at Beachy Head, and their evidence appeared compelling. In his defence, it was said that his worries about his wife's illness and personal financial difficulties had 'caused him to lose control of himself', but the court was unconvinced and sentenced him to imprisonment.[1] A few years later, a Gloucestershire vicar found himself in a similar predicament after a day trip to London ended in ignominy in Trafalgar Square. The defence drew attention to the fact that he had taken 'a little drink' and insufficient food, but bolstered the claim that this had been an unprecedented and fleeting loss of control by introducing a medical witness, Dr R. G. Chase, 'who had known the accused for three years' and could testify that 'his mental condition was unstable'. Eminent Gloucestershire men stepped into the dock to agree that their vicar had a previously spotless reputation, but had seemed 'not quite normal' in recent times. The court released the vicar, technically on remand but with a sympathetic statement that his further attendance would not be enforced.[2] By the mid-1950s, an expert from Harley Street might be welcomed to discuss a defendant's childhood and 'urge for exhibitionism' in one courtroom, while in another the issue of mental abnormality went unmentioned.[3] Medical involvement, and its impact, remained unpredictable.

[1] 'Misbehaviour at Beachy Head', *The Times,* 28 August 1920, p.7.
[2] 'Country Vicar's Lapse', *The Times,* 19 January 1922, p.7.
[3] 'General Messervy Bound Over'; and, by contrast, 'Ex-schoolmaster Sent to Gaol', *Yorkshire Post and Leeds Mercury,* 25 March 1955, p.4.

Such cases illustrate how some of the ideas about sexual crime that have been explored in the foregoing chapters came to be used in practice. Issues that had little to do with medicine, and much more to do with legal and penal practices, shaped the presence, absence, and content of medical opinion relating to sexual offenders. The first section of this chapter will examine procedural issues, including conceptual and statutory changes that took place over the period in question. It will suggest that these changes made considerable space for doctors to inform the courts about mental disorder in cases of sexual crime, and that medical approaches became firmly established within the legal system. However, their application was far from uniform. As the second section goes on to explore, the presence and absence of medical evidence could be shaped by the status of the defendant and his access to legal advice, his medical history and conduct in court, the nature of the offence, and the strategy of his legal representatives. Access to medical and legal expertise became more widespread from the late 1940s, but there remained many situations in which medical evidence was not thought useful or relevant to legal proceedings. Finally, by examining the content and contrasts within medical testimony, this chapter will assess the extent to which medical evidence was shaped by legal requirements, and damaged by the adversarial legal system.

The efforts of doctors to introduce medical approaches to sexual offenders was not simply a struggle to overcome resistance from within the legal profession to medical innovation. 'Although it is traditionally alleged that the law has been materially and profoundly shaped by the expanding “medicalization” of deviance', Joel Eigen has written, 'the relations between medicine and law may in fact be much more nearly reciprocal'.[4] This is very much in evidence here. Legal procedures did adapt to accommodate medical theories, but so too did medical evidence respond to the

[4] Eigen, *Witnessing Insanity*, pp.46-7.

requirements of the courts. The happy marriage of legal and medical thought depended upon a combination of willing judges and convincing arguments for the defence, the availability of medical witnesses and practical solutions for treatment, and some agreement as to when sexual offenders required special management. In providing an indication of the practical impact of the medical theories discussed in Part One, this chapter reinforces several key arguments. It demonstrates that the mid-twentieth century was extremely important for the dissemination of medical approaches to sexual deviance, broadly defined, and that medical engagement was characterised by flexibility and responsiveness, reflecting and reacting to the needs of the judiciary as well as widely held beliefs about sexual behaviour.

The conclusions of this chapter are extremely tentative due to the considerable limitations created by the available sources. Doctors could be called to examine those accused of sexual offences at the time of arrest, by the magistrate or judge at any stage, by defence counsel, or by the prosecution. Unless medical opinion was significant for the trial or sentencing, however, copies of medical reports were not usually retained and their content was not discussed.[5] All prisoners were examined by a doctor and, as described in Chapter 3, if they were accused of a sexual crime, this examination was extended to pay particular attention to mental state. By the late 1940s, prison doctors were still responsible for about 58% of all medical evidence produced in prosecutions for sexual crimes, but these reports were not usually kept.[6] The few surviving medical reports are extremely difficult to access. In recent years, new legislation designed to preserve the anonymity of the victims of sexual crime has meant that many of the

[5] This problem had already been identified in the 1950s, when an attempt to conduct research into the management of sexual offenders revealed that medical evidence was often given orally only, while in other cases 'the medical reports could not be traced or had been destroyed'. Radzinowicz, *Sexual Offences*, p.72.
[6] Radzinowicz, *Sexual Offences*, p.72.

records of the Director of Public Prosecutions, the police, and the Prison Commission, which were formerly accessible, have been closed. Files containing medical information about living persons are also usually closed, and court records are incomplete. Sources are therefore limited to those very few surviving papers regarding criminal proceedings in which the crime has not been classed as sexual in nature, a victim has not been identified, those named are believed to have died, or files which have otherwise escaped notice.[7] This chapter therefore relies upon fragmentary records, complemented by newspaper reports of proceedings that were for some reason newsworthy. Detailed analysis of the kind produced recently for different geographical and temporal contexts is not yet possible.[8] Although what follows is limited and based upon incomplete evidence, it offers some provisional conclusions about the impact and uses of changing medical thought.

### 5.1 Developments in legal procedure

An important conceptual change took place within the judiciary around the end of the First World War. As discussed in Chapter 2, prison doctors drew attention to the growing frequency with which they provided the courts with reports regarding a prisoner's state of mind. This was not simply because court personnel had become more alert to possible mental disorder. Rather, their perception of the extent to which mental imbalance could be taken into account had shifted. Judges began to permit and even solicit medical reports after a guilty plea, when insanity in its legal sense was not under consideration. Non-specific forms of mental disorder, insufficient to lead to certification, were

[7] Some of these files do not appear to have been identified as containing personal information about a victim of sexual crime. Others were open in the recent past, but have since been closed. In keeping with the spirit of contemporary legislation, I have not used the names of any complainants.

[8] These include Bergenheim, 'Sexual Assault, Irresistible Impulses, and Forensic Psychiatry in Sweden'; Bates, '"Not an Exact Science"', especially Part Two.

acknowledged as influential in sentencing decisions, as was the case for the Gloucestershire vicar mentioned above.[9] Physical and mental illness might be combined to create an impression of generalised weakness, as occurred in 1924 when a doctor gave evidence that Herbert Gosnell had both 'a certain amount of arterial disease of the brain' and 'some affection of the nervous system as well'. The judge concluded that the crime had been caused by Gosnell's 'mental and bodily condition', and bound him over.[10] In neither of these cases was the sanity of the accused in doubt, but medical opinion was used to justify non-custodial responses.

This was undoubtedly given impetus by the appearance of soldiers with shell shock and other disabilities attributed to wartime service. As Peter Barham has argued, many soldiers were acknowledged to be mentally unwell but were carefully protected from the prognostic doom of certification as insane.[11] Their mental state was accepted as a factor in their altered conduct and capabilities, but did not necessarily constitute insanity or require certification and hospitalisation. In some legal proceedings, wartime disabilities were explicitly acknowledged. A former captain was indicted for 'an act of indecency with a boy' in 1920, and his lawyer stated that his client had been 'blown up at Vimy Ridge, and suggested that his mind was affected at the time of the alleged attack. He was suffering from dissociated memory'. Although the judge would not go so far as to allow into evidence a supporting statement from the defendant produced under hypnosis, he did accept this defence and acquitted the former captain of the crime, noting that his 'condition was due to what he had passed through during the War'.[12] Speaking in defence of a former lieutenant, counsel suggested that not only the head

[9] 'Country Vicar's Lapse'.
[10] 'Obscene Libel Charge'.
[11] Barham, *Forgotten Lunatics of the Great War*, p.41, p.87.
[12] 'Former Captain's Defence', *The Times,* 30 June 1920, p.13, and 'Former Captain's Acquittal', *The Times,* 1 July 1920, p.13.

injuries sustained by the defendant in a motor accident but also 'his war service at an early age' may have led to the 'abnormal state of mind' which had prompted his many indecent offences.[13]

In such cases, judges might justify their decisions to acquit or discharge the accused by attributing sexual crime to the presence of an illness. It was often implied or explicitly promised that the accused would immediately submit himself to appropriate medical care. After hearing a guilty plea to five charges of indecent assault in 1926, a judge agreed with the evidence of eminent London physician Dr Bruce-Porter that the cause of the crime was the defendant's nervous exhaustion and general debility. Dr Bruce-Porter testified that, with treatment, his patient 'should approach normality by three months' and the judge 'had no other conclusion to come to, but to assent to the prisoner being medically treated'. The accused was bound over and discharged into the care of his friends, on the understanding that treatment could then be pursued.[14] A commercial traveller from Sheffield pleaded guilty to a charge of indecent exposure in 1939, and, after the testimony of Dr A. B. Davies, the magistrates again decided to bind him over and 'expressed the hope' that he would 'benefit from treatment'.[15] Whether any such treatment was, in fact, received went unexamined.

Outcomes such as these may have been relatively rare, and the courts did not always demonstrate a willingness to permit or even encourage medical treatment rather than conventional punishment. In a 1927 trial for gross indecency, the defence argued

[13] 'Back to Mental Home', *The Burnley News,* 8 May 1929, p.7.
[14] Report from Vine Street Police Station dated 28 November 1926, in 'Indecent assaults on chambermaids in Regents Palace Hotel', The National Archives (London), MEPO 3/397.
[15] 'Accused Sheffield Man "Frantic with Distress"', *Sheffield Telegraph and Independent,* 19 August 1939, p.11. Another example can be found in 'The Hartlepools Day by Day', *Northern Daily Mail,* 8 November 1948, p.4.

that the accused 'was suffering from a disease and submitted that the most suitable place for him was in a home, not a prison'. After presenting no fewer than four medical witnesses in support, the defence barrister offered for the accused to repair to a medical institution for a period of two years. 'His Lordship agreed with Learned Counsel's remarks that it was more a medical than a criminal matter', a Metropolitan Police memo recorded, but the judge felt that 'he was obliged' to impose imprisonment nonetheless.[16] In a similar case in Lincolnshire, the judge 'recognised that the case was a mental one', but felt that the defendant 'must pay the penalty provided by the law' and go to prison rather than a hospital.[17] In another from 1934, in which the accused had caned his sexual partner and been charged with assault, a 'doctor gave evidence that the caning was a form of sexual perversion and it was stated that a Harley Street neurologist had said he could cure the man'. However, medical cure was not an option as far as the judge was concerned. He preferred a sentence of 18 months' imprisonment.[18] Even those sympathetic to medical interpretations might feel that punishment was still the only possible remedy.

Expert evidence from doctors was sometimes actively ignored or criticised outright by the judiciary. On this basis, some doctors complained that the courts were wilfully ignorant of the latest advances in medical science, or even that psychiatric witnesses were treated with 'gross contempt and discourtesy'.[19] In 1924, a Dr J. A. Bell testified that a young man charged with attempted gross indecency was 'mentally deficient, amounting to imbecility. He required care, supervision, and control'. The judge

[16] Memorandum from Inspector to Superintendent of the Metropolitan Police dated 27 May 1927, in 'Gross indecency with boys: conviction of an Indian Army Major (retired)', The National Archives (London), MEPO 3/404.
[17] 'Prison for a North Lincs Vicar', *Hull Daily Mail,* 9 November 1926, p.9.
[18] Editorial in *The Penal Reformer*, vol.1, issue 1, July 1934, p.4. A copy of this can be found in the Archives of the Howard League, Modern Records Centre (Warwick), MSS.16B/4/3/1.
[19] Glover, *The Roots of Crime*, p.31.

disagreed. 'It was the old story of mental deficiency after an offence had been committed', complained His Lordship, who concluded after questioning the young man in the dock that he 'could not call the prisoner mentally defective'.[20] To illustrate the seemingly capricious nature of legal decisions, Drs Henderson and Gillespie gave two contrasting case studies in their leading textbook on psychiatry, both of which related to sexual offenders. In one, the medical examiner had found both a 'disordered mental state' and physical signs of syphilis, while in the second the defendant 'did not show any abnormal emotional state' or other signs of illness. The first prisoner was fined, while the second was certified as insane and hospitalised.[21] Reactions to medical evidence could be surprising in their hostility or inconsistency.

Without a larger number of cases to draw upon, it is impossible to say whether such reactions and decisions amongst the judiciary were influenced by the perceived gravity of each offence, the nature of the medical evidence, the personality or history of the defendant, or simply the particular views of individual judges. The personalities of those involved and their presentation could be just as important as the content of a medical report. As Joel Eigen has observed, any trial might have played out very differently with even a slight adjustment to the cast of characters.[22] Prison doctor Hugh Grierson, for example, was said to have been on friendly terms with many eminent judges, which may have equipped him rather better than others to negotiate the discrepancies between legal practice and medical theory, and to withstand cross-examination.[23] Others seem to have struggled with the environment of the court. Dr Hubert's presentation of his evidence during the trial of Neville Heath was later

[20] 'Judge Differs from Doctor', *Gloucestershire Echo,* 7 June 1924, p.6.
[21] Henderson and Gillespie, *A Text-Book of Psychiatry for Students and Practitioners*, 3rd edn, pp.569-570.
[22] Eigen, *Witnessing Insanity*, p.55.
[23] 'H. A. Grierson, O.B.E., M.C., M.B. B.S.', *British Medical Journal,* 1 (1966), 1428.

described by his instructing barrister as 'quite ghastly'. Although a variety of explanations have been posited for this, he was undoubtedly much less experienced as an expert witness than the doctors called by the prosecution.[24] In 1947, another doctor found himself in an awkward position in open court. Dr Caudwell of Lincoln Prison was reportedly 'rebuked by Mr Justice Croom-Johnson at the Notts. Assizes… for boggling about reading a passage from his medical report' during the trial for an unspecified indecency. The passage in question addressed the defendant's lack of 'appreciation of the nature of sex' and 'habit of discussing his sexual activities without shame'.[25] Perhaps the doctor did not share his patient's readiness to discuss sexual matters amongst strangers, and the judge was evidently irritated by his reluctance to speak frankly. Such upsets might transform the reception of medical evidence before its content was even considered.

Procedure as well as personality had an impact upon the role of medical opinion. One important consideration may have been the lack of clear authority for a judge to make and enforce an order for medical treatment. To certify the accused as insane was the only clear-cut route to compel treatment, although some judges do appear to have used imprisonment with enforced treatment in mind.[26] Before the Criminal Justice Act of 1948, judges seeking a medical solution could either hope that an offender would keep to their word and obtain treatment if they were released, or use

[24] J. D. Casswell, *A Lance for Liberty* (London: George G. Harrap, 1961), pp.252-253. Hubert's poor performance has been attributed to a traffic accident on his way to the court, a rumoured drug habit, and his own mental illness: Byrne, *Borstal Boy*, p.103; Francis Selwyn, *Rotten to the Core? The Life and Death of Neville Heath* (London: Routledge, 1988), p.209; Casswell, *A Lance for Liberty*, pp.251-254.

[25] 'Remitted from Lincoln: Youth Committed to Institution', *Nottingham Evening Post,* 18 June 1947, p.1.

[26] As prison doctors frequently complained, judges sometimes despatched offenders to prison in order to receive medical treatment. See, for example, 'Indecency with Boys', *The Times,* 11 November 1953, p.11. See also Chapter 6 of this thesis for further discussion of treatment options inside and outside prison.

the broad-brush language of the 1907 Probation Act to introduce an element of enforcement. Hamblin Smith had noted as early as 1924 that in a small number of cases within his study of sexual offenders, the court had agreed 'to place the man on probation, with the condition in some instances that he should receive proper mental treatment'. Passing references elsewhere suggest that this was not unique.[27] However, before 1948 it was rare, and seen as entirely unfeasible by some judges. At the Devon Assizes in 1926, the magistrates stated that a 17-year-old defendant found guilty of a nameless offence 'was not wholly responsible for his actions' and 'should be sent to an institution', but this 'seemed impossible' to them, presumably because he was not certifiable as insane or mentally defective. Instead, the magistrates decided that 'the best way to protect himself and others appeared to be to send him to prison for a longer term' than others convicted of the same offence.[28] Evidently, a direction for treatment while on probation was not perceived as an option.

Statutory provisions for psychiatric treatment as a condition of probation were explored in the late 1930s, as part of the unsuccessful Criminal Justice Bill of 1938. Perhaps in light of this, the *BMJ* reported one such situation, mentioned in the *Leeds Mercury* in that same year. 'Wakefield magistrates recently made a probation order in the case of a young man charged with a sexual offence', the editorial advised, 'containing a condition that he should enter a certain mental hospital for six months as a voluntary patient'.[29] This was carefully characterised as a 'legal experiment', and the voluntary aspect was emphasised. In theory, a failure to attend hospital or comply with

[27] Hamblin Smith, 'The Mental Conditions Found in Certain Sexual Offenders', p.645. Further examples of psychiatric treatment for offenders on probation before 1948 can be found in Allen, *The Sexual Perversions and Abnormalities*, p.121; Parker, *The Twisting Lane*, p.158 (from 1942); and 'Appellant to Continue Medical Treatment', *The Times,* 24 February 1942, p.6.
[28] 'Devon Assize: Judge on Unnatural and Sexual Offences', *Devon and Exeter Gazette,* 5 November 1926, p.12.
[29] 'Probation at Mental Hospital'.

treatment constituted a breach of probation and could lead to imprisonment, both before and after the 1948 Act. At the same time, offenders retained their right to refuse treatment if such a refusal appeared 'reasonable in all the circumstances'.[30] In practice, it is not clear that the medical, legal, and probationary services were sufficiently well co-ordinated to monitor patient-probationers very closely at all. Realistically, the patient's ready co-operation and willingness to attend hospitals or clinics were essential.

A wider use of probation for sexual offences in particular, with or without a formal order for psychiatric treatment, was not always welcomed. One magistrate insisted in 1925, when sentencing a man of 'excellent character and reputation' to three months' imprisonment for an unspecified act of indecency, that although some people thought this should be handled with probation, 'one has to consider the possible effect of such disgusting conduct on others, and women and girls must be protected'. A probation order would, in his view, be 'ridiculous and impossible'.[31] A gardener with a history of indecent assaults who acquired a fresh conviction in 1924 had been under careful observation, and the Bench concluded that he was a 'pest'. They felt they could do nothing other than send him to prison.[32] For those whose sexual misconduct was felt to cause distress or harm to others, imprisonment was often thought necessary as a means of protecting potential victims.

---

[30] 'Editorial', *British Journal of Delinquency,* 2 (1951), 1-4 (p.2). The executive committee of the Howard League originally passed a resolution to oppose 'the coupling of treatment as an inmate of a mental home with probation', and was anxious about a probationer's ability to refuse, for example, operations on the brain. Eventually their concerns were assuaged with assurances that treatment could always be refused. See minutes of meetings of 28 November and 5 December 1938, in Modern Records Centre (Warwick), MSS.16B/1/3, and minutes of meeting of 14 November 1947, in MSS.16B/1/5.

[31] 'Punishment of Crime'. If any medical evidence was presented in this case, it was not mentioned.

[32] '"Pest" Sent to Prison', *The Newsman,* 26 July 1924, p.3.

Research undertaken in the early 1950s by criminologist Leon Radzinowicz attempted to gather detailed data about sexual offences from 14 districts of England and Wales. This found that a conviction for a sexual offence still resulted in imprisonment in a quarter of all cases, and that there were 'broadly speaking, six categories of sexual offenders who are more often than not sent to prison'. These were the violent offenders, those who persistently offended against children or abused positions of authority to do so, those who repeated offences 'in a specific locality causing public alarm', and those with previous convictions who had been unresponsive to other methods of punishment or medical treatment. The sixth group featured individuals 'whose misconduct was often trivial' but who were a repeated nuisance and 'merited a salutary lesson'.[33] This analysis of sentencing trends suggests that, at least towards the end of the period under examination, an individual's history of offending was often weighed up alongside the exact nature and circumstance of their particular crime. Medical diagnoses or evidence did not necessarily have an important role to play. Although medical opinion regarding the defendant was probably more commonly introduced in the 1950s than had been in the case in the 1920s, judges consistently found some individuals to be entirely unsuitable for anything other than imprisonment.

Sentences involving treatment were not entertained for all cases of sexual crime. However, the availability of evidence from prison doctors and the possibility of treatment while on probation did create opportunities for medical methods of dealing with offenders. This flexibility, along with the formalisation of psychiatric treatment as a condition of probation in the Criminal Justice Act of 1948, may help to explain the absence of sexual psychopath legislation in England, in contrast with much of the USA and Canada. Although probation had been adopted in many American states in the early

[33] Radzinowicz, *Sexual Offences*, pp.xxi-xxii, and discussed in more depth on pp.183-200.

twentieth century, it was usually only available to adolescents. Provisions for probation for adults had only been introduced in all states of America by 1956. 'Nowhere else in the world', reported *The Times* somewhat jubilantly in a 1952 survey of the probation services in England, 'has [probation] been developed comprehensively for any but juveniles'.[34] As criminologist Simon A. Cole has pointed out, American laws targeting the sexual psychopath were 'enlisted with the goal of subjecting sex offenders to medical treatment', a goal that was largely achieved in England – in theory, at least – by the option of medical treatment for adult probationers.[35]

References to medical treatment for sexual offenders on probation appear with more frequency in the medical and general press from the mid-1940s. Joe Sim has argued that the Criminal Justice Act meant that the 'influence of medical personnel in the determination of the offender's path through the criminal justice system was substantially increased'.[36] In fact, even before it became law the courts were already requiring a quarter of sexual offenders on probation to receive medical treatment.[37] Whether medical personnel should acquire any *more* influence was then addressed in connection with debates surrounding homosexual offences, which often considered sexual offences more widely as well.[38] 'It would be a bit odd', reflected one member of

[34] 'After-Care of Offenders', *The Times,* 9 December 1952, p.3.
[35] Cole, 'From the Sexual Psychopath Statute to "Megan's Law"', p.293. This is not to suggest that other factors did not contribute to the notable differences between North American and British approaches. Most important, in all likelihood, was the absence of any particularly widely publicised and terrible crimes against children in England – these tended to be the instigators for sexual psychopath laws elsewhere.
[36] Sim, *Medical Power in Prisons*, p.77.
[37] Radzinowicz, *Sexual Offences*, p.241. Examples from around the time of the 1948 Act include 'Charlton Man to Undertake Treatment', *Gloucestershire Echo,* 25 October 1949, p.5; 'Wendover: Milk Roundsman Bound Over', *Bucks Herald,* 22 October 1948, p.8, and 'Kenilworth Magistrates' Court: To See a Doctor', *Leamington Spa Courier & Warwickshire Standard,* 10 December 1954, p.10, both of which relate to charges of indecent exposure; and 'To Reside at Mental Hospital', *Biggleswade Chronicle,* 29 June 1951, p.3, for a case of indecent assault and gross indecency.
[38] One contributor to a fevered exchange under the title 'Homosexuality' in the 1946 Letters pages of the *British Medical Journal* mentioned his own involvement in obtaining medical

the Wolfenden Committee, 'if of all the sexual offenders, which you as doctors liken one to the other, you merely chose the homosexual [for treatment]'.[39] Notably, their deliberations failed to include prostitution within this group. They also failed to establish how, in very practical terms, medical influence could be extended or made more consistent. As the next section will explore, the presence, absence, and uses of medical testimony remained eclectic.

### 5.2 Medical evidence: Its presence and absence

The uses of medical ideas and approaches within legal proceedings were not only dependent upon judicial views of mental illness and court-mandated treatment. As Matt Houlbrook has shown, from the late 1920s elite defence lawyers and their clients were also beginning to see the potential in associating sexual crime with mental disorder. One eminent barrister's 'remarkable career as a queer defense lawyer', as Houlbrook characterised it, illustrates that medical evidence was increasingly regularly solicited and deployed as a means of constructing a legal defence during the period under examination. Medical interpretations of sexual crimes were put forward to ensure that well-to-do clients could avoid imprisonment.[40] As one policeman put it, 'the professional man who has got a career' has 'an awful lot to lose' and 'will fight tooth and nail, and they have counsel. The favourite thing is doctors, and it is most amazing the diseases that these people develop'.[41] Although vicars, teachers, doctors, lawyers, and other middle-class men facing disgrace may have piqued journalistic interest for reasons other

---

evidence and treatment for the husband of a patient who was charged with indecent exposure. Hardy, 'Homosexuality'.

[39] So said Mr Mishcon, a solicitor, to Drs Dicks and Kelnar of the Tavistock. Meeting of 14 September 1955, in 'Transcripts of evidence hearings: Committee on Homosexual Offences and Prostitution', The National Archives (London), HO 345/14.

[40] Houlbrook, *Queer London*, pp.247-252.

[41] Evidence of PC Butcher, 7 December 1954, in 'Transcripts of evidence hearings: Committee on Homosexual Offences and Prostitution', The National Archives (London), HO 345/12.

than the nature of their legal defence, the reporting of such cases regularly makes mention of medical witnesses.[42]

The best-connected defendants could not only avoid imprisonment, but were also able to ensure that their cases were not even reported in the press. This may distort the historical record, with the trials of the lowly and unrepresented rarely thought worthy of comment, and the most eminent defendants ensuring a veil of silence. Martin Brown, for example, was a wealthy Canadian stockbroker who was arrested and charged with a series of indecent assaults on the maids working at a central London hotel. He called upon friends in high places and made several attempts to have the charges against him dropped. In the event, they were reduced from indecent assault to common assault and he was discharged after the sympathetic remarks of the prosecution were enhanced by the testimony of his doctor. His arrest and trial at the Old Bailey do not seem to have been covered in the press at all. Unusually, his name is still redacted from the archival catalogue as well.[43] Mitford Brice, the son of a barrister and acquaintance of royalty, appeared in court in 1936 charged with indecent assault and was remanded for nearly a month for examination by the prison doctor and any other doctors of his choosing. Brice had a talented legal team, which included Henry Curtis-Bennett and Norman Birkett, both prominent criminal defence barristers. He also had a well-documented history of mental illness dating back to a period of time spent in a military hospital in 1919. Despite

[42] Examples of these featuring a vicar, a solicitor, a bishop's brother, and a bank clerk respectively can be found in 'Country Vicar's Lapse'; 'Obscene Libel Charge'; 'Worcestershire Rector Bound Over', *The Times,* 23 November 1929, p.9; 'Bishop's Brother to Be Examined', *Northampton Mercury,* 24 December 1941, p.3; '"Painful Case" of a Cashier', *Derby Daily Telegraph,* 9 April 1941, p.6.

[43] The accused is variously named as Mervyn Brown and Martin Brown. 'Indecent assaults on chambermaids in Regents Palace Hotel', The National Archives (London), MEPO 3/397.

several previous criminal convictions, he was bound over to be of good behaviour and discharged. This, too, went unreported.[44]

Such cases may have been relatively isolated. They are nonetheless suggestive of a connection between the introduction of medical evidence and explanation in any particular case of sexual crime, and an affluent defendant with experienced and skilful legal advisers. Labourers and the unemployed were often unrepresented, particularly in the 1920s and 1930s, in the lower courts and in the early stages of proceedings. Defendants would give statements to the police after being cautioned and without receiving legal advice, and would also prepare their own statements in defence or mitigation while awaiting trial or sentencing. These statements were usually a combination of explanations and apologies, but did sometimes adopt medical terminology. A former seaman provided one such statement from his cell in Wandsworth prison, as he awaited sentencing in April 1926 for indecent exposure and assault of the arresting officer. 'I must say I was not responsible for what I was doing', he claimed. 'I have I know', he went on,

> been convicted before for this kind of offence, and every time I have been in a muddled condition. I am very sorry for what I have done now, I am now going to fight against this evil and give it up, being a nuerotic [sic] I unfortunately take to drink, which I know is the cause of the trouble I am now in, I simply lose my reason.

Neurosis and alcohol were not the only matters that he wanted the judge to bear in mind. 'I have a good army record', he stated, and provided a full account of his service, his injuries, his time as a prisoner of war, and his pension. 'I should like to say I had no conviction to the year 1921', he concluded pointedly, hinting strongly that his war service

[44] 'Mitford Brice: attempting to procure a boy aged 15', The National Archives (London), MEPO 3/994.

may have disturbed his mental balance.[45] However, he had no legal advice. There is no sign that any medical evidence was introduced to back up his claims, and no character witnesses were produced. If a prison doctor examined him, which presumably did take place, nothing of note was found. Perhaps unsurprisingly in these circumstances, his appeal fell on deaf ears and he was sentenced to 17 months in prison.

In a similar case, a gardener from Epsom was apprehended in 1935 for a series of indecencies in the area. The accused represented himself, insisted that he was not the culprit despite fairly damning evidence, and the only witness he called in his defence seems to have been the vicar who employed his wife. However, 'after hearing of his previous convictions, one of which was for an indecent assault on a girl age 13 years', the vicar announced that 'he did not now desire to speak as to character... He however pleaded that the accused be sent to a home instead of prison so that he could be treated for the mental disease from which he was suffering'. The vicar was the only person to mention mental illness, and no medical evidence was produced. Without further ado, the gardener was sentenced to three months in prison with hard labour.[46] Although previous convictions could count against a defendant, with the aid of a lawyer and a Harley Street expert the outcome for these individuals might have been very different.

[45] Statement dated 4 April 1926 in 'Middlesex Assizes: Depositions 1918-1936', London Metropolitan Archives, MXS/B/01/004. He received an 11-month prison sentence for the indecency, and 6 months for assault. See Calendar of Prisoners, London Metropolitan Archives, MXS/B/03/014.

[46] 'Indecent notes and attempted larceny of schoolgirl's clothing', The National Archives (London), MEPO 3/945. The charge was for publishing obscenities: women's stockings and underwear had been going missing from washing lines, and at least one family had subsequently received the stained missing items wrapped in obscene notes, posted back through the letterbox. Defendants were still often unrepresented into the 1940s. See 'York Man's Record of Sadistic Acts', *Yorkshire Evening Post,* 20 July 1942, p.5.

For the less wealthy, expert opinion of their mental state could be proactively requested by the courts, and many magistrates seem to have been influenced by the behaviour of the defendant over and above the nature of his crime. Throughout the period under examination, if defendants behaved strangely in court or had a history of mental disturbance, the views of a prison doctor would be invited. Often, however, it seems that the primary objective was to establish whether the accused was fit to plead, rather than any more detailed consideration of his state of mind and motivations. George Cook, for example, was arrested for the indecent assault of a 16-year-old girl, and there appears to have been some concern over his level of intelligence. The medical officer of Brixton prison agreed that Cook showed 'a certain amount of mental defect', but was able to confirm that it was 'not enough to justify his being certified under the Act. He is very ignorant, indeed almost illiterate; and so appears to a casual observer more defective than he really is'.[47] Bert Mealey, charged with rape and incest in 1930, was also remanded for medical enquiry on account of appearing 'very talkative' when arrested, with pupils 'dilated giving the eyes a "wild" expression. He seemed very strange in manner', and his wife reported a recent history of highly erratic behaviour. Here and in the case of a youth charged with indecent assault in 1939, the suggestion came from the police that the conduct of the defendant while in custody had been sufficiently troubling to merit further medical enquiry.[48]

A history of psychiatric treatment was mentioned with increasing regularity as the prompt for further investigation. Hugh Chapman, a 34-year-old seaman, was remanded for medical enquiry in 1934 'owing to his demeanour in court'. This

[47] Statement dated 29 July 1924 in 'Middlesex Assizes: Depositions 1918-1936', London Metropolitan Archives, MXS/B/01/004.
[48] 'Father sentenced to seven years penal servitude for rape of daughter', The National Archives (London), MEPO 3/419; and 'For Mental Observation', *Dover Express and East Kent News,* 20 January 1939, p.12.

unspecified 'demeanour' may have led the magistrate to wonder whether Chapman was certifiable as insane or mentally defective, but Chapman had also 'been attending a clinic for psychological treatment'.[49] Marcello Sequenza, charged with indecently assaulting a neighbour in 1950, informed the arresting officer that he had been 'discharged from the R.A.F. with nervous disability', and the prison doctor accordingly provided full details of his medical history and present mental state.[50] Sequenza and Chapman were both sentenced to terms of imprisonment. Concern on the part of the judiciary regarding a history of mental treatment might prompt medical enquiry and even judicial sympathy, but did not necessarily lead to discharge or acquittal, or further provisions for treatment. Perhaps significantly, in neither of these cases does there seem to have been a medical expert called by the defence. As was explained in a booklet produced by the ISTD in the early 1950s, the prosecution could make use of an expert paid for by public funds, whether a prison doctor or other authority. 'The accused, on the other hand, must either employ a specialist from his own resources or, if granted legal aid, rely on the assistance provided', the booklet concluded.[51] The means to pay for a medical expert was often necessary, even if a legal aid lawyer were available to recommend it in the first place.

Some few impecunious defendants did arouse the interest of campaigning groups such as the Howard League, and the voluntary efforts of Tavistock or ISTD clinicians or other doctors provided their services for free. In order for doctors to be alerted to such cases, they often relied upon the efforts of sympathetically minded judges. The Birmingham judiciary had, of course, been responsible for the transfer of Hamblin Smith to their region to advise them more frequently on the mental state of

[49] 'Hugh Chapman: persistent importuner', The National Archives (London), MEPO 3/992.
[50] Case of Marcello Carlo Sequenza, February 1950, in 'Middlesex Assizes: Depositions 1949-1961', London Metropolitan Archives, MXS/B/01/006.
[51] *Psychology and Criminal Procedure* (London: Institute for the Scientific Treatment of Delinquency, n.d. [c.1952]) p.14.

offenders in 1919, and Mullins in London availed himself of the services of the Tavistock and ISTD clinics in the 1930s. In Bradford at around the same time, Dr Eurich was receiving referrals from the court of one particular magistrate, in the form of drunks, shoplifters, and 'men convicted of petty sexual offences', and provided advice and treatment at no charge. Magistrate Coddington was evidently passionate about the advantages of this approach, promoting it in the local press and to the Magistrates' Association, and suggesting that the Home Office might want to publish their results for the benefit of a wider audience.[52] This was tolerated rather than actively encouraged, though, and these pockets of enthusiasm for psychological enquiry appear to have been the exception rather than the rule.

The extension of legal aid provisions and the establishment of the NHS may both have played a role in the greater frequency with which medical evidence was heard from the late 1940s onwards. In 1939, in the case of a Fusilier charged with indecent offences against children, his lawyer's account of previous psychiatric treatment and claims of 'mental aberration' were unsupported by medical evidence and a prison sentence followed.[53] By 1949, defendants from all walks of life could have a doctor at their trial. Dr Sessions Hodge gave evidence in the case of a railway greaser charged with indecent exposure, and a Dr Macgregor reported on the mental state of a farm labourer convicted of indecent assault.[54] A lorry driver and a miner also benefited from legal representation and medical reports obtained by their counsel which argued that mental abnormality

[52] F. J. O. Coddington, 'Factors in Petty Crimes', *Yorkshire Post,* 8 February 1939, p.3; 'F. W. Eurich, M.D.', *British Medical Journal,* 1 (1945), 312; 'Psychological Treatment of Crime, 1921-41', The National Archives (London), HO 45/18736.
[53] 'Dangerous Mental Aberrations', *Dover Express and East Kent News,* 1 September 1939, p.14.
[54] 'Girls Complain of Railway-Man's Conduct', *Somerset County Herald,* 4 June 1949, p.3; 'Probation for Ollerton Labourer', *Nottingham Evening Post,* 12 October 1949, p.5.

was the cause of the crime and treatment the answer.[55] Not every case of sexual crime saw the production of a psychiatrist in court, but there seems to have been much wider use of opportunities to introduce medical evidence for the defence from the late 1940s.

A persistent absence of any comment in court as to the state of mind of the defendant is particularly pronounced in cases of rape and indecent assault of women and girls. This bears out the argument proposed in earlier chapters of this thesis, that the 'perversions' received far more medical attention than crimes associated with heterosexual sex. A Private admitted attempted rape while on leave in Dover in 1940, and stated plaintively in his hand-written statement that 'I did not know what I was doing, I must have lost my head, I did not go there intending to do her harm'. A cursory note from the Medical Officer of Maidstone prison recorded that he had 'found no evidence of mental disease or defect', and the Private was duly sentenced to a severe five years' penal servitude.[56] James Darnley, charged with the rape of a servant in his household in 1928 and reported to be in a state of extreme drunkenness upon arrest, was swiftly sentenced to 7 years' penal servitude without pause for medical evidence; and Alan Gressey, who pleaded guilty to a horrifying array of sexual violence perpetrated upon his 78-year-old landlady in 1958, does not seem to have received any particular attention from the prison doctor either.[57] John Cole, whose trial in 1947 for a series of robberies and rapes was closely followed in *The Times*, was granted legal aid and his

[55] 'Young Girls Assaulted', *Somerset County Herald,* 23 April 1949, p.3; 'On Medical Report', *Dover Express and East Kent News,* 15 April 1949, p.6.
[56]'Defendant: DUTTON, John', The National Archives (London), CRIM 1/1227.
[57] 'Defendant: GESSEY, Alan David', The National Archives (London), CRIM 1/2936. Further examples can be found in '"Pest" Sent to Prison'; 'Defendant: GATZIAS, Samuel Harold', The National Archives (London), CRIM 1/475; 'Defendant: HARRIS, Frederick', The National Archives (London), CRIM 1/358; 'Defendant: JAMES, Wynford Reginald', The National Archives (London), CRIM 1/3106; the case of James Fohwesser, heard at Willesden Court House on 26 January 1922, 'Middlesex Assizes: Depositions 1918-1936', London Metropolitan Archives, MXS/B/01/004; and the case of George Lush, heard at Highgate on 18 December 1936, in 'Middlesex Assizes: Depositions 1936-1949', London Metropolitan Archives, MXS/B/01/005.

lawyer observed that he 'must be a sexual maniac', but no medical evidence as to Cole's state of mind was reported.[58] A Plymouth man, convicted of incest with his daughter, also seems to have been sentenced to penal servitude without any consideration of mental state.[59] In cases of rape, medical attention remained focused upon the bodies of complainants rather than the minds of the accused.

Offences against children, including girls, do seem to have been treated as a medical matter by the courts with more frequency than offences against women. A Blackpool teacher, charged with indecently assaulting girls aged 10 and 11, was placed on probation in 1955 on condition that he become an in-patient at a local mental hospital for a year.[60] A labourer was remanded for a medical report after pleading guilty to an assault of a 9-year-old girl and was also placed on probation, as was a pensioner found guilty of an offence against a 12-year-old.[61] This tends to support the suggestion put forward in Chapter 3, that offences against young children were more readily perceived as signs of abnormality or illness than were offences against older teenagers or adult women. The willingness of the courts to despatch such offenders for treatment rather than imprisonment may also suggest that such a perception was not distinctive to the medical profession, but mirrored widely held beliefs about abnormal sexual conduct.

The absence of medical evidence in court may also reflect the content of any expert opinion that had been sought. Both defence and prosecution obtained the advice of medical experts more often than they introduced it as evidence, since any views that

[58] 'Alleged Attacks on Women', *The Times,* 17 October 1947, p.2 and covered on subsequent days, culminating in '15 Years' Sentence on Cole', *The Times,* 23 October 1947, p.2.
[59] 'Devon Assize: P.S. for Plymothian', *Devon and Exeter Gazette,* 5 November 1926, p.12.
[60] 'Probation for Teacher', *Yorkshire Post,* 27 September 1955, p.1.
[61] 'On Probation', *Biggleswade Chronicle,* 11 May 1951, p.10; 'Put on Probation', *Nottingham Evening Post,* 29 August 1945, p.1.

were unfavourable to their case could be ignored. As Dr Matheson explained, he actively tried to make sure that he would not have to participate in legal proceedings unless he could 'report something which will be of help to the man'. If, after examining a defendant, Matheson concluded that his findings would not provide any useful defence, he would 'see the defending counsel and tell him that we have examined this man, that if he does ask for a report it will not be favourable to his client. I tell him off the record what we have ascertained'. Unsurprisingly, this frankness meant that Matheson was 'seldom called in those circumstances' to give evidence for the defence.[62] No doubt he was not the only doctor to conduct assessments and provide reports regarding sexual offenders, only to find that his view was not useful.[63] In other situations, medical evidence was not produced until after a conviction. During Wildeblood's trial, for example, he initially denied the charges outright. Only after the guilty finding was Dr Jack Hobson called to address the matter of Wildeblood's illness and treatment. In this and presumably many other cases, if the defendant was found not guilty, there was simply no need for expert medical evidence to be introduced.[64]

Similar procedural issues remained a barrier throughout the period in question, as far as those in favour of much more extensive psychiatric examination of sexual offenders were concerned. Although greater space had been made for medical evidence to be heard during court proceedings and for the courts to encourage medical treatment, they could not compel a medical examination for those not remanded to prison. Defendants released on bail before their trial would not be seen by a prison

[62] Meeting of 1 November 1955, in 'Transcripts of evidence hearings: Committee on Homosexual Offences and Prostitution', The National Archives (London), HO 345/14.
[63] A further possible example is that of Dr Desmond Curran, who reportedly examined Neville Heath on behalf of the defence, but was not called as a witness. See Dr Grierson's note of 2 September 1946 in 'HEATH, Neville', The National Archives (London), HO 144/22872.
[64] 'Three Men Sent To Prison', *The Times,* 25 March 1954, p.4.

doctor, and did not necessarily seek out their own medical expert. 'He is an awful ass if he does not', exclaimed one member of the Wolfenden Committee when informed of this fact, but no witnesses could suggest an entirely satisfactory solution.[65] Nor did judges have to follow any medical recommendations they received, and indeed some complained that the quality and usefulness of medical evidence were extremely variable.[66]

Furthermore, the law under which prosecutions were brought or the likely penalty might render medical evidence unnecessary. Radzinowicz discovered in the late 1940s that medical evidence about a defendant was only presented in 11% of cases of homosexual offences, compared to 22% of heterosexual offences. Prison doctor F. H. Taylor had established a similar discrepancy amongst sexual offenders on remand in Brixton prison, in that a medical report was requested in only 54% of homosexual offences, but in 71% of heterosexual ones.[67] This struck Radzinowicz as surprising and in need of explanation. He had evidently assumed that homosexual offences would have been more likely to generate medical evidence than those classed as heterosexual, but uncovered an administrative reason for this apparent anomaly. Many homosexual offences, he explained, were proceeded against under local byelaws and vagrancy laws, in which a conviction was easier to obtain but the penalty was usually a fine.[68] Evidence addressing mental state would serve little purpose, as a custodial sentence was

[65] Meeting of 15 October 1954, in 'Transcripts of evidence hearings: Committee on Homosexual Offences and Prostitution', The National Archives (London), HO 345/12.
[66] See, for example, the comments of Sir Laurence Dunne, Chief Metropolitan Magistrate, meeting of 4 October 1955, in 'Transcripts of evidence hearings: Committee on Homosexual Offences and Prostitution', The National Archives (London), HO 345/14.
[67] Radzinowicz, *Sexual Offences*, p.69; F. H. Taylor, 'Homosexual Offences and Their Relation to Psychotherapy', *British Medical Journal,* 2 (1947), 525-529 (p.525). Radzinowicz counted indecent exposure separately, as neither homosexual nor heterosexual. Taylor does not specify what is included as 'heterosexual'.
[68] Radzinowicz, *Sexual Offences*, p.69.

impossible. In testimony to the Wolfenden Committee, the Chief Metropolitan Magistrate confirmed something similar, conceding that in cases involving a 'professional man with no criminal record of any sort', 'the punishment is usually so light that, no, I am afraid I do not try and get medical evidence'.[69] If the punishment for an offence was likely to be mild, then magistrates and lawyers may have been less likely to go to the trouble of seeking medical advice. Radzinowicz was certainly confident that this affected homosexual offences to a disproportionate degree. His conclusions cannot be confirmed from the limited information within official statistics, but do raise the possibility that medical evidence in cases of heterosexual crime might have been more common than the medico-legal (and journalistic) attention devoted to homosexuality and indecent exposure suggests.

Across all prosecutions for sexual offences, medical information about the defendant had reportedly been sought in only 21% of cases in the late 1940s.[70] In the first few decades of the period under examination, medical evidence was largely the province of wealthier defendants, often in conjunction with expert defence lawyers. The courts did seek their own medical advice in cases of suspected insanity or mental defect, and some judges were particularly keen to make use of medical expertise in a wider variety of cases. The greater availability of both lawyers and doctors from the late 1940s had a significant impact upon the presence of medical testimony, but even so, the practicalities of the courtroom as well as the nature of the offence might preclude their involvement. Despite fairly widespread acknowledgements that sexual offences were

[69] Evidence of Sir Laurence Dunne, Chief Metropolitan Magistrate, meeting of 4 October 1955, in 'Transcripts of evidence hearings: Committee on Homosexual Offences and Prostitution', The National Archives (London), HO 345/14.
[70] Radzinowicz, *Sexual Offences*, p.69. It is not clear whether this figure includes medical testimony introduced before conviction, or only that which was considered after conviction but before sentencing.

often a 'mental matter', medical information about the mental state of a sexual offender was not used by the courts with any regularity or consistency.

### 5.3 The nature and reception of medical evidence

If the insistence of the Prison Commissioners is to be believed, then all those accused of sexual offences and remanded to custody were examined as to their mental state upon arrival in prison. However, such examinations frequently generated cursory reports. After Charles Roberts had been examined in prison following his arrest for buggery in 1929, Dr Watson of Brixton prison simply noted that his patient was 'clearly a sexual pervert, but I have found no evidence of insanity or mental defect'.[71] This short statement was typical of the reports submitted by prison doctors, even when considering those accused of murder whose own lives hung in the balance. Sidney Derry, who had killed his wife and children and attempted suicide, was examined in 1921 by Hamblin Smith. Surprisingly, given Hamblin Smith's specialism in the field of mental disorder, his report took up just a few lines: 'when he came here he was suffering from an attack of insanity. I consider that he is now recovering, and that he is fit to plead to the indictment'.[72] There is unfortunately no record of whether Hamblin Smith was called to give evidence regarding the 'attack of insanity' and its bearing upon the crimes. He may have been able to expand on his views in person, but there was clearly no requirement for any further comment in writing.[73]

[71] Report dated 18 March 1929 in The National Archives (London), CRIM 1/461.
[72] Report of Dr Maurice Hamblin Smith dated 3 February 1921 in 'Assizes: Oxford Circuit: Jones', The National Archives (London), ASSI 6/56/6.
[73] It is also possible that such reports followed an official, or semi-official, template, although I have not been able to find any reference to one.

Longer and more detailed reports became more common from the 1940s. These often included commentary on the domestic, social, and sexual life of the accused. As Radzinowicz noted in 1957, the details within medical reports on sexual offenders were often 'similar to those found in reports of probation officers'.[74] After examining a man charged with gross indecency, Dr Matheson of Brixton prison provided the court with commentary on the man's family history and his account of the crime as well as the possibility of successful treatment.[75] Dr Calder, in another case, addressed the defendant's sexual, domestic, and financial life in impressive detail. 'He and his wife submit themselves to voluntary restrictions of marital relations for fear of having another child', Calder reported, 'and sexual frustration may have had much to do with the offence'. He went on to say:

> Little, I am afraid, can be done about the marital relations for they certainly are in no position to have another child at present and birth control is under the ban of their church. On a £5 a week income he pays £3-4-0 in rent and instalment premiums and has recently been in such a nervous state that he, an ex-sergeant of the Guards, has broken down daily and wept. I do not consider that he requires psychological treatment but he is in real need of help by a social worker.

Calder added brief confirmation that the defendant 'is not insane or feeble-minded' as an afterthought.[76] His careful consideration of the defendant's social situation supports the argument that a broad picture of possible motivations and solutions, as well as certifiable mental disorder, had become a part of the doctor's repertoire.

As these extracts demonstrate, medical reports might also include specific recommendations regarding the best way to deal with the offender. Recommendations of some kind were made in about 60% of medical reports on sexual offenders, and were

[74] Radzinowicz, *Sexual Offences*, p.73.
[75] Case of Jack Liddle and John Cowlard, statement dated 6 February 1950, in 'Middlesex Assizes: Depositions 1949-1961', London Metropolitan Archives, MXS/B/01/006.
[76] Case of John Porter and William Redpath, statement of 5 December 1949, in 'Middlesex Assizes: Depositions 1949-1961', London Metropolitan Archives, MXS/B/01/006.

followed more often than not by the courts.[77] They might be generalised or specific, calling for psychological or physical treatment. 'I consider that this lad has rather deeper psychological problems than is perhaps appreciated', reflected one prison doctor in a case of indecent exposure, 'but I think it is important that the present offence should not result in even greater inhibition and repression'. He went on to suggest that 'probation will be adequate', and to confirm that arrangements could be made for the youth 'to be seen at the clinic those weeks when he is not working on a morning shift'.[78] Another gave careful consideration to an unspecified 'double rupture' which was reportedly giving 'some anxiety; he is erroneously projecting the reasons for his behaviour and his sexual inadequacy on to this physical defect and he would benefit considerably from a radical operation – both physically and mentally'.[79] Judges might specifically solicit the doctor's opinion regarding treatment as a condition of probation, as was the case for defendant Jack Liddle in 1950. Doctors hired by the defence also addressed the possibility of a cure, writing, for example, that 'I feel that I might be able to help this man by relatively simple measures', or that 'further treatment was still necessary to effect a cure'.[80]

Medical recommendations were not always in the positive. 'I do not consider that Psychotherapy would be of any assistance to him', wrote the medical officer of Pentonville prison in 1950. John Dunne, his patient, had pleaded not guilty to two charges of indecently assaulting boys.[81] Marcello Sequenza, who had raised the subject

[77] Radzinowicz, *Sexual Offences*, pp.74-5.
[78] Radzinowicz, *Sexual Offences*, p.73.
[79] Radzinowicz, *Sexual Offences*, p.77.
[80] Cases of Jack Liddle and John Cowland heard on 14 January 1950, and case of Walter John Harris heard on 4 April 1952, in 'Middlesex Assizes: Depositions 1949-1961', London Metropolitan Archives, MXS/B/01/006; 'General Messervy Bound Over'.
[81] Case of John Anthony Dunne, in 'Middlesex Assizes: Depositions 1949-1961', London Metropolitan Archives, MXS/B/01/006.

of his previous mental illness upon arrest, was said to belong 'to that group of individuals subject to frank mental breakdowns who are never quite normal but who recover to such a degree that they can be, and have to be, discharged from care'. 'I have no hope', concluded Dr Calder, 'that he would return to a mental hospital as a voluntary patient'.[82] He could not be certified as insane, but treatment without his co-operation was impossible. This view may have contributed to the judge's preference for a prison sentence rather than probation.

Medical evidence was thus responding to the needs of the judiciary by suggesting practical solutions and concrete conclusions. Although some doctors did speculate as to the underlying cause of sexual crimes and associated mental disorders, they tended to avoid detailed consideration of aetiology. Instead, they emphasised the absence of acceptable sexual outlet, and ignorance or low intelligence. In the 1940s, Sessions Hodge stated in court that one defendant was 'dull and backwards' and Dr Bailey described another as 'feeble-minded', and in both cases the defence successfully obtained a probation order with treatment rather than imprisonment.[83] By avoiding the still-controversial language of psychology, psychoanalysis, and endocrinology, these doctors presented the courts with accounts of sexual misconduct that were easily intelligible. As Victoria Bates has argued, in criminal trials of the 1880s questions of 'mental competency' were 'treated as matters of common sense rather than medical issues'.[84] This continued to shape the evidence given by friends, neighbours, defence lawyers, and also doctors, well into the twentieth century. Character witnesses might make mention that 'the accused had become feeble in mental and bodily health, and at

[82] Case of Marcello Carlo Sequenza, in 'Middlesex Assizes: Depositions 1949-1961', London Metropolitan Archives, MXS/B/01/006.
[83] 'Girls Complain of Railway-Man's Conduct', and 'Young Girls Assaulted'. Further examples can be found in Radzinowicz, *Sexual Offences*, pp.247-248, pp.76-77, p.79.
[84] Bates, '"Not an Exact Science"', p.143.

times his mind wandered and he was not quite normal', while doctors spoke in similarly general terms of mental instability, the 'toxic aftereffects' of medical procedures or prescription drugs, a 'nervous disposition', or the effects of exhaustion and alcohol.[85]

Such reports also carefully avoided any comment regarding the responsibility of the accused and whether or not he could have been expected to resist temptation or refrain from his criminal actions. By addressing insanity and mental defect, precipitating causes of sexual crime, and the possibility of medical cure, doctors attempted to provide the courts with useful information while avoiding any encroachment on the process of legal decision-making. Prison doctors may have been rather more adept at this. Evidence from private physicians was sometimes less straightforward and threatened to delve into the murky waters of individual responsibility and free will. The suggestion from Dr J. A. Hadfield that a defendant's 'physical condition might have influenced his mind so that he would succumb to the temptation to commit offences' received short shrift from the judge, who pointed out that 'a diseased condition of the mind or body was not recognised by the law as releasing a man from the penal obligation for the commission of crime'.[86] Hubert, in the high-profile trial of Neville Heath, pursued an equally unpopular line of argument by suggesting that Heath had 'a sense of irresponsibility in other things' and therefore could not be held responsible for the sadistic murders he had committed.[87]

[85] 'Country Vicar's Lapse'; 'General Messervy Bound Over'; 'Obscene Libel Charge'; 'Hugh Chapman: persistent importuner', The National Archives (London), MEPO 3/992; 'Indecent assaults on chambermaids in Regents Palace Hotel', The National Archives (London), MEPO 3/397.
[86] 'Charge against Ex-Mayor', *The Times,* 20 April 1928, p.5.
[87] Byrne, *Borstal Boy*, p.127.

The difference between medical evidence designed for use in legal proceedings, and medical enquiry taking place away from the glare of the courtroom is illustrated by the records of Harold Jones. Although no medical evidence was needed during his trial, the Prison Commissioners agreed that their doctors 'should keep a careful eye upon him & report' on his condition on a regular basis, and he was examined by Norwood East at least twice a year for over a decade. The prison authorities were anxious to assess his suitability for detention with other young offenders, and in later years to judge whether he could safely be released. Questions that would have been pertinent to a court, such as the precipitating causes of his crimes, his state of mind at the time, and whether a medical cure was possible, faded to the background. Norwood East and his successors considered Jones's personality and maturity instead, weighing up his conduct and the risks he posed to the public, rather than just his fitness to stand trial or his suitability to receive treatment. From the outset, Norwood East resolved that Jones' crimes were 'due to sadism', a diagnosis that does not seem to appear in courtroom testimony until the late 1930s. A detailed analysis of Jones' sexual history was set alongside his demeanour and apparent reaction to his crimes. As Chapter 6 will argue, this attention to personality and performance could help to determine whether sexual offenders were suitable candidates for treatment, but in the absence of any facilities for treatment they were for research purposes only. Possible long-term causes of sadism were explored, such as the development of 'the sexual impulse' in 'an irregular manner'.[88] This detailed analysis and diagnosis were unusual within medical evidence for court purposes, which focused instead on broad-brush explanations and practical advice.

[88] Report of William Norwood East dated 5 November 1923 in 'Harold Jones: Convicted at Monmouth 28 October 1921 of Murder and Sentenced to Death', The National Archives (London), PCOM 9/742.

In these more private medical notes, doctors were also able to acknowledge the limitations of their knowledge. 'No scientific means are available to ascertain whether the perversions which were associated with the two murders are still present', wrote Norwood East in 1933. His decision that Jones was not yet safe for release was not only a question of the risk he posed to the public, but also of the fact that 'other convicts serving their full sentence for murder would probably be adversely affected if he served a less sentence than themselves'.[89] Statements for court, and answers given by doctors in the role of expert witnesses, typically had to present much more certainty than this and had to remain focused on whichever issues were material to the case being argued. With a prisoner under sentence, Norwood East could explore possible causes, and could attempt to correct the irregularities that had occurred in the prisoner's sexual development, on an informal basis. By the time Harold Jones had served twenty years in prison, he was believed to have 'changed and matured much since this adolescent experience'. Given that this, in 1941, coincided with an urgent need to empty prisons and to provide men for the military, he was thought safe enough to release.[90]

That medical evidence was sensitive to the questions and demands of the legal profession accords with recent interpretations of the relationship between psychiatry and the law. This has moved away from an oppositional model, in which the two professions were seen as eternally at loggerheads, or a medicalisation model, in which

[89] Report dated 14 January 1933 in 'Harold Jones: Convicted at Monmouth 28 October 1921 of Murder and Sentenced to Death', The National Archives (London), PCOM 9/742.
[90] Notes from 1941 in 'Harold Jones: Convicted at Monmouth 28 October 1921 of Murder and Sentenced to Death', The National Archives (London), PCOM 9/742. Jones' life after release remains largely unknown, although Neil Milkins has found that he does not seem to have joined the army. He married and lived in west London until his death in 1971. Milkins has also proposed that he may have committed further murders, although the evidence for this is circumstantial. Neil Milkins, *Every Mother's Nightmare: Abertillery in Mourning* (Abertillery: Old Bakehouse, 2008); Neil Milkins, *Who Was Jack the Stripper? The Hammersmith Nudes' Murders* (Abertillery: Rose Heyworth Press, 2011).

psychiatrists were seen as expansionists striving to invade the courtroom and wrest authority from the judiciary.[91] Some doctors did complain about the attitude of the judiciary (and vice versa). However, a more significant source of difficulty for those who wanted to see much more use of medical expertise was the contrast that could be drawn between different doctors' views in court. Disagreements between doctors were at risk of being exaggerated by the nature of the adversarial trial system, which demands the performance of conflict between defence and prosecution. This performative element has been highlighted by historians of crime such as Lucy Bland, who has written that a drama of disagreement and contradiction 'could be fully played out in an English court, given the adversarial nature of English law where confrontation and rhetorical swordplay are permitted... The system is known as adversarial because it is, in effect, a battle between the defence and the prosecution'.[92] As doctors were usually called by either defence or prosecution, this battle might very well focus upon points of disagreement between them.

The danger of over-emphasising medical disagreements from a historical perspective is countered by the fact that such battles were rarely closely documented. In the case of a former major charged with gross indecency, for example, although four doctors were called by the defence to argue with one voice that the defendant suffered from a disease requiring treatment, there was no mention of any medical evidence

[91] Roger Smith, for example, argued that fundamentally contradictory understandings of the world prevented lawyers and doctors from reaching agreement, and that doctors had to battle for their ideas to achieve legal recognition. Smith, *Trial by Medicine*, p.10. See also Kathleen Jones, 'Law and Mental Health: Sticks or Carrots?', in *150 Years of British Psychiatry, 1841-1991,* ed. by German E. Berrios and Hugh Freeman (London: Gaskell, 1991), pp. 89-102; Pat Carlen, 'Psychiatry in Prisons: Promises, Premises, Practices and Politics', in *The Power of Psychiatry,* ed. by Peter Miller and Nikolas Rose (Cambridge: Polity Press, 1986), pp.241-266 (p.265, p.243).
[92] Lucy Bland, *Modern Women on Trial: Sexual Transgression in the Age of the Flapper* (Manchester: Manchester University Press, 2014) p.150.

offered in rebuttal.[93] As previous chapters have argued, different doctors did prefer different theories in relation to sexual deviance and its treatment, but those who were engaged with the issue were rarely wedded to any one aetiological model or cure. Within the court setting, though, small points of divergence could be magnified. In one trial, this might undermine the influence of the expert witness called by one side or the other, but across many trials it raised serious questions about the value and authority of medical expertise as a whole.

Medical disagreements are given their most detailed exploration in murder trials, in which the relationship between sexual sadism and mental disorder was sometimes under scrutiny. Here, the importance of the adversarial legal system is clear. In the trial of Neville Heath, the expert witness for the defence diagnosed Heath as suffering from moral insanity, while those for the prosecution focused instead on their assessment that he was not insane or mentally defective. Moral insanity was a medical concept, but it was not quite the same as the 'moral defective' as defined by statute. The distinction rested upon the requirement in law for moral defect to have been demonstrably present from childhood; there was no such rigid stipulation within the medical model.[94] In fact, the medical views of the three experts differed very little. Points of disagreement within the specifics of their evidence and presentation were emphasised to make a compelling legal argument. Hubert's failure to introduce any evidence relating to Heath's childhood proved damaging, as did the clarity of the medical witnesses for the prosecution. While Hubert struggled in cross-examination to explain why this particular 'perverted sadist'

[93] 'Gross indecency with boys: conviction of an Indian Army Major (retired)', The National Archives (London), MEPO 3/404. The case was not reported in the press. As the defendant was released on bail pending trial rather than held in prison, it is probable that he was not seen by a prison doctor at all. Another example can be found in 'Bishop Speaks for Accused Ex-Curate', *Sevenoaks Courier and Kentish Advertiser,* 4 March 1949, p.7.
[94] The Mental Deficiency Acts and moral defect are discussed in Chapter 2.

should be found insane but *not* 'every sexual pervert', his former colleagues were perfectly clear that a perverted act did not constitute certifiable mental defect.[95]

This clarity, or 'plain-talking, no-nonsense approach', has been characterised as common amongst prison doctors of the period who were out of their depth.[96] As some doctors were quick to observe when the value and validity of medical testimony were questioned, 'the term psychiatrist is unprotected' so virtually anyone could hold themselves out as an expert on the mind.[97] By the 1940s, the qualifications and expertise of prison doctors were coming under scrutiny on this basis. Campaigners had complained from as early as 1922 that 'none of the medical officers' within prisons 'have any special qualifications for the diagnosis or treatment of mental cases', perhaps without fully realising exactly how rare such qualifications were at the time.[98] As late as the early 1960s, though, very few prison doctors held the Diploma in Psychological Medicine, and staff shortages throughout the 1940s and 1950s compounded the problem.[99] The National Association of Prison Visitors noted in 1945 that in some cases 'the medical officer had no aptitude for the psychological aspects of medicine', which

[95] Further examples of debates surrounding sexual sadism and criminal responsibility can be found in 'CLARKE, Sydney Joseph', The National Archives (London), DPP 2/2405, and 'Conflict of Medical Evidence in Boy Murder Trial', *Manchester Guardian,* 5 July 1955, p.4.
[96] Bowden, 'William Henry de Bargue Hubert', p.337. A more charitable interpretation might be that prison doctors, who often appeared regularly in court, were familiar with the kind of clarity and, indeed, the specific terminology that were necessary in court.
[97] *Psychology and Criminal Procedure*, p.2. See also the comments of a Dr Macdonald at the 31st Meeting of the Advisory Council on the Treatment of Offenders: 'the advice given to courts by practising psychiatrists was not uniformly good and a minority of psychiatrists, by the nature of their evidence in courts, were bringing no credit to this branch of the medical profession'. Diplomatically, given that the two most senior medical men within the prison service were present, he added that the 'standard of evidence given to courts by Prison Medical Officers was good'. 'Report on treatment of offenders with psychopathic characteristics, and background notes', The National Archives (London), HO 326/63.
[98] Hobhouse and Brockway, *English Prisons To-Day*, p.261. The Maudsley only awarded about ten or fifteen Diplomas in Psychological Medicine each year.
[99] *The Organisation of the Prison Medical Service*, pp.1-2.

might be compounded by an extremely heavy caseload.[100] Defence lawyers had also begun to use the lack of specialist qualifications amongst prison doctors to undermine their evidence, and Dr Grierson, for one, was forced to agree in open court that he was not 'a psychological specialist' nor had he worked anywhere 'which dealt exclusively with mental cases'. His protest that he 'took a course in mental disease' once may have sounded less than impressive.[101]

The differences in medical opinion that could be drawn out within criminal proceedings, as well as the differences in qualifications or confidence amongst doctors, raised questions about its authority. As forensic psychiatrist Derek Chiswick has acknowledged, the subjective nature of psychiatric testimony presents a particular challenge to its status as expert evidence, to say nothing of the distortions to the doctor–patient relationship that might be induced.[102] Contradictory evidence in court provided fodder for the suspicion that medical evidence was eternally malleable, and could be fashioned to suit almost any purpose at all. Although prison doctors allegedly provided reports to the court and not for the benefit of the prosecution or the defence, 'there is a feeling abroad', one commentator noted in 1948, 'that the Prison Medical Officer is on the side of the prosecution'.[103] It is certainly true that the energies and attention of doctors employed by the state, which included police and prison doctors, were at times given motivation and direction by the strategies and activities of the legal

[100] Meeting of 19 December 1945, in 'Minutes of the first 27 meetings: Advisory Council for the Treatment of Offenders', The National Archives (London), HO 326/56.
[101] Byrne, *Borstal Boy*, p.129.
[102] Chiswick, 'Use and Abuse of Psychiatric Testimony'.
[103] Meeting of the Advisory Committee on the Treatment of Offenders, 3 March 1948, in 'Report on treatment of offenders with psychopathic characteristics, and background notes', The National Archives (London), HO 326/63.

defence.[104] It is also telling that when more than one prison doctor examined a prisoner, as became common with more complex cases from the later 1930s, their views were rarely at odds.[105] Whether the hierarchical nature of the prison service prevented disagreement between doctors of different status, or whether conflicting opinions were debated and resolved privately at the earliest opportunity, the result was that the service could present a confident, united front.

Something similar may well have taken place privately amongst doctors in the employ of the defence, in that dissenting opinions could be abandoned before trial. While doctors called by the prosecution, particularly prison doctors, were suspected of taking an excessively hard line or an out-dated approach to disorder and crime, doctors for the defence were sometimes viewed with suspicion as attempting to excuse or exonerate the unpleasant conduct of criminals.[106] The resulting presentation of expert evidence, in which the experts for each side spoke with one voice and were pitted against colleagues called for the other, may have limited the influence of medical voices within legal proceedings just as much as matters of procedure or practicality.

## Conclusion

Medical evidence regarding sexual offenders assumed a more prominent role over the course of the period under examination. Changes to judicial attitudes and practices had

[104] Dr Grierson's reports in the case of James Wyeth, for example, suggest a close working relationship with the prosecution. 'Defendant: WYETH, James', The National Archives (London), CRIM 1/1415. Grierson also informed the office of the Director of Public Prosecutions when psychiatrists for the defence came to examine Neville Heath.

[105] See, for example, the medical reports from prison doctors in 'PEAKE, Arthur Jefferson', The National Archives (London), PCOM 9/809; 'PEAKE, A. J: Murder', The National Archives (London), DPP 2/408; 'HEATH, Neville', The National Archives (London), HO 144/22872.

[106] This is perhaps most evident in the attitude towards Dr Hubert in Casswell, *A Lance for Liberty* and Selwyn, *Rotten to the Core?*. See also the comments of PC Butcher on 7 December 1954 in 'Transcripts of evidence hearings: Committee on Homosexual Offences and Prostitution', The National Archives (London), HO 345/12.

an impact, and made space for medical experts to contribute. Such contributions often responded to legal language and requirements, attempting to focus on common-sense explanations and practical solutions over and above diagnoses and speculative discussion. Although doctors and judges did not always find themselves in agreement, many expert medical witnesses were sensitive to the needs of the legal system, and many judges welcomed their advice. Until the later 1940s, cases making use of medical evidence usually involved affluent defendants with legal representation, or judges who were actively interested in a psychological approach and sought out medical advice from doctors working *pro bono*. The absence of medical evidence was therefore not simply a matter of judicial resistance. A lack of legal representation or acceptable alternatives to the traditional methods of punishment could eliminate opportunities for medical reporting, and the extension of legal aid provisions and psychiatric treatment on probation may both have encouraged more consideration in court of mental abnormality. There are also signs that the nature of the crime itself may have been influential, although from the fragmentary evidence this is difficult to establish with certainty. Offences against adult women, in particular, seem to have rarely involved any medical evidence regarding the mind of the accused.

As this suggests, the presence, absence, and influence of medical evidence were far from uniform. Even as the availability of probation orders with treatment, NHS doctors, and the heightened profile of medical views of homosexual offences gave impetus to the wider use of medical witnesses, there remained many cases of sexual crime in which medical views of the defendant did not play an important role. When medical evidence featured prominently, the nature of the adversarial legal system threatened its authority and value to the courts. Small points of disagreement were magnified, and the expertise of medical witnesses was challenged. Legal historians have

observed a 'widening gap between the attitudes of the prison medical service and those of asylum doctors or private practitioners called in by the defence' from the early 1900s, and in fact this seems to have become particularly pronounced in the 1950s.[107] The wider use of psychiatric evidence had only served to spotlight its weaknesses. The same applied to the more frequent use of medical methods of treatment. As the next chapter will discuss, the value of medical approaches to sexual crime was limited by the significant restrictions, both practical and conceptual, that were placed upon who could be treated, and who could be cured.

[107] Loughnan and Ward, 'Emergent Authority and Expert Knowledge', p.31.

# Chapter 6: 'Cured by hospital treatment'[1]

*'No one knows what to do with me. A very sick man, I've been told; but I can't understand that.... what does that mean? First they tell me I'm that, and then when I've been in the hospital for a while they tell me I can go because I'm cured. But I never have been.'*[2]

Between the ages of 20 and 45, Harry Mills had been imprisoned and hospitalised on numerous occasions as a result of his persistent indecent exposure. He had received almost every possible treatment that modern medicine could offer, but nothing seemed to have any long-term impact. 'You know you can't be cured', he said, but at the same time he continued to hope that 'perhaps one day something'll work, it'll die down, there'll be no more trouble'.[3] Russell George, whose story opened this thesis, was adamant that his two years of intensive psychotherapy had indeed cured him. Graham Davis, who was interviewed for the same collection after serving a prison sentence for buggery, could report a brief encounter with medicine. He had been told by a prison psychologist to '"re-orientate" my attitude', but as he 'never told me how, or to what' Davis had to conclude that he was 'still disorientated'.[4] Wilfred Johnson, serving a five-year prison sentence for indecent assaults of young boys, had eagerly requested some form of medical treatment, only to be greeted with incredulity and a flat refusal. Nat Burke, after years of homelessness interspersed with prison sentences for importuning and one attempt at psychotherapy, had concluded: 'What I really need treatment for... is for drink. I think I'm an alcoholic'.[5] Andrew Brown, convicted of multiple counts of rape, had spent most of his adult life in mental institutions and a diagnosis of

[1] In 1953 a man reportedly appealed against his sentence for gross indecency on the grounds that he 'now knew that it was possible to be cured by hospital treatment'. 'Indecency with Boys'.
[2] Parker, *The Twisting Lane*, p.154.
[3] Parker, *The Twisting Lane*, p.161.
[4] Parker, *The Twisting Lane*, p.113.
[5] Parker, *The Twisting Lane*, pp.56-57, p.133.

'psychopathic disorder' was strongly implied, while Billy Atkinson's history of indecent assaults and behaviour during his interviews were apparently suggestive of 'a mild manic-depressive psychosis'.[6] These were, as Parker was quick to confirm, not necessarily representative of all sexual offenders, but in his and their attempt to reveal 'something of who and what and how they are', medical interpretations loomed large.[7] At the same time, becoming a patient and receiving a cure were far from guaranteed.

This chapter will consider how and why some sexual offenders, but not all, came to receive medical treatment. Attempts to provide a cure took place within a range of settings, from the *ad hoc* psychotherapeutic interventions of the general practitioner to court-mandated appointments with a psychiatrist. Their full extent can only be estimated. Historian Pat Thane has touched upon the difficulty of capturing informal structures of healthcare provision, and this chapter will follow her lead in using memoirs and other first-person accounts to fill in some of the gaps.[8] This chapter will argue that relatively small numbers of sexual offenders had an opportunity to be 'cured by hospital treatment'. Medical involvement in legal proceedings was not universal, as Chapter 5 showed. Not all offenders would hear medical interpretations of their offences, and a still smaller proportion received treatment, even though a criminal conviction was by no means a prerequisite for medical encounters. Patient numbers were limited by the available resources, both within prisons and elsewhere. They were also restricted by doctors, who often argued that many sexual offenders were incurable. Here, the diversity of causes played an important role. Medical assessments of curability paid less attention to the nature of any particular sexual crime, and focused instead upon the individual's performance in the consulting room and his personal history. Questions of

[6] Parker, *The Twisting Lane*, pp.210-211, p.92.
[7] Parker, *The Twisting Lane*, introductory note [n.p.].
[8] Pat Thane, *Foundations of the Welfare State*, 2nd edn (Harlow: Pearson Education, 1996), especially pp.19-21.

the personality, previous conduct, and co-operation of the patient combined with the availability of suitable treatment to determine who could be cured.

This analysis will offer little by way of consideration of 'the patient's view', in Roy Porter's memorable phrase, or the contribution of medical intervention towards 'the making of deviant subjectivity'.[9] As Jennifer Terry has argued in her chapter by that name, and as some of the stories from *The Twisting Lane* have demonstrated, the 'deviant' might volunteer for treatment and find medical interpretations useful. Others, as recent oral history projects have revealed, recalled medical treatment as profoundly damaging.[10] Analysis of these experiences or of any sense of illness or identity that surrounded or emerged from such treatments lies beyond the scope of this thesis. Instead, this chapter responds to Flurin Condrau's call for 'carefully contextualised analyses of "patients"' in which a specific 'arena' of patients is defined.[11] Patients, here, cannot be understood by studying their own accounts of experiences, perceptions, and reactions to medicine, or by examining the construction of illness and associated creation of patients.[12] They can be more usefully defined by their access to treatment, and medical adjudications of their 'curability'. Sexual offenders who did *not* become patients, whether for any number of practical reasons or because they were interpreted as incurable, slipped out of this particular arena. While remaining potentially disordered by environmental, psychological, physical, and constitutional problems that medicine could explain, they could not be successfully treated and returned to the ranks of the law-abiding.

---

[9] Roy Porter, 'The Patient's View: Doing Medical History from Below', *Theory and Society,* 14 (1985), 175-198; Terry, 'The Seductive Power of Science in the Making of Deviant Subjectivity'.
[10] Smith *et al.*, 'Treatments of Homosexuality'; Dickinson, 'Mental Nursing and "Sexual Deviation"'.
[11] Flurin Condrau, 'The Patients' View Meets the Clinical Gaze', *Social History of Medicine,* 20 (2007), 525-540 (p.536).
[12] Condrau draws this distinction, the two sides of which he associates with Porter and David Armstrong respectively.

By the time that the interviews recorded in *The Twisting Lane* were undertaken in the 1960s, Harry Mills' status as a potential patient was becoming less certain. On the occasion of his first arrest for indecent exposure in 1942, he had been an ideal candidate for cure. Available facilities for his treatment combined fortuitously with his own youth, eloquence, and ready co-operation. In the years that followed the Second World War, resources remained under pressure and data regarding the results of treatment were discouraging. Mills' own case history was beginning to count against him as he grew older and his personal catalogue of failed treatments grew longer. In all likelihood, his prison sentences were too short for him to be considered for transfer to one of the prison psychological units. A medical approach to sexual offenders had taken root, but in its effort to explain many different types of sexual crime and to provide for a wide range of outcomes, medicine acknowledged that far from all sexual offenders could be treated. The failure of medicine to stop Harry Mills from reoffending meant that his chances of re-establishing himself as a patient and finding the cure he so desperately sought were increasingly remote.

### 6.1 Treatment in prison

The prison medical staff of the 1920s and 1930s may have claimed some expertise in the interpretation of sexual crime, but their opportunities to offer treatment and cure were limited. Before the formal introduction of psychotherapy in 1934, attempts to provide psychologically informed assistance could take place as part of examinations and assessments of mental state. The doctor of Liverpool prison felt sure that some of the 'improvement in the mental condition of certain cases in the observation ward' at his prison could be attributed, at least in part, to 'personal interviews with the Medical Officers'. These, he felt, might 'assist the patient to re-adjust his attitude towards his problems and render him better able to face the future on his return to the outside

world'.[13] Similarly, the attention paid by the prison medical staff to Harold Jones was officially in order to assess his suitability for detention with juveniles or release, but in practice, it could include some attempts at 'psychological help'. Dr Methven was confident that these interviews had enabled Jones to gain 'good insight into his condition', which might be of benefit to him in future.[14] Even after psychological units had begun to spring up, prison officials remarked that it 'is not easy to assess with precision the amount of minor psychotherapy undertaken by medical officers' across all prisons.[15] Informal efforts to provide help, while not constituting treatment or cure in any strict sense, were perhaps taking place.

This, however, would inevitably vary from doctor to doctor, and from prison to prison. As several prison memoirs of the period made clear, the medical staff members differed dramatically from each other in their approach to the individuals under their care.[16] Some, including Norwood East, Hamblin Smith, and, later, Dr Young seem to have been interested in attempting 'minor' (and unrecorded) psychotherapy throughout their long careers. Others, as Wilfred Johnson's memories of requesting treatment while in prison suggest, may have been much more dismissive. Levels of staffing and overcrowding would also have an impact upon the amount of time that doctors could spend with individual prisoners, with treatment potentially more likely in larger prisons with full-time and more experienced medical staff. The doctors at local prisons, who were often general practitioners balancing prison work with their own practice, generally

[13] *Report of the Commissioners of Prisons and the Directors of Convict Prisons for the Year 1938* (London: H. M. Stationery Office, 1939) p.66.
[14] First of Dr Methven's reports from 1941, in 'Harold Jones: Convicted at Monmouth 28 October 1921 of Murder and Sentenced to Death', The National Archives (London), PCOM 9/742.
[15] *Report of the Commissioners of Prisons for the Year 1951* (London: H. M. Stationery Office, 1952) p.85.
[16] Macartney and Mackenzie, *Walls Have Mouths*, pp.113-116; Jim Phelan, *Jail Journey* (London: Secker & Warburg, 1940) p.113, p.204, pp.238-240.

received short shrift in prison memoirs.[17] The interests and views of individual doctors as well as the scale of their workload would undoubtedly have been important.

Treatment on a more official footing could be provided by external specialists, but this was extremely rare. Occasional references to the attempted cure of a prisoner at a Harley Street clinic during the early 1930s emphasise the unique nature of the case. In fact, it is likely that all such mentions refer to the same high-profile individual, Augustine/Austin Hull.[18] Ex-prisoner Richmond Harvey recalled a fellow prisoner in Wormwood Scrubs who was physically male, but female in appearance and demeanour and who had been convicted for living with a man, as his wife. 'In all my experience of prison life', he noted, 'this was the only man for whose mental and moral welfare the authorities adopted special and extraordinary measures'. He was taken regularly to 'a specialist in Harley Street, with the object of curing him of his girlish habits'.[19] Dr Henry Dicks of the Tavistock clinic recalled the sensational arrival 'three times weekly of a prisoner serving a sentence for homosexual offences' in the early 1930s, quite possibly the same individual.[20] Hull's case, which would fit Harvey's description, had attracted the attention of the Howard League, which had argued that there was clear evidence of mental disorder and that Hull should be managed by means of medicine rather than imprisonment.[21] Public pressure of this kind had induced the Home Office to make special arrangements for psychological treatment, transferring Hull to Wormwood

[17] For example, Wildeblood, *Against the Law*, pp.103-104.
[18] Accounts and analysis of Hull's case are in McLaren, *Twentieth-Century Sexuality* p.107; Lesley Hall, *Sex, Gender and Social Change in Britain since 1880*, 2nd edn (Basingstoke: Palgrave Macmillan, 2013) pp.123-124; Oram, *Her Husband Was a Woman! Women's Gender-Crossing in Modern British Popular Culture*, pp.83-84.
[19] Harvey, *Prison from Within*, p.264.
[20] Dicks, *Fifty Years of the Tavistock Clinic*, p.45.
[21] Policy sub-committee meeting of 18 January 1932 and executive committee meeting of 22 April 1932, in 'Howard League Committee Meetings 1932-1937', Modern Records Centre (Warwick), MSS.16B/1/2.

Scrubs for easy access to London specialists. This was, evidently, far from an everyday occurrence, though.

The recruitment of a psychotherapist at Wormwood Scrubs meant that such treatment could be provided, from the mid-1930s, without recourse to Harley Street. As mentioned in Chapter 3, sexual offenders featured prominently when the first prison psychological unit opened in 1934. A total of 124 sexual offenders were approved for treatment with Hubert between 1934 and 1939, representing just over half of his patients even though sexual crimes only accounted for about 4% of the prison population.[22] As psychological and psychiatric treatment gradually spread throughout prisons in the years following the Second World War, sexual offenders consistently numbered about half of those treated, with about half of these classed as homosexual offenders. Other diagnoses or classifications were remarkably varied, including cases of transvestism, flagellation, bestiality, fellatio, indecent exposure, sadism, and fetishism, as well as occasional cases of incest and assaults of women or girls.[23] Treatment for women in prison, beyond the provision of VD clinics, remained unmentioned.

Despite the predominance of sexual offenders within prison psychological units, the most common refrain about treatment for sexual offenders in prison was that the nation laboured under a sad delusion regarding its existence. Judges, it was held by some former prisoners, campaigners, and doctors, held a misconception in this respect and assumed too frequently that a prison sentence would include medical treatment or cure. This had been the case even before the prison staff had included psychotherapists. In 1927, for example, as a labourer of doubtful mental state was convicted of gross

[22] Norwood East and Hubert, *The Psychological Treatment of Crime*, p.150.
[23] *Report of Prisons for 1949*, p.92; *Report of Prisons for 1958*, p.103; *Report of Prisons for 1962*, p.60.

indecency, the judge sentenced him to a term of imprisonment while expressing the belief that the 'prison doctor would be good enough... to give special attention to prisoner's mentality'.[24] A few years later at the Durham Assizes, another judge feared that there was 'very little left' of the mind of a man charged with an unspecified sexual offence. He asked the prison doctor how long he would need to 'to certify him as to his mentality', and upon hearing that it would take around three months, passed a prison sentence of exactly that duration to allow for further examination and confirmation that the man was insane.[25] Rather like the practice of holding prostitutes on remand so that treatment for VD could be dispensed, this made use of prisons and their staff to deliver medical examinations and treatment. Norwood East's complaints about this practice suggest that these were not isolated incidents.[26]

Although prison doctors complained that judges were improperly assuming that sexual offenders in prison would receive treatment, their concerns were rather different from those of campaigners. This latter group expressed their views with increasing volume as the legislation surrounding homosexual acts between men was debated in the 1940s and 1950s, and were often used to bolster claims that prison was an inappropriate response to such crimes. Former prisoners, perhaps most notably Peter Wildeblood, described themselves as having been willing to undergo treatment, only to find that there was none available to them. In a book that was sent to every MP in the wake of the appointment of the Wolfenden Committee, Wildeblood maintained that at 'Wormwood Scrubs, which is so often pointed out as a centre for the psychological treatment of

[24] 'Bucks Autumn Assizes', *Bucks Herald,* 22 October 1927, p.4.
[25] 'Sapped His Own Mind: Judge and a Prisoner's Mentality', *Northern Daily Mail,* 17 November 1931, p.5.
[26] He acknowledged that 'the magistrates might have had in mind the protection of the public from a man who was a nuisance', in the case of persistent sexual offenders, but protested that this was not the proper purpose of a prison sentence. *Report of the Commissioners of Prisons and the Directors of Convict Prisons for the year 1932* (London: H. M. Stationery Office, 1934) p.35.

offenders, the facilities for such treatment were not so much inadequate, as virtually absent'. He reported meeting 'many men who had been told by judges that they were being sent for three, or five, or seven years to a place where they would be properly looked after' but that 'nothing whatever was being done for them'. Most importantly, in cases such as his own, treatment *was* available elsewhere.[27] The anonymous author of 'Prison and After' agreed that at 'no time during my imprisonment was there any reference to the psychological treatment promised by the Judge', and that it was in fact 'an illusion – one, I may add, that is still widely held in judicial circles and still frequently quoted as a justification for prison sentences in homosexual cases'.[28] 'When judges promise treatment in prison to unlucky sex offenders given long sentences', agreed writer and former prisoner Rupert Cooke-Croft, 'they do not perhaps realize that there is one psychiatrist to twenty-five thousand prisoners'.[29]

Campaigners may have been inclined towards exaggeration in the name of making a clear and persuasive case for homosexual law reform, but Cooke-Croft's estimate was not too far from the truth. Nor was the discussion exclusive to former prisoners. In 1948, one respondent to a Howard League questionnaire complained vigorously that amongst the sexual offenders he had met in the course of his own medical practice, 'Each admitted <u>not having seen a Dr for any reason whatsoever</u>'. One particular case had unsuccessfully 'asked to be sent to Broadmoor' but 'to my knowledge nothing has been done <u>in prison</u> to try & help this man recover from his terrible condition'.[30] Dr Clifford Allen, psychoanalyst and staunch supporter of

[27] Wildeblood, *Against the Law*, pp.186-187, pp.91-92.
[28] 'J. D.', 'Prison and After', *The Howard Journal of Criminal Justice,* 9 (1955), 118-124 (p.121).
[29] Rupert Croft-Cooke, *The Verdict of You All* (London: Secker & Warburg, 1955), p.221-222. The same point was made in George Dendrickson and Frederick Thomas, *The Truth about Dartmoor* (London: Victor Gollancz, 1954) p.167.
[30] 'Enquiry into Mental Health in Prisons', Modern Records Centre (Warwick), MSS.16C/3/MH/1-19. Underlining in original.

psychotherapy for offenders, wrote with frustration in the *BMJ* that 'I have seen many patients who have been imprisoned but have never seen one who has had any form of psychotherapy by the prison doctor'.[31] Although the ex-prisoners he encountered in his private London practice may not have been entirely representative of the former prison population at large, he was quite right to notice that only a very few of those imprisoned for sexual offences would have a chance to receive treatment.[32] This was not only the case for those convicted of homosexual offences, as the experiences of many of those interviewed by Tony Parker demonstrate. Harry Mills, for one, had only received treatment as an alternative, not accompaniment, to prison.

Perhaps in response to these criticisms, prison doctors voiced growing insistence that very few sexual offenders in prison *should* become patients. Despite remaining adamant that they should always be examined by a doctor before trial or sentencing, prison doctors expressed less confidence that sexual offenders were particularly amenable to treatment. 'Of the cases examined here', wrote the doctor of Leeds prison in the mid-1930s, 'the sex perverts present the greatest problem. The number of those who can be treated with any hope of a cure is so small'.[33] An unnamed prison doctor at one of the psychological units pointed out that although a great many sexual offenders were referred for his consideration, the question of how much could be 'achieved psychotherapeutically for these patients is a very controversial question'. For many, 'the prospect of improvement with psychotherapy is, I think, remote'. 'Of course I am all in favour of every sexual offender being psychiatrically investigated', he hastened to add, but 'it would be a mistake to give the impression that many of them can be treated

[31] Allen, 'Homosexuality', p.450. It is not impossible that the Howard League survey respondent was, in fact, Clifford Allen himself.
[32] Figures for around this time are in *Report of Prisons for 1949*, pp.92-93, p.17.
[33] *Report of Prisons for 1936*, p.71.

psychiatrically'.[34] Another prison doctor wrote in stronger terms. He was, he felt, 'entitled to deplore in the strongest possible terms the opinion so widely held today that psychotherapy affords a panacea for all abnormality of conduct, particularly that in the sexual field'.[35] *The Psychological Treatment of Crime* featured large numbers of case studies of sexual offenders to illustrate when successful treatment was 'impossible', 'completely hopeless', 'out of the question', or when 'material was so unpromising from the therapeutic angle that very little could be done'.[36] Such case studies encompassed those guilty of all types of sexual crime, including homosexual offences, indecent exposure, indecent assaults of women, thefts of women's clothing, and arson that was diagnosed as associated with sexual sadism. The report emphasised that the nature of the crime was not necessarily indicative of prognosis, and it was amongst adolescent offenders, rather than sexual offenders, that the most suitable candidates for cure were found.[37]

In resisting calls for more sexual offenders to be managed medically, prison doctors drew attention to the possibility that this group might abuse opportunities for treatment. The difficulty was, they argued, that participating in psychotherapy might offer some improvement on normal prison conditions, such that offenders would be keen to volunteer. As a member of the Prison Medical Reform Council put it, 'most prisoners will jump at the opportunity for any kind of medical treatment, merely to escape from their cells for a short time daily'.[38] In relation to sexual offenders in particular, prison doctors suspected that many had no real desire to be rid of a disorder that potentially afforded them pleasure. The 'vast majority of these cases', said the

[34] *Report of Prisons for 1954*, p.138.
[35] *Report of Prisons for 1949*, p.121.
[36] Norwood East and Hubert, *The Psychological Treatment of Crime*, p.95, p.110, p.111, p.99, p.118, p.120.
[37] Norwood East and Hubert, *The Psychological Treatment of Crime*, p.153.
[38] Reid, *The Case of the Homosexual*, p.7.

doctor at Leeds, 'believe that perversion is better than cure'.[39] Norwood East related the case of an offender convicted of indecency who had been considered for treatment, but it became clear that 'he appreciated the practical benefits that might accrue to him if he was regarded as an interesting psychological problem rather than as a man who had made no effort to counteract his weakness by his own efforts'. Although he 'ingratiatingly and plausibly expressed contrition for his offences and his realisation of his mental abnormality', this was determined to be false and the devious offender was quickly removed from the treatment programme.[40] In order to become a patient while in prison, offenders would have to overcome considerable suspicion.

Misgivings regarding the motivations of sexual offenders seeking treatment in prison meant that even the most eager volunteers might be turned away. An unnamed doctor at Maidstone prison related his experience with a prisoner who 'wanted his dreams analysed, but at the first interview it was found that what he really wanted was a softer mattress to lie on'.[41] Needless to say, his treatment was brought to an abrupt halt. Wilfred Johnson had embraced the belief that his indecent assaults might have been symptoms of disorder, describing a 'kind of illness almost... like a malady come upon you'. He asked to see the prison doctor, to find out if anything could be done for him. 'Why haven't you tried to get treatment for yourself while you were out, instead of waiting till now?', the doctor demanded to know. This 'great big man', 'more like a publican than anything else' in Johnson's eyes, was suspicious that after twenty years of persistent sexual crime, only an eight-year prison sentence seemed to have instilled a desire for cure. Johnson was despatched with the verdict that 'there's no treatment we

[39] *Report of Prisons for 1936*, p.71. This was echoed by Desmond Curran, who highlighted 'the very comprehensible difficulty in cooperation shown by the patients' when they obtained sexual gratification from their perversions. Curran, 'Sexual Perversions and Their Treatment', p.345.
[40] *Report of Prisons for 1936*, p.63.
[41] *Report of Prisons for 1933*, p.41.

can give you, so you're wasting my time'.[42] This experience was echoed by 'Norman', interviewed for another collection by Tony Parker, who had a large number of convictions for sexual assaults and rape. Upon arriving in prison for the first time in the late 1950s, he reportedly 'asked for treatment or help of some kind, but I was told there wasn't any, it was up to me to go and see a doctor myself when I got out'.[43] Expressing a desire to become a patient while in prison was evidently not enough.

Detailed information about the extent of treatment within prisons was rarely published. A summary of the outcomes of psychotherapy and other interventions was even more rare, often given in the express hope that it would 'do something to correct the opinion prevalent in some quarters that a vast number of cases – especially those of a violent and sexual nature – have only to be subjected to specialised psychiatric treatment for their anti-social proclivities to be effaced'.[44] At the same time, the prison service was defensive that it achieved as much as could be expected. In the 1950s, Landers protested that a reconviction rate of 40% amongst the 'sex cases' treated at Wormwood Scrubs should not be considered too great a failure. These patients, he argued, 'have already had the opportunities of other forms of treatment' in various other institutions without any success, and would invariably have an extremely high rate of reconviction if no treatment at all were given.[45] Sexual offenders in prison were not only faced with limited resources for treatment and a suspicion that they might

[42] Parker, *The Twisting Lane*, pp.56-57.
[43] Parker, *The Frying-Pan*, pp.181-182.
[44] *Report of Prisons for 1952*, p.98.
[45] See Norwood East and Hubert, *The Psychological Treatment of Crime*, p.78; and *Report of the Commissioners of Prisons for the Year 1957* (London: H. M. Stationery Office, 1958) p.95. The same argument has also been used recently in relation to Grendon, where the high cost per prisoner is justified on the basis that 'the type of prisoner that Grendon accepts' is likely to be far more challenging than a prisoner in a 'normal' prison, and Grendon therefore has far more in common with 'Rampton, Ashworth and Broadmoor, or with the dangerous and severe personality disorder units'. See David Wilson, 'Grendon: A Prison in Danger', *Inside Time,* <http://www.insidetime.org/articleview.asp?a=843> [accessed 6 August 2013].

volunteer only to alleviate boredom, but were also seen as particularly likely to be incurable.

Even though psychological services within prisons gradually increased in scale, only a small number of carefully selected sexual offenders were permitted to attempt a cure. The majority were deemed unsuitable. The prison medical service became, in some respects, a victim of its own enthusiasm, with interest in research and more thorough mental examinations quickly overtaken by the need to identify the most promising cases for treatment. In 1939, Norwood East and Hubert had offered the preliminary conclusion that 'a considerable number' of sexual offenders 'need further investigations and the trial of more specialist methods', but that this would require a great deal more investigation.[46] Just a few years later, this 'emphasis... on investigation of suitable cases' had been replaced with the delivery of treatment to those very few who seemed to be the most hopeful prospects for cure.[47] That this coincided with the heightened attention paid to sexual offenders in the post-Second World War years proved damaging. As Matt Houlbrook and Chris Waters have argued, criticisms of the existing laws surrounding male same-sex acts often made use of the idea that homosexuality was a disease, which led to wider expectations or assumptions that treatment and cure might be the solution.[48] Within prisons, these expectations proved impossible to meet. By contrast, as the next section will discuss, doctors elsewhere were able to accept more sexual offenders as patients, even if a cure remained equally elusive on the other side of the prison wall.

[46] Norwood East and Hubert, *The Psychological Treatment of Crime*, p.152.
[47] *Report of Prisons for 1942-1944*, p.65.
[48] Houlbrook, *Queer London*, especially pp.247-257; Waters, 'Disorders of the Mind'.

## 6.2 Treatment at liberty

Despite great enthusiasm in some quarters for medical assessments of sexual offenders before sentencing, this group made up a surprisingly small proportion of the first referrals from the courts to private clinics. In the twelve months to March 1931, the Tavistock saw only 15 patients with broadly defined 'sex difficulties', representing slightly over 1% of its patient roster of 1,342 individuals. The reason for this was twofold: firstly, although its referrals from the courts were increasing, they remained a very small proportion of the Tavistock's patient intake as a whole, with the vast majority coming from general practitioners, hospitals, and the friends and employers of the unwell. Criminal activities were, therefore, unlikely to form a significant burden of its work. Secondly, and perhaps more importantly, the clinic initially tended to categorise its patients by diagnosis. Neuroses, anxiety, and backwardness were found to be far more frequent amongst its patients than 'sex difficulties', although conceivably the neurotic, anxious, and backward may have displayed abnormal sexual conduct or even committed sexual crimes. Sexual offenders did not yet have a presence in clinic records as a distinct group.[49]

This had begun to change within specialist clinics by the 1930s. To some extent, this was in reaction to growing medico-legal interest in sexual offenders more generally, leading to a change in classification policies. It may also have reflected a difference in the composition of their patient population, as courts and probation officers singled out sexual offenders more regularly. In a study of its work from 1921 through to 1937, the Tavistock gave details of its 'sexual offender' patients, irrespective of diagnoses of anxiety or neurosis, and specified that these included 'homosexuality, exhibitionism,

[49] *Report of the Tavistock Square Clinic for Functional Nervous Disorders for April 1930-March 1931* (London: Tavistock Square Clinic, n.d. [c.1932]) p.12.

sexual assault, habitual prostitution and one case of transvestism'.[50] In 1934, the ISTD saw 71 new patients of whom 21% were 'sex cases'. The 'sex cases' increased to 47% of all new patients by 1937 and peaked at 49% of new referrals in 1941. Referrals of sex cases declined during the later war years, reportedly due to an increased focus upon younger people, but probably continued to comprise between 20% and 30% of new patients throughout the 1940s and 1950s.[51] In the 1950s, this group was said to include cases of indecent exposure, indecent assault, and homosexuality, with homosexual offences accounting for just under half of referrals and indecent exposure about one third.[52] From the 1930s, therefore, sexual offenders convicted or suspected of a variety of offences were likely to be counted as a distinct group in these specialist sites, but actual numbers remained small in line with the limited patient intake of these clinics.

Comprehensive information about treatment provided in hospitals to sexual offenders, or by psychiatrists working independently or based within universities, is not readily available. However, it seems that these efforts may have been small in scale. In one report from 1937, those patients seen in the observation ward of a mental hospital and diagnosed with 'moral abnormalities' numbered just 6 out of a group of 518, and there was no mention of sexual disorder, perversion, or crime at all. In another, a series

[50] 'Report from the Tavistock Clinic sent by J R Rees to Sir Alexander Maxwell', The National Archives (London), HO 45/18736, File 438456/33.
[51] Annual Report for 1934, in 'Reports and minutes of meetings of the Institute for the Scientific Treatment of Delinquency', Archives of the Centre for Crime and Justice Studies (London), [uncatalogued]; Glover, *The Diagnosis and Treatment of Delinquency*, pp.10-11; Glover, *Sexual Abnormality*, p.10; Glover, *The Problem of Homosexuality*, p.3. Although complete figures are not available for the years after 1948, when the clinic was absorbed into the NHS, assorted comments in these publications and the annual report for 1957 suggest that in 1952, sexual offences made up 23% of all new cases, 27% in 1953, and 29% in 1957. The figures for 1957 are held in 'Archives of Ismond Rosen', Wellcome Library (London), PPROS/D/1.
[52] Handwritten notes in 'Archives of Ismond Rosen: Exhibitionism: Group therapy', Wellcome Library (London), PP/ROS/E/2; and the annual report for 1957 in 'Archives of Ismond Rosen', Wellcome Library (London), PPROS/D/1.

of 70 patients included only 2 suffering from 'sex perversion'.[53] The fact that hospitals may have lagged behind the specialist clinics was acknowledged by Dr Aubrey Lewis of the Maudsley, as he reflected upon the future ambitions of this hospital in the early 1940s. 'The Maudsley', he wrote, did not have 'the close relationship with the courts or the industrial medical or other services which it would be good to foster. Delinquency, except in children was not reckoned as a department of Maudsley work' and had thus far been left to the Tavistock and ISTD.[54] Accounts of treatment for sexual offenders in diverse hospital settings after the Second World War suggest that, again, the numbers involved were small, and attention to this particular field may have depended to a great extent upon the specific interests of individual doctors. Specialists including Dr Desmond Curran, Dr Jack Hobson of the Middlesex Hospital, and Dr Sessions Hodge at the Burden Neurological Institute were all actively involved in the treatment of sexual offenders as a broad category of patient in the post-war years, as was Glover in private practice.[55]

Details of probation orders with a condition of medical treatment have not been retained in court archives, and still less is known about conditional discharges, acquittals, and other court decisions in which treatment was unofficially encouraged.[56] Two studies by criminologists, relating to the early 1950s, offer some insight into the situation by this point. Radzinowicz's enquiries established that medical evidence was

[53] E. U. H. Pentreath and E. Cunningham Dax, 'Mental Observation Wards: A Discussion of Their Work and Its Objects', *Journal of Mental Science,* 83 (1937), 347-365 (p.355); J. Bierer, 'Psychotherapy in Mental Hospital Practice', *Journal of Mental Science,* 86 (1940), 928-952 (p.942).

[54] Memorandum by Aubrey Lewis dated 18 August 1942, in 'Papers of Sir Aubrey Lewis: correspondence, reports, copy minutes and papers', Bethlem Royal Hospital Archives & Museum (London), AJL-12.

[55] This is indicated by their evidence to the Wolfenden Committee, in 'Transcripts of evidence hearings: Committee on Homosexual Offences and Prostitution', The National Archives (London), HO 345/14, and by publications including Curran, 'Sexual Perversions and Their Treatment'; Sessions Hodge, 'Medico-Legal Aspects of the Treatment of the Sexual Offender'.

[56] Some information is available about psychiatric probation orders in general, in Walker and McCabe, *Crime and Insanity in England*, vol. 2, pp.66-67; T. C. N. Gibbens, K. Soothill, and C. Way, 'Psychiatric Treatment on Probation', *British Journal of Criminology,* 21 (1981), 324-334.

placed before the courts in around 20% of all cases of sexual crime, and about 16% of sexual offenders were placed on probation. Of these, just over a quarter were required to undergo medical treatment as a specific condition of probation, most commonly to be delivered on an out-patient basis by hospitals or psychological clinics. Thus, by the early 1950s, approximately 7% of convicted sexual offenders were receiving psychiatric treatment on an official footing outside of prisons.[57] This was clearly a small proportion, even if rather more were seeing a doctor on an informal basis after trial. Nonetheless, an offender had a better chance of becoming a patient in this way than inside prison. There was also a disproportionate chance that sexual offenders, rather than violent or property offenders, would be managed in this way. Max Grünhut's analysis of psychiatric probation orders in the year 1953 found that 636 had been issued, of which 216, or one third, were for sexual offences.[58] This, he was at pains to point out, was lower than might be expected solely because of the huge number of offenders against property who were prosecuted each year, creating a weight of numbers that threatened to distort the record. He emphasised that sexual offenders were, in fact and in his view quite correctly, over-represented.

The chances of a sexual offender becoming a patient appear to have increased for those serving in the armed forces during or in the aftermath of the Second World War. This period also saw working-class men referred for treatment as well. Of the eight sexual offenders interviewed by Tony Parker in the late 1960s, two were first sent for psychiatric treatment while enlisted in the army in the 1940s. Harry Mills was a baker who had been brought up in a children's home and given his professional training by the charity of the Church Army, and Nat Burke was a former store-boy at a Dublin brewery who remembered being raised in 'great poverty' during the 1930s. Both were quite

[57] Radzinowicz, *Sexual Offences*, p.xxi, p.183, p.218, p.236, p.263.
[58] Max Grünhut, *Probation and Mental Treatment* (London: Tavistock Publications, 1963) p.12.

unlike the elite clientele of King's Counsel and Harley Street during the interwar period.[59] In an effort to salvage them for the military, they were presented to army psychiatrists after their indecent acts, and Mills was able to continue in his duties almost without pause. Similarly, although the prompt for Thomas Worsley's treatment was 'what they used to call a nervous breakdown' rather than any criminal act, a referral from an army doctor during the war for psychoanalysis provided him with an opportunity to 'wrestle' with problems including, but not limited to, his sexual attraction towards adolescent boys.[60] The involvement of psychiatry in the war effort bolstered its status and allowed the delivery of medical treatment for sexual problems to proliferate.

The relatively small proportion of sexual offenders receiving treatment even after the war may have been, in part, down to the limited resources that were available outside as well as inside prisons. Edgar Jones has argued that although psychotherapy was much celebrated during the Second World War, this created levels of demand and expectation that were too high for psychiatrists to meet afterwards.[61] Complaints about the lack of facilities for psychiatric treatment were voiced with regularity. 'It is all very well to say that the Court is empowered to order medical treatment', protested Dr Denis Carroll, but 'how are they to get it? It is hard enough in London, it is practically impossible in rural areas, and very difficult in the provincial cities'.[62] The Manchester and Salford Council of Social Services asserted that facilities were entirely 'inadequate to meet the present situation': 'In the north-west region, to serve a population of over six millions, there are... 28 hospital out-patient clinics' of which 'none are at present able to

[59] Parker, *The Twisting Lane*, p.148, p.123, p.126.
[60] T. C. Worsley, *Flannelled Fool: A Slice of Life in the Thirties* (London: Alan Ross, 1967) pp.211-212.
[61] Jones, 'War and Psychotherapy'. He also suggests that the achievements of psychotherapy may have been exaggerated in the name of morale.
[62] Denis Carroll, 'Mental Treatment in Delinquency under the Criminal Justice Bill', *Probation Journal,* 3 (1939), 101-103 (p.103).

give effective psycho-therapeutic treatment'. 'All are overcrowded', the Council went on to say, 'and unable to accept patients without delay'.[63] Justice of the Peace Lady Inskip reported that after an investigation into the situation in Bristol, if numbers of patients increased at all, 'there would be great difficulty in finding the psychiatrists to do the work'.[64]

After the establishment of the NHS and the passage of the long-delayed Criminal Justice Bill into law in 1948, hospitals with psychiatric facilities did make their services available. Selected offenders could be dispatched to mental hospitals around the country. The Maudsley, for one, established a dedicated clinic under Dr Peter Scott specifically in order to meet the Act's requirements in relation to treatment for probationers in the London area.[65] Harry Mills attended hospitals in Buckinghamshire and Surrey after his first experience as a patient at a Birmingham military hospital during the war.[66] However, limited space and personnel meant that, even if both offender and magistrate were enthusiastic about the possibility of a probation order with medical treatment, the necessary expertise and facilities were still not always available unless the offender had private means. As Ellis had recognised in the 1930s, 'unless the offender is well-to-do he cannot be sent to an institution for expert investigation and treatment'.[67] This 'problem from the practical point of view', for Clifford Allen, was that 'there are so few places where [treatment] can be obtained', even within the NHS, and so opportunities remained vastly more accessible for those with money. If a sexual offender

[63] Memorandum from the Manchester and Salford Council of Social Services, to the 'Advisory Council for the Treatment of Offenders', The National Archives (London), HO 326/55. Unfortunately there are no records available about the operation of this clinic.
[64] Meeting of 19 March 1947, in 'Minutes of the first 27 meetings: Advisory Council for the Treatment of Offenders', The National Archives (London), HO 326/56.
[65] Mentioned in A. Leitch, 'The Open Prison', *British Journal of Delinquency,* 2 (1951), 25-33 (p.46).
[66] This was quite possibly Northfields, the much celebrated military hospital. Parker, *The Twisting Lane*, p.148, p.151, p.152.
[67] Ellis, *Psychology of Sex*, p.168.

could not 'afford private treatment', Dr Allen said, it 'is almost impossible for him to be cured'.[68] This was reiterated within the evidence gathered by the Wolfenden Committee, in which Home Office representatives acknowledged that although clinics providing out-patient treatment could be useful in dealing with sexual offenders, there 'are not as many places of that kind as we would wish to see', and 'pressure on accommodation' within psychiatric hospitals hindered the transfer of those on remand for specialist assessment.[69] Even by 1960, doctors felt that there were insufficient specialists and clinics to deal with the problem satisfactorily. 'I think what one is up against', Rosen reflected, is 'the lack of facilities provided in this country'. Rosen himself reported treating sexual offenders at his London clinic from as far away as Hull.[70]

Despite these difficulties, clinics and hospitals were not restricted to treating only those referred by the courts. Some individuals, aware that they might be considered abnormal, sought out medical advice themselves.[71] One clinic study from the 1950s found that although 67% of its 'homosexual' patients had been referred by court officials, the remainder had come via hospitals, GPs, Approved Schools, welfare workers, or entirely independently. A brush with the law might serve as a prompt for seeking medical advice, but it was by no means a prerequisite. Even family members might instigate treatment. Dr David Stafford Clark observed that, in his professional experience of fetishism and cross-dressing, 'in every case the complaint was made by the wife'. Although he was quick to point out that a patient could not actually be treated in their

[68] Clifford Allen, 'Sexual Offenders', *British Medical Journal,* 1 (1949), 547-548 (p.547);
[69] Meeting of the Committee on 15 October 1954, in 'Transcripts of evidence hearings: Committee on Homosexual Offences and Prostitution', The National Archives (London), HO 345/12.
[70] 'Archives of Ismond Rosen', Wellcome Library (London), PPROS/D/1.
[71] Examples include 'Thomas' in Weeks and Porter, *Between the Acts*, p.65.

absence, his comment hints at conversations with worried family members that may have been taking place in consulting rooms around the country.[72]

Even though such patients may not have committed any criminal act, let alone have received a conviction, they were often still classed as offenders. 'All of them had committed offences', maintained Rees of the 'sex cases' treated at the Tavistock in the 1930s, 'though not all of them had come within notice of the police'. In fact, he was incorrect. His cases included 'female homosexuality', which was, as the clinic's official report later acknowledged, not criminalised at all.[73] Similarly, although researcher Mary Woodward had found that fully one third of the patients treated for homosexuality at the ISTD had *not* been sent by the courts, the term 'offender' remained in the title of her study. This confusion between diagnosis and crime is neatly captured in a 1953 textbook on psychological disorder by Neustatter. Some mental disorders, he wrote, were not simply illnesses that might cause the patient to break the law, but were 'offences in their own right'. The clearest examples for him were the sexual perversions, since 'if they are indulged in, they are illegal in themselves'. In this explanation, 'sexual perversion' served as both a mental disorder and a criminal act, whether or not any breach of the law was actually involved. Before being accepted as a patient, the 'sexual offender' did not need to be guilty of *criminal* acts at all.

[72] Woodward, 'The Diagnosis and Treatment of Homosexual Offenders', p.45; Good, 'The Danger in our Midst', pp.58-59; Talk entitled 'Essentials of the Clinical Approach in General Psychiatry' by D. Stafford Clark, in 'Archives of Ismond Rosen: Sexual Deviation: 'The Pathology and Treatment of Sexual Deviation' two-day conference, Royal Society of Medicine, Oct 1960', Wellcome Library (London), PP/ROS/D/1.

[73] Woodward, 'The Diagnosis and Treatment of Homosexual Offenders'; Neustatter, *Psychological Disorder and Crime*, p.12; Letter from Dr J. R. Rees dated 19 February 1939 and report from the Tavistock Clinic in 'Psychological Treatment of Crime, 1921-41', The National Archives (London), HO 45/18736.

It is likely that worried individuals consulted GPs or psychiatrists more frequently in the wake of public discussions of sexual crimes. Such discussions were given a new prominence as newspaper reporting became more explicit from the late 1940s. Adrian Bingham has identified this as a turning point for the press, with an increase in coverage of stories to do with sex and the adoption of a newly medical or scientific approach.[74] Newspaper coverage of homosexuality, such as the *Sunday Pictorial*'s infamous series on 'Evil Men' of 1952, likely also drove some to seek a cure. One individual who requested treatment remembered that 'the newspapers were full of the most vituperative filth that made me feel suicidal', and recalled feeling 'totally bewildered that my entire emotional life was being written up in the papers as utter filth and perversity'.[75] Another echoed that 'all I had to do was open the daily paper and it was rubbed in my face how evil and perverse I was. It made me feel like ending it all. I knew I had to do something; it was either kill myself or cure myself'.[76] Importantly, this was not limited to reports about homosexuality. One psychiatrist mentioned seeing a number of patients after the trial of Neville Heath, 'who had throughout their lives been troubled by sadistic impulses and who feared that they might behave like that well-known sadistic murderer'.[77] High-profile reportage may have had an impact, irrespective of the nature of the offence itself, albeit within the limitations of medical facilities already addressed.

The extent of interest in homosexual offences, in both historical and contemporary settings, conceals the wide variety of 'sex cases' that were treated. Indecent exposure was a frequent feature of newspaper reports of medical treatment, as were indecent assaults of children. A remarkable array of diagnoses including

[74] Bingham, *Family Newspapers*, p.12.
[75] Smith *et al.*, 'Treatments of Homosexuality', p.427.
[76] Dickinson *et al.*, '"Queer" Treatments', p.1349.
[77] Curran, 'Sexual Perversions and Their Treatment', p.347.

fetishism, bestiality, 'gerontophilia', 'narcissism', 'phallic fixation', 'polymorphous perversion', and 'bestiosexual oralism' were all also open to medical consideration. Case studies from the 1950s, in particular, also explored the treatment of unusual fetishes and violent sexual impulses.[78] In terms of the numbers referred from the courts to doctors, indecent exposure seems to have vied with homosexuality as the most common. This was certainly Grünhut's finding for the year 1953, when rather more of the psychiatric probation orders handed down for sexual offences were for indecent exposure than for homosexual offences.[79] However, indecent exposure was reported to the police and prosecuted much more frequently. In the year of Grünhut's study, the *proportion* of homosexual and indecent exposure offences which led to psychiatric probation orders was roughly equal. Heterosexual crimes were about half as likely to be managed in this way.[80] Although heterosexual offences were not overlooked, it would appear that they were of less interest to doctors *and* less frequently seen as requiring a cure.

In general terms, doctors affiliated to the Tavistock and ISTD were more confident than their colleagues working in prisons that sexual offenders were suitable for treatment. Discussing those with 'sexual perversions' of all kinds in the 1930s, Hadfield maintained that 'many of them are cured'.[81] A Tavistock survey from 1935 found that about half of all their patients 'can be judged relieved three years after their discharge from treatment', but those with sexual problems showed an even better rate

[78] Dicks, *Fifty Years of the Tavistock Clinic*, p.78; Neustatter, 'The Results of Fifty Cases Treated by Psychotherapy', p.797; Walker and Strauss, *Sexual Disorders in the Male*, especially pp.167-174; Allen, *The Sexual Perversions and Abnormalities*, p.121, p.153; Joshua Bierer and G. A. van Someren, 'Stilboestrol in Out-Patient Treatment of Sexual Offenders: A Case Report', *British Medical Journal,* 1 (1950), 935-936; Raymond, 'Case of Fetishism Treated by Aversion Therapy'.
[79] Grünhut, *Probation and Mental Treatment*, pp.15-16.
[80] Data gathered from official criminal statistics for 1953, which list 2,639 convictions for indecent exposure, 3,445 for 'rape and other offences against females', and 2,166 for 'unnatural offences and attempts'. *Criminal Statistics Relating to Crime and Criminal Proceedings for the Year 1953* (London: H. M. Stationery Office, 1954) pp.17-18.
[81] Hadfield, 'Some Aspects of the Psychopathology of Sex Perversions', p.1029.

of cure. Of the small group of 30 patients with 'sexual difficulties', nearly three quarters were considered 'relieved'.[82] The ISTD reported a similarly elevated success rate amongst some sexual offenders.[83] This confidence had become less pronounced by the 1950s, as evidence emerged to suggest that the future of the sexual offender who became a patient was uncertain. Radzinowicz's research had found that one third 'of the sexual offenders who were given medical treatment in conjunction with probation were reconvicted within four years. The results for homosexual offenders were extremely disappointing (52%) and for indecent exposure hardly satisfactory (38%)'.[84] Drs Gibbens and Scott at the Maudsley felt that the fundamental problem for juvenile sex offenders was an unsatisfactory home background, about which doctors could do little, while many adults simply did not complete their treatment at all. As a result, the doctors' results with sexual offenders were 'poor'.[85] Glover acknowledged that 'about half the cases do not change as the result of treatment' and only 'a small percentage' could truly be cured.[86] Dr John Fisher of the Tavistock reported that he had treated 'various fetishisms and perversions – locks of hair, high-heeled shoes, whips, leather, women's clothes, etc.' by 'psychotherapy, suggestion, hypnosis, psycho-analysis, and re-education therapy, without, I fear, any lasting success'.[87] Doctors might still attempt treatment, but increasingly accepted that a cure was far from guaranteed.

[82] Mary C. Luff and Marjorie Garrod, 'The After-Results of Psychotherapy In 500 Adult Cases', *British Medical Journal,* 2 (1935), 54-59 (p.56). 'Relieved' was taken to include both 'much improved' and 'improved'.
[83] Glover, *The Problem of Homosexuality*, p.19.
[84] Radzinowicz, *Sexual Offences*, p.264, p.218.
[85] Appendices A and B of the notes prepared for the Maudsley Sub-Committee convened to give evidence to the Wolfenden Committee, in 'Papers of Sir Aubrey Lewis: correspondence, reports, copy minutes and papers', Bethlem Royal Hospital Archives & Museum (London), AJL-12. Although compiled for the Wolfenden Committee, these notes addressed male sexual offenders in general.
[86] Glover, *The Problem of Homosexuality*, p.16.
[87] Fisher, 'Correspondence: Fetishism Treated by Aversion Therapy'.

A note of optimism was introduced by reports of success with hormone treatments and aversion therapies. Dr Fisher, who viewed his psychotherapeutic efforts as failures, was hopeful that 're-conditioning' methods held the solution, and case studies of successes in the treatment of sexual offenders by these means were beginning to appear by the late 1950s. Aversion therapy was even attempted on one reported occasion at Wormwood Scrubs prison, in 'an interesting case of fetishism'.[88] More common in the 1950s, however, was the use of synthetic oestrogens. Dr Jack Hobson claimed to have been using hormones with success since the early 1940s, and Neustatter referred in 1953 to one patient who had been receiving stilboestrol for ten years. This suggests that hormone treatment was quietly adopted during the war years, and brought to wider medical attention after the war when anxiety about sexual crime, and homosexuality in particular, was widespread.[89] Sessions Hodge proclaimed his early experimentation on 15 sexual offenders to be a great success, and by 1955 he had reportedly treated between 250 and 300 patients by this method, with almost impeccable results.[90] The published research of the Burden Institute also coincided with an individual, but strikingly similar, case study from the staff of Runwell Mental Hospital in Essex.[91] Meanwhile, the synthetic hormones stilboestrol and diandrone were being used at St Ebba's Hospital in Epsom in the 1940s for patients diagnosed with a variety of disorders, including 'various forms of excessive sexuality'. This could be 'excess of hetero- or homosexuality, with complications such as self mutilation, excess masturbation, castration fantasies and exposure'.[92] Hormone therapies, as was the case

[88] *Report of Prisons for 1958*, p.103.
[89] Neustatter, *Psychological Disorder and Crime*, p.159.
[90] Evidence of Dr R. Sessions Hodge, in 'Transcripts of evidence hearings: Committee on Homosexual Offences and Prostitution', The National Archives (London), HO 345/14.
[91] Bierer and van Someren, 'Stilboestrol in Out-Patient Treatment of Sexual Offenders: A Case Report'.
[92] Dalton E. Sands, 'Further Studies on Endocrine Treatment in Adolescence and Early Adult Life', *Journal of Mental Science,* 100 (1954), 211-219 (p.212, p.215).

for psychotherapy, were not restricted to homosexual offenders, although they may well have been over-represented amongst those so treated.

Importantly, however, these treatments were not proposed as a permanent cure, nor as a method of addressing underlying disorders leading to offending behaviour, whether mental or physical. The Runwell doctors recommended hormone injections as an 'adjunct' which could reduce danger to the public while 'various methods of psychotherapy and re-socialization' were attempted. Sessions Hodge and others were clear that the value of oestrogens lay simply in the reduced likelihood of offences being committed, and that this effect dissipated shortly after treatment ceased.[93] Hormones could therefore be used as a means of controlling the criminal, but for a long-term cure, psychotherapy remained key. As the next section will explore, the suitability of an offender to receive psychotherapy did not depend solely upon the availability of doctors, clinics, accompanying drugs, or probation orders to act as enforcement. In attempting to explain why some sexual offenders should become patients while others should not, doctors not only revealed some of their biases and confusion, but also demonstrated the usefulness of flexible medical theories of cause.

### 6.3 Who could be cured?

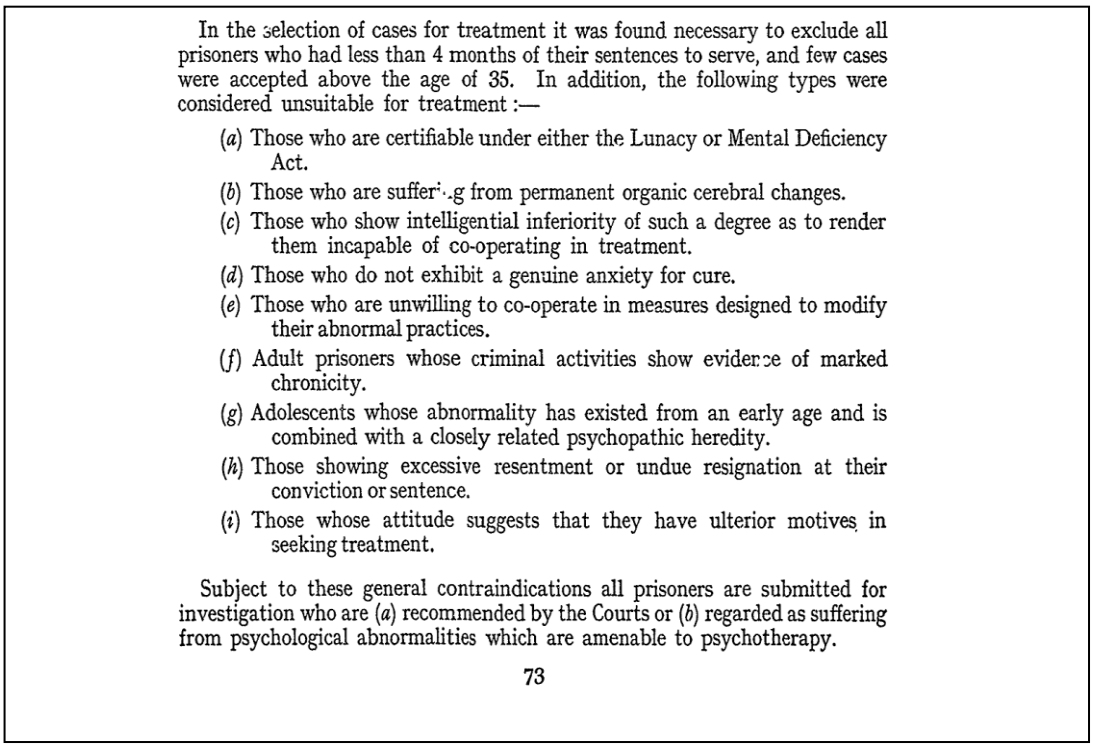
The factors for consideration in determining whether an offender was curable or not remained remarkably consistent throughout the period under examination. These were, in summary, the age and intelligence of the offender, their attitude towards treatment, their sexual history, and, of course, the practical question of whether they had sufficient time or money. In the 1930s, the director of the Tavistock had concluded that the

[93] Evidence of Dr J. A. Hobson, in 'Transcripts of evidence hearings: Committee on Homosexual Offences and Prostitution', The National Archives (London), HO 345/14.

important factors affecting prognosis were 'age, duration of the symptoms, intelligence of the patient, the degree of desire for cure or for change which the patient experiences, and his social situation'.[94] Case studies in *The Psychological Treatment of Crime* also emphasised age and intelligence, the extent and range of sexual misconduct in an offender's history, displays of shame and remorse, and co-operation with medical enquiry.[95] Social situation, within the prison context, was limited to the amount of time that was available before release. The same criteria were repeated by a prison doctor in 1949, and codified in more detail by the Director of Prison Medical Services in the list shown in Figure 3.[96] Similar indications of suitability were echoed again in articles from 1954 and 1957, in which the ideal patient was characterised as 'of good intelligence', or at least not 'dull and educationally retarded', 'not a hardened recidivist' or 'given over to vice', 'prepared to co-operate fully in treatment'.[97] In those cases of older offenders, with a long history of sexual crime or aberration unaccompanied by remorse or any desire to be cured, one doctor wrote that 'I frequently have a feeling of having arrived too late' to be able to deliver any form of effective treatment.[98]

This sense of arriving too late was, perhaps understandably, more frequent with older offenders. Younger offenders enjoyed something of a natural advantage, having had less time to accrue a lengthy criminal history. They were also granted rather more leeway in their reactions and responses to medicine, thanks to the view that some

[94] Rees, 'Prognosis in the Sexual Neuroses', p.948.
[95] Norwood East and Hubert, *The Psychological Treatment of Crime*, pp.94-95, p.121, p.84, p.98, p.118, p.120.
[96] Figure 3 is an extract from the 1949 report of Dr Methven, Prison Commissioner and Director of Medical Services. *Report of Prisons for 1949*, p.73. A colleague wrote that he had excluded 'those by virtue of age; those who would not benefit because of limited intelligence; those who clearly show no evidence of any will to co-operate; those summarily convicted, where the sentence is far too short'. *Report of Prisons for 1949*, p.121.
[97] John J. Landers, D. S. Macphail, and R. Cedric Simpson, 'Group Therapy in H.M. Prison, Wormwood Scrubs: The Application of Analytical Psychology', *Journal of Mental Science,* 100 (1954), 953-960 (pp.953-954); Calder, 'The Sexual Offender', p.37.
[98] Calder, 'The Sexual Offender', p.34.



In the selection of cases for treatment it was found necessary to exclude all prisoners who had less than 4 months of their sentences to serve, and few cases were accepted above the age of 35. In addition, the following types were considered unsuitable for treatment :—

(*a*) Those who are certifiable under either the Lunacy or Mental Deficiency Act.

(*b*) Those who are suffering from permanent organic cerebral changes.

(*c*) Those who show intelligential inferiority of such a degree as to render them incapable of co-operating in treatment.

(*d*) Those who do not exhibit a genuine anxiety for cure.

(*e*) Those who are unwilling to co-operate in measures designed to modify their abnormal practices.

(*f*) Adult prisoners whose criminal activities show evidence of marked chronicity.

(*g*) Adolescents whose abnormality has existed from an early age and is combined with a closely related psychopathic heredity.

(*h*) Those showing excessive resentment or undue resignation at their conviction or sentence.

(*i*) Those whose attitude suggests that they have ulterior motives in seeking treatment.

Subject to these general contraindications all prisoners are submitted for investigation who are (*a*) recommended by the Courts or (*b*) regarded as suffering from psychological abnormalities which are amenable to psychotherapy.

73

**Figure 3: Summary of offenders excluded from treatment at Wormwood Scrubs**

sexual offences were a common but transient feature of adolescence. The connection that was drawn between sexual crime and immaturity, discussed in Chapter 4, was not only an explanation but also a potentially easy solution. Maturity, rather than medicine, could remedy the problem. Norwood East discussed the importance of 'physiological imbalance' causing an excess of sexual impulse during adolescence, and gave an example of a 19-year-old with numerous convictions for indecent assaults and indecent exposure, whose imbalance, his doctor had originally speculated, 'might right itself when maturity was attained'. And so it proved to be, since four years after his release from Borstal 'there was no suggestion of sex excesses'.[99] Successfully traversing the choppy waters of puberty could mean that sexual offences would abate of their own accord.

This did not mean that doctors did not actively attempt to cure younger offenders. Agreement that the younger sexual offender was much more likely to be

[99] Norwood East, 'Responsibility in Mental Disorder', p.209.

cured was virtually universal, and youth was an extremely positive sign for treatment. The Prison Commissioners acknowledged time and again that although they would 'give a chance to all', the rehabilitative efforts of the criminal justice system should concentrate on the young.[100] Glover felt that the pessimism of *The Psychological Treatment of Crime* owed a great deal to the advanced years of so many of its participants, and that younger offenders would have generated much more positive results.[101] Desmond Curran argued that real change could very rarely be effected in sexual offenders over the age of 25, while the list in Figure 3 gave a maximum age of 35.[102] In practice, this enthusiasm for younger patients may have been bolstered by the fact that magistrates also showed a preference for seeking medical advice and using probation orders for younger offenders. In Birmingham in 1943, for example, 910 of the 1,121 cases that had been dealt with by a probation order – fully 81% – were individuals aged under 17.[103]

The attention given to intelligence, amongst offenders of any age, can be explained at least in part by the nature and popularity of psychotherapy. This method of treatment required the offender to engage in discussion and reflection upon his offence and its possible causes. Those who did not or could not do so were inevitably discounted as unsuitable for treatment. Adequate communication skills and evidence of insight into medical interpretations of sexual deviance were therefore essential for a prospective patient, and were often equated with intelligence. Examples of sexual offenders who

[100] *Report of Prisons for 1924*, p.28.
[101] Introduction to Mullins, *Crime and Psychology*, p.40.
[102] Curran, 'Sexual Perversions and Their Treatment', p.345.
[103] Minutes of meeting of 18 October 1944, in 'Minutes of the first 27 meetings: Advisory Council for the Treatment of Offenders', The National Archives (London), HO 326/56. Similarly, at the subsequent meeting on 17 January 1945 when a representative of the Magistrates' Association was asked his views on the appointment of psychiatrists around the country to assist with probation cases, he responded immediately that in cities it was already possible to 'never deal with a child without having a report'. The question of psychiatric assessments of adults did not merit a mention.

were turned away on these grounds included an 18-year-old sadist who could not be treated because of his 'mental subnormality' and 'almost complete lack of experience in verbalizing his mental content', and a 19-year-old with three convictions for indecent exposure with whom treatment was impossible due to his 'general retardation' and 'poorly developed psyche'.[104] By contrast, as Norwood East and the Tavistock directors agreed, the most successful cases were those 'of high enough intellectual capacity to profit' from treatment.[105] Sessions Hodge put the question of intelligence in its most blunt form, saying that he could not provide psychotherapy to 'persons of a low intellectual and cultural level'. His greatest successes in psychotherapy had been with 'persons of superior intelligence and superior cultural level', and he felt that he could only treat those 'where, in fact, we can, in some degree, talk the same language'. 'Superior intelligence' quite possibly meant something on a par with his own, and was for many doctors an important criterion for long-term cure.[106] Offenders who were deemed to be insufficiently intelligent, as recorded in point (c) of Figure 3, remained untreatable.

Assessments of intelligence, eloquence, and 'cultural level' were entwined with status, wealth, and general respectability. The impact of this upon the provision of treatment may have changed from the 1940s, with treatment more readily available for servicemen found guilty of sexual crimes, irrespective of their wealth or social standing. Even so, affluence and high levels of education remained common attributes amongst patients. The frequency with which the well-educated offender was to be found in the psychological unit at Wormwood Scrubs was reflected in the observation that too many

[104] Norwood East and Hubert, *The Psychological Treatment of Crime*, p.121, p.110.
[105] 'Report from the Tavistock Clinic sent by J R Rees to Sir Alexander Maxwell', The National Archives (London), HO 45/18736, File 438456/33.
[106] Walker and Strauss, *Sexual Disorders in the Male*, p.179; Committee meeting of 31 October 1955 in 'Transcripts of evidence hearings: Committee on Homosexual Offences and Prostitution', The National Archives (London), HO 345/14.

'well-educated members' presented a real difficulty. Anecdotal commentary on the usefulness of including the occasional 'naive simpleton of barrow-boy mentality' to bring the rest of the group down to earth provides a flavour of the typical social makeup of those involved in group therapy.[107] Intelligence might present itself as a familiarity with the works of leading sexologists or psychologists, and perhaps unsurprisingly, this in turn indicated 'the capability of obtaining a fair degree of psychological insight', and a good chance that treatment might succeed.[108] It did not quite pass without comment that the criteria for providing treatment might favour the wealthy over the poor, an element of the pathologisation of deviance that has not gone unremarked by historians.[109] Prison doctor W. Calder recognised that his patients were predominantly the 'more intelligent, highly educated men' who were 'apt to come from the higher income groups; the more dull and less literate men come as a rule from a less fortunate section of the community... One law for the rich and one for the poor!'[110]

Sexual offenders who were socially equal or superior to their doctors, who were otherwise upstanding citizens, who cut a familiar and pleasant figure, were more likely to be accepted as patients. 'It is probably a good rough guide', wrote Dr Mackwood, 'to say that any subject who is in some respect likeable, in whom there is some distinction between the act and the agent, or whom one would not have suspected had one met him casually, is hopeful of benefit from treatment.'[111] In other words, if the individual were otherwise respectable, 'likeable', and not overtly defiant of social mores, then

[107] Landers *et al.*, 'Group Therapy in H.M. Prison', p.954.
[108] Norwood East and Hubert, *The Psychological Treatment of Crime*, p.147.
[109] For example, see Frank Mort, *Dangerous Sexualities: Medico-Moral Politics in England since 1830*, 2nd edn (London: Routledge & Kegan Paul, 2000), especially the first section on the period 1830-1860; Bourke, *Rape*.
[110] Calder, 'The Sexual Offender', p.35.
[111] Mackwood, 'Male Homosexuality', p.17.

treatment might succeed in bringing about a cure. A 'pleasing and attractive personality', in Norwood East's words, was an excellent starting-point for cure.[112]

As well as a pleasing personality, doctors were required to consider the extent of co-operation and enthusiasm for treatment that their potential patient demonstrated. These were specified in points (d) and (e) of Figure 3, and were not simply a matter of ensuring that patients had entered into the medical encounter voluntarily. Medical attitudes towards the co-operation of sexual offenders were not grounded in a desire to protect the rights of the patient. Co-operation was instead seen as a matter of degree, and its extent had a direct impact upon prognosis. The greater the willingness displayed by a potential patient to be cured, the greater the likelihood of success. Glover mentioned that 'the degree of desire for cure or for change which the patient experiences' was extremely significant, and sexual offenders who came to his clinic 'of their own free will' – and were presumably therefore motivated to change – often showed greater improvement than those referred by the courts.[113] A survey of ISTD doctors found that 14 out of 18 respondents 'held that the factor of co-operation was more important than any of the others described' in terms of the eventual success of treatment, and Clifford Allen agreed that 'psychotherapy is possible only when there is a strong desire to be cured'.[114] One member of the Advisory Council on the Treatment of Offenders agreed in 1947 that amongst psychiatrists ‘there is a widely held view that psychiatric treatment of offenders is most likely to be successful' when 'there is a maximum voluntary effort on the part of the patient'.[115] The issue was that compulsory treatment was simply less likely to succeed. The ready willingness of offenders such as

[112] Norwood East and Hubert, *The Psychological Treatment of Crime*, p.92.
[113] Rees, 'Prognosis in the Sexual Neuroses', p.948.
[114] Glover, *The Problem of Homosexuality*, pp.16-17; Allen, 'Homosexuality', p.449.
[115] Memorandum of Mr Howard, Secretary to the Council, dated 10 January 1948 in 'Report on treatment of offenders with psychopathic characteristics, and background notes', The National Archives (London), HO 326/63.

Harry Mills and Russell George to receive medical treatment signified that they were good prospects for cure.

Co-operation and desire for cure were extremely closely bound up with diagnosis. Here, the logic underpinning medical practice was somewhat confused. A lack of co-operation was, for psychotherapy, a practical obstacle that was difficult to overcome. At the same time, the absence of co-operation or enthusiasm for treatment could contribute to a diagnosis that marked an offender out as incurable. By being unco-operative, the sexual offender became difficult (if not impossible) to treat, and simultaneously acquired a diagnosis to support this outcome. This diagnosis was usually psychopathy or constitutional perversion: 'the psychopathic sexual offender', it was agreed, 'often fails to profit by any form of therapy'.[116] One offender given as an example of this was said to display an attitude of complete 'self-satisfaction', despite the many ways in which his sexual conduct appeared abnormal, and 'his co-operation would have been entirely negative if treatment had been seriously attempted'. In this case study, it seemed that the very fact of his self-satisfaction contributed to his status or diagnosis as a 'constitutional pervert'.[117] If an offender 'considered that he was unjustly treated and was unable to appreciate the fact that his callous conduct was an affront to decency' – if, in short, he displayed no desire to change – the medical conclusion may well have been that he possessed a 'generalized moral abnormality' akin to psychopathy.[118] A lack of interest in becoming a patient and being cured were not only practical problems, but were also used as diagnostic tools for establishing constitutional perversion or psychopathy. 'Such perverts naturally do not seek cure', as Hadfield put it,

[116] William Norwood East, 'Delinquency and Crime', *Journal of Mental Science,* 90 (1944), 382-398 (p.369).
[117] Norwood East and Hubert, *The Psychological Treatment of Crime*, p.95.
[118] Norwood East and Hubert, *The Psychological Treatment of Crime*, p.118.

because of the very nature of their abnormality.[119] The constitutional case would not want to undergo treatment, but was in any case incurable. By failing to engage with or respond to medical intervention, these sexual offenders confirmed their pessimistic diagnosis.

This diagnosis was presented as all the more convincing if an offender's history included numerous different sexual perversions, indulged over a long period of time. Early 'evidence of sexual abnormality' in childhood, continued into adulthood with 'sexual interest in practically all fields', was strongly suggestive of constitutional psychopathy.[120] Descriptions of sexual offenders who seemed to have been delivered to the doctor 'too late' for treatment to be effective therefore appeared to combine the ideas of someone 'given over to vice' as a matter of habit or preference, and the presence of an incurable, 'constitutional' disorder.[121] However, the doctor was still required to weigh up different factors, as even those with many previous offences could be accepted for treatment if they seemed sufficiently enthusiastic about submitting to a cure. One offender convicted of stealing women's clothes to wear who 'also obtained satisfaction by self-flagellation accompanied by phantasies of complicated masochistic relationships' was said to be 'concerned about his condition' and had 'studied psychoanalytic literature in order to gain some insight'. It was therefore concluded that treatment 'should prove of benefit to him in spite of his bad recidivist history'.[122] Similarly, a freelance journalist and artist who 'in the sphere of sex had developed along abnormal lines since childhood' and 'showed strong evidence of a sexually perverted constitution' turned out to be 'extremely co-operative and developed considerable

[119] Hadfield, 'Some Aspects of the Psychopathology of Sex Perversions', p.1029.
[120] Norwood East and Hubert, *The Psychological Treatment of Crime*, p.95.
[121] Norwood East and Hubert, *The Psychological Treatment of Crime*, p.95; and, again in Calder, 'The Sexual Offender', p.37.
[122] Norwood East and Hubert, *The Psychological Treatment of Crime*, p.124.

psychological insight in relation to his problems'. His prognosis was thought to be excellent.[123] Although the sexual psychopath or constitutional pervert was usually characterised as extremely difficult to cure by medical means, on rare occasions a cure could be achieved. This flexibility allowed for all possible outcomes, irrespective of diagnosis.

Displays of remorse or shame fed into medical judgements of the extent of an offender's willingness to be cured. They also influenced diagnoses and prognoses. Just as self-satisfaction might indicate psychopathy and incurability, so might unhappiness and regret point to a curable condition. The case of 'true perversion', in which 'it is highly probable that the case will be difficult in the extreme', was often contrasted with more hopeful prospects, particularly the neurotic or obsessive. 'If the sexual offence is an example of the perverse habits frequently found in the neurotic', explained Dr Denis Carroll, 'then it is true that such a case will usually respond to treatment'.[124] This neurotic sexual offender could be distinguished from the constitutional pervert by their attitude towards their crime. The neurotic or obsessive offender displayed distress and regret over their offence. This was exemplified in the case of a middle-aged man who 'was thrice found guilty of exposing himself'. This offender 'admitted the offence, and said he deplored it and struggled against its commission, that he realised he was ruining himself by it, but that it relieved him, and he alleged he could not control himself'.[125] This was viewed as a truly neurotic act, which was highly curable. Similarly, a man convicted of indecent exposure was described by his doctor as 'in the most abject misery' and 'almost frantic with distress' after having committed the crime, and

[123] Norwood East and Hubert, *The Psychological Treatment of Crime*, p.143.
[124] Carroll, 'Psychological Treatment of Delinquents and Some of Its Problems', p.164.
[125] Norwood East, 'The Interpretation of Some Sexual Offences', p.421; Norwood East, *An Introduction to Forensic Psychiatry in the Criminal Courts*, pp.307-308.

treatment was proving most successful.[126] 'An 'obsessional patient', explained Norwood East, 'usually admits and deplores his weakness, whereas a denial suggests shame for an act appreciated as disgraceful, and not regarded as pathologically excusable by the offender'.[127] Those who expressed disgust at their own behaviour were likely to be diagnosed as obsessives or neurotics, and were therefore seen as eminently suitable patients. 'Anxiety is the cardinal sign to look out for and which points to a case being ripe for treatment', reiterated Dr Mackwood, 'and it shows itself as worry, shame, disgust and guilt'.[128]

The issues of co-operation, desire for cure, and remorse regarding the offence were therefore entangled with both diagnosis and prognosis, but the logic applied by doctors was somewhat circular. It was difficult to treat an uncooperative offender by psychotherapeutic means, but, fortunately for the doctors involved, uncooperative offenders were less likely to suffer from a curable disorder. By virtue of being unwilling to submit to a medical cure, or indeed by failing to show that treatment had succeeded, sexual offenders could find themselves diagnosed with an incurable condition. Diagnosis and prognosis were not clearly defined categories, and were strongly influenced by the attitude of an offender towards his crime and its possible cure. Harry Mills and Russell George, who both spoke eloquently of their shame and remorse, may have been viewed as neurotic or obsessive with a good chance of benefiting from all that modern medicine could offer.

[126] 'Accused Sheffield Man "Frantic with Distress"'.
[127] Norwood East, *Medical Aspects of Crime*, p.193. This is a reproduction of his 1924 essay on exhibitionism, and this is one of a very small number of additions, suggesting that his thoughts on this had crystallised in the intervening years.
[128] Mackwood, 'Male Homosexuality', p.17.

It was, therefore, a particular sort of sexual offender who was most likely to sustain the status of patient after any initial medical examination. With psychotherapy as the bedrock of treatment, the sexual offender's personality and performance became all-important. The best candidate for treatment could be identified through his age, his intelligence, his personality, and his attitude towards the offence and medical treatment. An offender of good social standing, who could express shame and insightful reactions to medical interpretation itself, stood at the opposite end of the medical scale from the seemingly callous and disinterested constitutional or psychopathic offender, and was more likely to be recognised as a possible patient. Although the potential for group therapy to extend treatment to a wider range of offenders was recognised by some doctors, and the uses of hormone therapies and other physical treatments could also have changed the parameters, these basic criteria for being considered curable did not alter.[129]

## Conclusion

As prison doctor John Landers ruefully remarked in 1938, 'the psychological viewpoint was very helpful in understanding' criminal conduct, but 'was not equally helpful in suggesting a line of treatment'.[130] The medical spirit was willing, but its ability to deliver a cure seemed weak. Opportunities for treatment were limited and the numbers receiving psychotherapy or other medical efforts were small. Furthermore, many offenders were seen as highly unsuitable for treatment, whether because they were insufficiently articulate or intelligent, because they lacked remorse and did not truly want to be cured, or because they simply would not co-operate in the process. As well as presenting practical problems, these factors could contribute to a diagnosis of constitutional perversion, or psychopathic personality, which was itself incurable. By the

[129] On group therapy, see *Report of Prisons for 1949*, p.80.
[130] Landers, 'Observations on Two Hundred Dartmoor Convicts', p.974.

1950s, conflicting claims were being made: that treatment was readily available within prisons for sexual offenders, that it was categorically not, that sexual deviance could be cured by an operation or by psychotherapy, that no attempts at cure had succeeded. Although many doctors clung tenaciously to their faith in the power of medical intervention, this was, they emphasised, for carefully selected cases only. They were at pains to emphasise that the many possible causes behind sexual offending were easier to diagnose than to cure. Attempts to assess the success of medical treatment in preventing repeated criminality tended to suggest that long-term change was rare.

On the occasion of his first arrest, Harry Mills had the advantages of youth, evident distress at his situation, no history of sexual crime, and the resources of the large military psychiatric hospital in Birmingham available to him. Even though he later claimed to know that treatment would not have a lasting effect, his hospital stays had always ended with him being assessed as cured. As someone who seemed to benefit from hospital treatment, he could be accepted as a patient on multiple occasions. As the years passed and his criminal record grew longer, though, the possibility of a psychopathic or constitutional disorder may have crept into his doctors' analyses. Given short prison sentences of only a few months at a time, he was not suitable for transfer to one of the psychological units in prisons, and his limited means precluded private psychoanalysis or other intensive out-patient care. Only his eloquence and persistent desire to be cured maintained the possibility of a return to the status of a patient. Medical approaches to sexual crime had taken root by the end of the 1950s, but their practical achievements in delivering cures were, and remained, extremely limited indeed.

# Chapter 7: Conclusion

In contemporary England, and indeed in many other nations, sexual offending gives every appearance of reaching epidemic proportions. The most recent figures from the Ministry of Justice recorded 53,700 sexual offences in England and Wales in the preceding twelve months, and acknowledged a potentially huge 'dark figure' that remained unreported to the police.[1] In the wake of revelations of sexual abuse perpetrated in previous decades by high-profile entertainers and politicians, there has been extensive coverage in the press of allegations, convictions, and enquiries into the failure of the authorities, past and present, to prevent, protect, and prosecute. Recent decades have also seen an astonishing increase in the proportion of those in prison who are serving time for a sexual crime. This has risen from 4% to 10% between 1980 and 2000, and from 10% to 17% in the last fifteen years.[2] Although these factors reveal little about the actual prevalence of sexual offending or the severity with which convicted offenders are treated, they are suggestive of a sense of crisis.

Meanwhile, attempts within medicine to diagnose and alter sexual impulses and behaviours remain contested. Preparation for a revised *Diagnostic and Statistical Manual of Mental Disorders* (DSM), which was eventually published in 2013 as DSM-5, reignited controversy over whether paraphilias should continue to be classified as mental disorders and whether new diagnoses such as hebephilia (attraction towards

[1] *An Overview of Sexual Offending in England and Wales* (Ministry of Justice, Home Office, and the Office for National Statistics, 2013), p.6. The report was published online in January 2013, at <https://www.gov.uk/government/publications/an-overview-of-sexual-offending-in-england-and-wales> [accessed 14 January 2014].

[2] David Barrett, 'Number of Convicted Sex Offenders in Jail Reaches Record High', *Telegraph,* 30 April 2015 <http://www.telegraph.co.uk/news/uknews/crime/11573580/Number-of-convicted-sex-offenders-in-jail-reaches-record-high.html> [accessed 1 May 2015].

adolescents), hypersexual disorder, and paraphilic coercive disorder (preference for non-consensual sexual activity) should be introduced.[3] Unease centres upon the pathologisation of normal and healthy variations of human behaviour and feeling, particularly given the close involvement of the pharmaceutical industry. This concern is relevant to diagnoses other than the paraphilias as well, such as Prolonged Grief Disorder and Attention Deficit Hyperactivity Disorder. In the context of sexuality, the stigmatising force of psychiatric classification has been recognised as particularly acute.[4] The practical outcomes are also significant: a recognised diagnosis may allow access to treatment covered by insurance, for example, and the legal, social, and medical impacts of characterising criminal conduct such as rape as the product of a psychiatric condition could be considerable. The DSM and its diagnostic criteria for the paraphilias currently have less impact in England than in the USA, but these issues and uncertainties reflect a persistent lack of clarity within psychiatry about the boundaries in human health and conduct over which it attempts to preside.

In other fields, research findings that purport to identify a genetic cause for sexual crime, and also for homosexuality, continue to make the headlines.[5] The interest in (and funding for) such research highlights an ongoing desire to find biomarkers for difference, and also has practical implications. The 'born bad' thesis raises questions about targeted crime prevention over and above wider social change to reduce sexual

[3] There is a list of publications on this at <http://www.dsm5.org/research/pages/publications.aspx> [accessed 20 January 2014]. An overview of proposed and accepted changes to the paraphilias in DSM-5 is provided in Michael B. First, 'DSM-5 and Paraphilic Disorders', *Journal of the American Academy of Psychiatry and the Law,* 42 (2014), 191-201.

[4] A feminist perspective is Katherine Angel, 'Contested Psychiatric Ontology and Feminist Critique: "Female Sexual Dysfunction" and the Diagnostic and Statistical Manual', *History of the Human Sciences,* 25 (2012), 3-24. The impact of the psychiatric classification 'gender dysphoria' on the lives of trans* people has also elicited a great deal of discussion.

[5] For example, Sample, 'Male Sexual Orientation Influenced by Genes, Study Shows'; Långström *et al.*, 'Sexual Offending Runs in Families'. This study received considerable coverage in mainstream news outlets.

crime, and 'born gay' has, as others have explored, a long history within debates over social policy and equal rights. Genetic aetiologies can be used to support calls for tolerance, calls for indeterminate detention, and modes of treatment focusing on management rather than cure. 'You can't cure people of paedophilia' was the view of one person involved in the provision of treatment to sexual offenders in 2015. 'If someone has a sexual preference for violence', he went on to say, 'it may be there forever'.[6] Treatment programmes therefore usually take the pragmatic step of attempting to provide offenders with the 'tools to cope', so that they are aware of risk and can take action to reduce their chances of reoffending. For a small number of prisoners, in an echo of the 1950s, these tools currently include hormone injections to reduce libido.[7]

Since the introduction of a national strategy specifically for the rehabilitation of sexual offenders in 1991, the Sexual Offender Treatment Programme (SOTP) has been rolled out across England and Wales. Although there are also programmes dedicated to addressing substance misuse and violent behaviour as well, particularly domestic violence, SOTPs feature heavily within the current suite of Offender Behaviour Programmes.[8] England also has the largest prison in Europe for sexual offenders, Whatton, which houses around 840 men and is a 'treatment prison'.[9] This emphasis upon sexual offenders as a single category of criminal, encompassing a wide variety of

[6] *Inside the Sex Offenders' Prison*, Pres. Rex Bloomstein, Prod. Simon Jacobs. Unique production for BBC Radio 4, first broadcast 31 March 2015.
[7] A treatment facilitator at Whatton referred to his role as providing offenders with 'tools to cope' with their own feelings when living in the community. *Inside the Sex Offenders' Prison,* 31 March 2015. The (re)introduction of hormone therapies was reported in Aikenhead, 'Chemical Castration'.
[8] See information from the Ministry of Justice, <https://www.justice.gov.uk/offenders/before-after-release/obp > [accessed 22 August 2015]. SOTPs are currently grounded in a cognitive behavioural approach.
[9] Information about Whatton is available from the Ministry of Justice, <https://www.justice.gov.uk/contacts/prison-finder/whatton> [accessed 22 August 2015], and in *Inside the Sex Offenders' Prison,* 31 March 2015.

actual crimes from rape to possession of illegal images, has interesting parallels with attitudes from the mid-twentieth century. Unlike the violent but non-sexual crime, or the offence against property, the sexual offender then, as now, was consistently perceived as a distinct problem requiring expert investigation and psychological or psychiatric treatment. Despite some controversy over the efficacy of treatment programmes, the recent discovery that too few staff and too many prisoners meant that only one in three sexual offenders could actually access such programmes in English prisons was described in 2014 as a 'disturbing' failure of the criminal justice system.[10]

This reflects a lack of confidence in conventional methods of punishment, as well as a perception of sexual crime as at least partly pathological. The same lack of confidence is evident in the introduction of sex offender registers and other methods of extended supervision, which are popular in the UK and the USA but not adopted elsewhere.[11] Through such practices, those elements of surveillance and control that were highlighted by critics of the penal reforms of the early twentieth century have taken a new form. Registers, pre-employment vetting, and other innovations such as foreign travel orders all suppose that there is something different about the sexual offender, that he (and sometimes now she) will be undeterred by prison and is highly likely to reoffend, presenting a persistent threat. These methods of management alongside SOTPs reflect two different models of the sexual offender that co-exist within contemporary penology. In one, sexual deviance is an integral, incurable aspect of the offender's personality, and in the other, the offender is psychologically disturbed but

[10] David K. Ho, 'Ineffective Treatment of Sex Offenders Fails Victims', *British Medical Journal,* 350 (2015), 24, and responses; Dugan, 'Sex Offenders Freed from Prison without Treatment Will "Create More Victims"'.

[11] Valuable analysis of current practices in England and Wales, in comparison with other jurisdictions, can be found in Anne-Marie McAlinden, 'The Governance of Sexual Offending across Europe: Penal Policies, Political Economies and the Institutionalization of Risk', *Punishment & Society,* 14 (2012), 166-192. Notably, countries including Spain, Italy, and Germany have objected to registers as an infringement of human rights.

potentially redeemable. Efforts to create space for such apparently contrasting explanations of sexual crime, and for correspondingly different outcomes, were at the heart of the medical approaches to sexual deviance that have been explored in this thesis.

By turning to the early to mid-twentieth century, this project has considered some of the origins of these multiple accounts of sexual crime and the quasi-medical language that habitually surrounds them. Historians of the medical study of sexuality have often neglected this period, focusing instead on the influence of late Victorian sexology and the post-Second World War research that began with Alfred Kinsey. Similarly, studies of forensic medicine, with some notable exceptions, have yet to examine twentieth-century developments in any detail.[12] In fact, the period under consideration is significant for both branches of historical enquiry. Medical attitudes and interest in sexual abnormality underwent a gradual but profound change: this was when a medical approach to sexual crime took root in England. Theories about sexual offenders found expression in medical texts from the 1920s, as some doctors began to insist that these criminals, as a distinctive group, were frequently driven by some form of illness. As medical theories spread and developed over the following four decades, so too did their practical impact upon the lives of sexual offenders.

This temporal focus, accompanied by attention to England in particular, provides a new context for understanding medical approaches to sexuality. Rather than situating them within nineteenth-century regulatory mechanisms, or the liberalising agenda of the 1960s, medical theories and interventions into supposedly abnormal sexual acts should be seen in the context of growing interest in the rehabilitation of offenders. This

[12] Such exceptions include the 2014 special edition of the *International Journal of Law and Psychiatry*, and scholarship examining infanticide and the insanity defence.

was an important feature of the criminological landscape of England in the early twentieth century, and demanded greater attention to the specific causes of each individual's criminality. Such causes might include their mental state as well as physical illness, environmental considerations, and even inherited or deeply entrenched features of personality or character. By the dawn of the 1960s, the energy behind this was declining, but the innovations of the preceding decades had lain important foundations for later years. Most of those involved, from both the medical and legal professions, were actively engaged in the management of offenders and therefore brought a focus upon practical solutions rather than theoretical propositions. Such solutions included opportunities for medical evidence to be heard in mitigation, and for treatment to play a role in prisons and probation orders. Alternatives such as compulsory psychiatric examinations, involuntary hospitalisation for treatment on the basis of sexual crime, or indeterminate sentences ending only when a 'cure' could be confirmed were not adopted. These presented significant conceptual difficulties in the context of the English legal system. The shape of the psychological approach to crime which *was* adopted in England therefore reflects the interaction of the medical and legal professions. Prison doctors, sitting at the intersection of medical and penal routes to rehabilitation, played an important role in this, and were amongst the first to single out sexual offenders as in need of particular attention.

Prison doctors and their colleagues drew attention to those guilty of many different types of sexual offence. Using 'sexual crime', broadly defined, as a category of analysis is therefore valuable in order to explore the nature and extent of this new medical approach more fully. Historians have paid considerable attention to the research, diagnoses, treatments, and medical language that swirled around homosexuality, particularly male homosexuality. This has sometimes encompassed

cross-dressing, inter-generational sex, and male prostitution. Female prostitution, rape, and child sexual abuse have also been the subjects of social and cultural histories.[13] Rather than considering medical approaches to any one type of sexual crime, an analysis of responses to sexual offenders as a whole draws upon the categorisations of the doctors and commentators under examination instead of our own. Such an approach is better suited to understanding the theories that were in operation, which did not always discriminate along the lines that we might expect. It also provides context for those medical approaches that have already received attention, and reveals some of the important influences that shaped medical approaches to sexual behaviour.

Continental sexology was once such influence, but doctors in England presented the study of sexual disorder as vital to understanding and managing the most persistent and troubling criminals. To justify their portrayal of the sexual offender as frequently mentally disordered, they highlighted the absence of intelligible motive in many sexual crimes. Here, ideas about the presence or absence of mental disorder were underpinned by widely held assumptions regarding healthy or normal sexual (and criminal) behaviour. Medical theories were deeply rooted in wider social anxieties and beliefs about crime, sexual conduct, and gender. Crimes with heterosexual and potentially reproductive sexual acts as their supposed motive were often excluded from medical enquiry, receiving little theoretical attention from doctors and less frequent medical explanations in the courtroom. With motive as an organising principle, and heterosexual sex accepted as a normal or healthy goal, sexual violence and assault in its heterosexual forms often escaped scrutiny. Medical approaches to the state of mind of those guilty of rape, incest, or indecent assault, when the victim was female, were notable in their absence. The offences of indecent exposure and homosexual acts attracted the most attention, as the

[13] Examples of these histories are given in Chapter 1.

most commonly reported crimes from within those designated the 'perversions'. Diagnosis and debate around sexual sadism, too, were a feature of some particularly high-profile trials. Crimes with exhibitionism, homosexuality, or sadism at their root were interpreted as disruptions to the maturation of the individual and the civilisation of the nation alike. Sexual offences committed by women, in contrast, received virtually no attention from doctors. Although VD was a perennial concern, women convicted of crime were usually conceptualised immediately as sexually deviant, and did not require the same diversity of explanations and solutions.

For male sexual offenders, many different medical theories of causation could comfortably co-exist. Here again, paying attention to the ways in which apparently contrasting types of sexual crime were interpreted is beneficial. The multiplicity of explanations reflected not only the fragmented nature of psychiatry in England during the period under examination, but also the quest for flexibility of interpretation and outcome that underpinned the project of medical enquiry. Sexual offences in their pathological manifestations were understood to result from difficult domestic or personal circumstances, unsatisfactory psychosexual development, cerebral disease, puberty and old age, glandular disturbance, low intelligence, unspecified hereditary or constitutional factors, or any combination of these. Psychiatrists borrowed freely from the fields of social work, endocrinology, psychoanalysis, neurology, and more. This 'ontological anarchy', to borrow Martin Pickersgill's phrase, allowed diagnosis and legal remedy to be moulded to fit the individual as doctor and judge found him, or wanted to see him.[14] Solutions could be equally varied, addressing marital life or sexual knowledge, involving operations upon the body, or delving into the psyche. Such variety allowed for the possibility that some sexual offenders bore very little responsibility for their crimes,

[14] Pickersgill, 'The Endurance of Uncertainty'.

which effectively absolved them of meaningful guilt, and some could be easily cured and permitted to return to society fully redeemed. Others, perhaps guilty of very similar offences, could bear the full weight of guilt and were seen as a persistent danger to others.

In practical terms, this led to changes to the ways in which courts dealt with sexual offenders. Research into medico-legal debates in England has typically focused on the insanity defence, in which tensions between medical and legal definitions of mental disorder were played out in dramatic and often widely reported circumstances. Little attention has been paid to the involvement of doctors giving evidence to influence sentencing decisions, rather than to determine insanity. Important developments in the nascent discipline of forensic psychiatry, and corresponding changes to methods of sentencing offenders, have therefore been overlooked. The attention paid by doctors to sexual crime in the early to mid-twentieth century, within the context of greater interest in rehabilitation and reform of the criminal amongst judicial and penal authorities, sought to give weight within the legal system to considerations of a vast borderland of mental disorder amongst offenders. Mental weakness of this kind might affect culpability and capacity to refrain from crime, but not sanity or criminal responsibility. The impact of its recognition therefore lay in new methods of managing sexual offenders who were thought to occupy this borderland, in which both doctors and judges were actively involved.

The extent to which medical theory could be put into practice depended upon various features of the English legal system, as well as the content of medical evidence itself. The availability of legal aid, the personalities of individual judges, and the nature of the adversarial legal system were all important. So too were opportunities for medical

treatment. Probation orders with conditions of treatment, as well as facilities for treatment in prison, were significant additions to the penal landscape, providing the judiciary with additional solutions in cases when punishment *tout court* seemed unsatisfactory. Medical evidence could provide intelligible explanations for seemingly inexplicable conduct, particularly the indecencies of hitherto respectable citizens, and the prospect of cure offered a route back to that respectability. Medical considerations were notably absent in trials involving offences against adult women, unless certifiable insanity had to be excluded. In this, the lack of medical interest may have influenced legal practice. However, legal interests were also influential, leading to an absence of expert testimony regarding minor offences when light penalties left judges and defendants with little incentive to seek alternative outcomes. Reports from doctors often included practical recommendations that could provide such alternatives. From the limited examples available for study, they also tended to use confident and easily understood terminology, avoiding speculation over responsibility or in-depth psychological aetiologies. The diversity within medical thought weakened its standing within the adversarial legal system, though, as even prison doctors saw their authority and status challenged in the 1950s. This weakness has had an important legacy, with medical approaches playing a lesser role in the management of sexual offenders in contemporary England than elsewhere in Europe.[15]

Limitations were also evident in the delivery of treatment in England. Analysis of treatments that have been provided in the past to those deemed sexually deviant has received little attention until very recently. This thesis complements work examining treatment programmes for sexual offenders in some Scandinavian countries, which has

[15] McAlinden, 'The Governance of Sexual Offending across Europe'; Michael Petrunik and Linda Deutschmann, 'The Exclusion–Inclusion Spectrum in State and Community Response to Sex Offenders in Anglo-American and European Jurisdictions', *International Journal of Offender Therapy and Comparative Criminology,* 52 (2008), 499-519.

addressed both the extent of treatment and the logic that underpinned it. In England, treatment was carried out relatively infrequently. Patient numbers were limited by resources, both inside and outside of prisons. Even those volunteering for treatment were sometimes turned away. Although sexual offenders had been singled out by doctors as requiring expert enquiry to uncover obscure motives and causes, many doctors also emphasised that, as a group, these offenders were not particularly susceptible to treatment. It was important, as new medico-legal methods of managing sexual crime were trialled, to be able to account for what often looked like failure. An examination of these explanations and efforts reveals that treatment was perhaps more commonly provided to those guilty of homosexual offences, indecent exposure, and other so-called perversions, but prognosis depended far more on personality than the nature of the crime. This allowed for the fullest possible flexibility of diagnosis and outcome. The less eloquent, who were perhaps unwilling or unable to engage in preliminary interviews or psychotherapy, as well as those without interest in understanding or changing their sexual conduct, could be designated incurable or untreatable. A performance of co-operation, insight, and remorse was extremely important, and the uncooperative offender might quickly find their disorder marked out as constitutional and incurable. In practice, some offenders may have been overlooked or rejected for potentially beneficial treatment, while others were coerced into treatment in the name of conformity and cure. In acknowledging both outcomes, we can recognise the complexities, then and now, for medicine in any involvement with crime and deviance.

The patterns identified here were firmly established by the end of the 1950s, but faced significant challenges in the 1960s. This thesis has therefore taken as its end point the year 1959. Medical theories about sexual offending changed very little in the

years that followed. Forensic medicine changed dramatically, however. Some have seen the 1960s as the era that heralded the emergence of forensic psychiatry as a distinctive discipline, after the Mental Health Act of 1959, the Emery Report that swiftly followed, and subsequent enquiries into prison medicine and secure hospitals.[16] The first academic Chair in forensic psychiatry was created in 1967, and a history of this new specialism had appeared before the decade was over.[17] Assessing, diagnosing, and treating sexual offenders formed one element of the forensic psychiatrist's portfolio, but in the context of rising crime rates and prisoner numbers in the 1960s, and newly identified social problems, their attention was diverted elsewhere. Young offenders and substance misuse were targeted, and with few secure beds and ever-growing uses of probation and early release, the job of assessing risk became a staple of the forensic psychiatrist's role. Research into sexual abnormalities and pathologies continued, but with increasing attention dedicated to offences against children.[18] Second-wave feminism and campaigns for sexual reform also began to transform the landscape in which doctors worked. Innovation within medical theories and treatments for sexual offenders were placed on hold.

This thesis has therefore focused attention on the early to mid-twentieth century in England. It has argued that during this period, the medical study of the sexual offender emerged and, in conjunction with adjustments to legal and penal policy and practice, gained an important foothold in the management of sexual crime. Medical approaches were closely connected to legal and penal interests, all of which reflected

[16] This view is expressed in, for example, Dharjinder Singh Rooprai and Tom Clark, *Practical Forensic Psychiatry* (London: Hodder Arnold, 2011) p.2.
[17] This chair was created for Dr T. C. N. Gibbens, and the history appeared in the form of Nigel Walker and Sarah McCabe, *Crime and Insanity in England* vol. 1 (Edinburgh: Edinburgh University Press, 1968).
[18] See Thomson, *Lost Freedom*, chapter 6; examples include Graham Rooth, 'Exhibitionism, Sexual Violence and Paedophilia', *Journal of Mental Science,* 122 (1973), 705-710; T. C. N. Gibbens and Joyce Prince, *Child Victims of Sex Offences* (London: ISTD, 1963).

widely held perceptions of normal and abnormal sexual and criminal conduct. Despite focusing upon sexual offenders, these conclusions have implications for histories of forensic medicine, particularly psychiatry, and sexuality more generally. They are founded upon an alternative method of examining the pathologisation of sexuality, concentrating not on particular sexual identities or behaviours, but on the act of interpretation. This adjusts attention away from 'genealogies' of sexuality, in Laura Doan's phrase, to the meanings attributed to sexual conduct and their uses in medico-legal settings.[19] It also demonstrates the diversity of medical thought, and the purpose that this plurality could serve. By considering medicine within its legal context, and by assessing practical outcomes, this thesis is also particularly relevant to criminological scholarship addressing the management of offenders, past and present. National differences appear to be considerable, and transnational comparisons of the regulation, punishment, and cure of sexual offenders offer a rich avenue for future research. Understanding the ways in which Russell George, Harry Mills, and others mentioned here were interpreted as sexual offenders, as abnormal, as less than fully culpable, and as occasionally curable, shines a light upon one of many possible ways of accounting for human sexual behaviour.

[19] Doan, *Disturbing Practices*, pp.14-15.

# Bibliography

## Primary sources

### Autobiographies, memoirs


Ackerley, J. R., *My Father and Myself* (Harmondsworth: Penguin, 1984 [1968])

'Anomaly', *The Invert*, 2nd edn (London: Tindall & Cox, 1948)

Casswell, J. D., *A Lance for Liberty* (London: George G. Harrap, 1961)

Croft-Cooke, Rupert, *The Verdict of You All* (London: Secker & Warburg, 1955)

Dendrickson, George, and Frederick Thomas, *The Truth about Dartmoor* (London: Victor Gollancz, 1954)

Dickinson, Goldsworthy Lowes, *The Autobiography of G. Lowes Dickinson* (London: Duckworth, 1973)

Dillon, Michael, *Self: A Study in Ethics and Endocrinology* (London: William Heinemann Medical Books, 1946)

Fallowell, Duncan, and April Ashley, *April Ashley's Odyssey* (London: Arena, 1983)

Harvey, Richmond, *Prison from Within* (London: George Allen & Unwin, 1937)

Lloyd, Ronald, and Stanley Williamson, *Born to Trouble: Portrait of a Psychopath* (Plymouth: Cassirer, 1968)

Lytton, Constance, *Prisons & Prisoners: Some Personal Experiences* (London: William Heinemann, 1914)

Macartney, Wilfred, and Compton Mackenzie, *Walls Have Mouths* (London: Victor Gollancz, 1936)

Phelan, Jim, *Jail Journey* (London: Secker & Warburg, 1940)

Price, Pete, and Adrian Butler, *Pete Price: Namedropper* (Liverpool: Trinity Mirror NW, 2007)

Rich, C. E. F., *Recollections of a Prison Governor* (London: Hurst and Blackett, 1932)

Wildeblood, Peter, *Against the Law* (London: Penguin, 1959 [1955])

Wood, Stuart, *Shades of the Prison House: A Personal Memoir* (London: Williams & Norgate, 1932)

Worsley, T. C., *Flannelled Fool: A Slice of Life in the Thirties* (London: Alan Ross, 1967)

## Government publications

*An Overview of Sexual Offending in England and Wales* (Ministry of Justice, Home Office, and the Office for National Statistics, 2013)

Annual Criminal Statistics, 1919-1960

Annual Reports of the Commissioners of Prisons, 1910-1963

*HM Chief Inspector of Prisons for England and Wales Annual Report 2012-13* (London: The Stationery Office, 2013)

Ministry of Justice, Offender Behaviour Programmes: <https://www.justice.gov.uk/offenders/before-after-release/obp>

Ministry of Justice, Whatton Prison: <https://www.justice.gov.uk/contacts/prison-finder/whatton>

*Report from the Departmental Committee on Prisons* (London: H. M. Stationery Office, 1895)

*Report of the Committee on Sexual Offences against Young Persons* (London: H. M. Stationery Office, 1925)

*Report of the Departmental Committee on Persistent Offenders* (London: H. M. Stationery Office, 1932)

*The Organisation of the Prison Medical Service* (London: H. M. Stationery Office, 1964)

*The Probation Service: Its Objects and Its Organisation* (London: H. M. Stationery Office, 1938)

Norwood East, William, and William Henry de Bargue Hubert, *The Psychological Treatment of Crime* (London: H. M. Stationery Office, 1939)

Pailthorpe, Grace, *Studies in the Psychology of Delinquency* (London: H. M. Stationery Office, 1932)

## Journal articles, textbooks, pamphlets

'Castration of Sex Offenders', British Medical Journal*,* 1 (1955), 897-898

'Children's Moral Welfare', *British Medical Journal,* 1 (1936), 1261-1262

'Criminal Science', *The Magistrate,* November (1940), 333-334

'Editorial', *British Journal of Delinquency,* 2 (1951), 1-4

'F. W. Eurich, M.D.', *British Medical Journal,* 1 (1945), 312

'H. A. Grierson, O.B.E., M.C., M.B. B.S.', *British Medical Journal,* 1 (1966), 1428

'H. Crichton-Miller, M.D., F.R.C.P.', *British Medical Journal,* 1 (1959), 116-117

'Indecent Exposure', *The Magistrate,* November-December (1940), 336-337

'Meetings of Branches and Divisions: Gloucestershire Branch', *British Medical Journal,* 1 (1924), 173

*National Council for Mental Hygiene: Report of the Proceedings of the Conference on Mental Health Convened by the Joint Committee of the National Council for Mental Hygiene and the Tavistock Square Clinic* (London: Adlard & Son, 1929)

'National Council for Mental Hygiene: Third Biennial Conference', *British Medical Journal,* 2 (1933), 1030-1034

'Probation at Mental Hospital: A Legal Experiment', *British Medical Journal,* 1 (1938), 260

'Psychiatry and the Criminal Law: A Maudsley Lecture', *British Medical Journal,* 2 (1948), 951-952

*Psychology and Criminal Procedure* (London: Institute for the Scientific Treatment of Delinquency, n.d. [c.1952])

'Psychopathology and Treatment of Sexual Deviation', *British Medical Journal,* 2 (1960), 1303-1304

*Report of the Tavistock Square Clinic for Functional Nervous Disorders for April 1929-March 1930* (London: Tavistock Square Clinic, n.d. [c.1931])

*Report of the Tavistock Square Clinic for Functional Nervous Disorders for April 1930-March 1931* (London: Tavistock Square Clinic, n.d. [c.1932])

'Reports of Societies', *British Medical Journal,* 2 (1938), 1167-1171

'Reports of Societies: The Criminal and the Doctor', *British Medical Journal,* 1 (1954), 980-981

'Review: Psychopathia Sexualis with Special Reference to Contrary Sexual Instinct by R. von Krafft-Ebing', *British Medical Journal,* 1 (1893), 1325-1326

'Scientific Treatment of Delinquency', *British Medical Journal,* 1 (1939), 1192-1193

'Sexual Offenders', *British Medical Journal,* 1 (1949), 446-447

'Sexual Psychology and Pathology', *British Medical Journal,* 1 (1902), 339-341

'Sir Norwood East, M.D., F.R.C.P.', *British Medical Journal,* 2 (1953), 1050-1051

*Tavistock Square Clinic for Functional Nervous Disorders: Report for the Years 1920-1927* (London: Tavistock Square Clinic, n.d. [c.1928])

'The Court and the Sexual Offender', *British Medical Journal,* 2 (1951), 1459-1460

'The Medico-Political Committee of the B. M. A.', *British Medical Journal,* 1 (1938), 336-337

'The Scientific Study of Sex Problems', *British Medical Journal,* 2 (1929), 508

'Treatment of Delinquency', *British Medical Journal,* 1 (1933), 625

'Vienna: Some Recent Medical Work', *British Medical Journal,* 2 (1922), 988-989

'W. L. Neustatter, BSc, MD, FRCP, FRCPsych', *British Medical Journal,* 2 (1979), 278

Allen, Clifford, 'Homosexuality', *British Medical Journal,* 1 (1946), 449-450

Allen, Clifford, 'Sexual Offenders', *British Medical Journal,* 1 (1949), 547-548

Allen, Clifford, 'Virilism with Mental Symptoms', *British Medical Journal,* 2 (1956), 604

Allen, Clifford Edward, *The Sexual Perversions and Abnormalities* (London: Oxford University Press, 1940)

Bennet, E. A., 'Homosexuality', *British Medical Journal,* 1 (1946), 450

Bierer, J., 'Psychotherapy in Mental Hospital Practice', *Journal of Mental Science,* 86 (1940), 928-952

Bierer, Joshua, and G. A. van Someren, 'Stilboestrol in Out-Patient Treatment of Sexual Offenders: A Case Report', *British Medical Journal,* 1 (1950), 935-936

Brown, William, 'Psychology and the Offender', *Probation Journal,* 1 (1934), 275-276

Burrows, Harold, 'Homosexuality', *British Medical Journal,* 1 (1946), 368

Burrows, Roland, 'Criminal Law and Procedure', *The Law Quarterly Review,* 51 (1935), 36-57

Buzzard, E. Farquhar, 'The Tavistock Clinic: A Correction', *British Medical Journal,* 1 (1928), 287

Calder, W., 'The Sexual Offender: A Prison Medical Officer's Viewpoint', *British Journal of Delinquency,* 6 (1955), 26-40

Calvert, E. Roy, and Theodora Calvert, *The Lawbreaker: A Critical Study of the Modern Treatment of Crime* (London: Lund Humphries, 1933)

Carroll, Denis, 'Mental treatment in Delinquency under the Criminal Justice Bill', *Probation Journal,* 3 (1939), 101-103

Carroll, Denis, 'Observations on the Psychiatric Handling of Delinquents', *The Medico-Legal and Criminological Review,* 8 (1940), 182-198

Carroll, Denis, 'Psychological Treatment of Delinquents and Some of Its Problems', *The Howard Journal of Criminal Justice,* 4 (1935), 162-166

Christoffel, Hans, 'Exhibitionism and Exhibitionists', *International Journal of Psychoanalysis,* 17 (1936), 321-345

Coleman, S. M., 'The Sexual Perversions and Abnormalities', *Journal of Mental Science,* 86 (1940), 1020-1021

Curran, Desmond, 'Homosexuality', *The Practitioner,* 141 (1938), 280-287

Curran, Desmond, 'Sexual Perversions and Their Treatment', *The Practitioner,* 158 (1947), 343-348

Curran, Desmond, and Eric Guttmann, *Psychological Medicine* (Edinburgh: Livingstone, 1943)

Curran, Desmond, and Paul Mallinson, 'Psychopathic Personality', *Journal of Mental Science,* 90 (1944), 266-286

Curran, Desmond, and Eliot Slater, 'Mental Disorder in General Practice: A Plea for Clinical Psychiatry', *The Lancet,* 225 (1935), 69-71

Dawson, W. R., 'Some Points Concerning the Diagnosis and General Treatment of the Feeble-Minded', *Journal of Mental Science,* 56 (1910), 459-470

Ellis, Havelock, *Psychology of Sex: A Manual for Students* (London: Heinemann, 1933)

Ellis, Havelock, and John Addington Symonds, *Sexual Inversion: A Critical Edition*, ed. by I. D. Crozier (Basingstoke: Palgrave Macmillan, 2007 [1897])

Epps, P., 'A Further Study of Female Delinquents Undergoing Borstal Training', *British Journal of Delinquency,* 4 (1953-1954), 265-271

Fisher, John W., 'Correspondence: Fetishism Treated by Aversion Therapy', *British Medical Journal,* 2 (1956), 1302

Forel, August, *The Sexual Question: A Scientific, Psychological, Hygienic and Sociological Study*, trans. C. F. Marshall (Brooklyn, NY: Physicians and Surgeons Book Co., 1931 [1906])

Franks, Cyril M., 'Case of Fetishism Treated by Aversion Therapy', *British Medical Journal,* 2 (1956), 1174

Gardner, Arthur R. L., 'In Memoriam: Dr M Hamblin Smith', *The Penal Reformer,* 3 (1936), 14-16

Gibbens, T. C. N., 'Recent Trends in the Management of Psychopathic Offenders', *British Journal of Delinquency,* 2 (1951), 103-116

Gibbens, T. C. N., and Joyce Prince, *Child Victims of Sex Offences* (London: ISTD, 1963)

Gillespie, R. D., *The Service of Psychiatry in the Prevention and Treatment of Crime* (London: Howard League for Penal Reform, 1930)

Glaister, John, *A Text-Book of Medical Jurisprudence and Toxicology*, 5th edn (Edinburgh: E. & S. Livingstone, 1931)

Glaister, John, *A Text-Book of Medical Jurisprudence, Toxicology, and Public Health* (Edinburgh: E. & S. Livingstone, 1902)

Glover, Edward, *The Diagnosis and Treatment of Delinquency, Being a Clinical Report on the Work of the Institute during the Five Years 1937 to 1941* (London: Institute for the Scientific Treatment of Delinquency, 1944)

Glover, Edward, 'The Investigation and Treatment of Delinquency', *British Medical Journal,* 1 (1947), 421

Glover, Edward, *The Problem of Homosexuality: Being a Memorandum Presented to the Departmental Committee on Homosexual Offences and Prostitution by a Joint Committee Representing the Institute for the Scientific Treatment of Delinquency and the Portman Clinic* (London: Institute for the Scientific Treatment of Delinquency, n.d. [c.1955])

Glover, Edward, *The Psycho-Pathology of Prostitution* (London: Institute for the Scientific Treatment of Delinquency, n.d.)

Glover, Edward, *The Roots of Crime* (London: Imago, 1960)

Glover, Edward, *The Social and Legal Aspects of Sexual Abnormality* (London: Institute for the Scientific Treatment of Delinquency, 1947)

Golla, F. L., and R. Sessions Hodge, 'Hormone Treatment of the Sexual Offender', *The Lancet,* 253 (1949), 1006-1007

Good, T. S., 'The Danger in our Midst: Crime and Abnormality', *The Howard Journal of Criminal Justice,* 3 (1932), 57-65

Grünhut, Max, *Probation and Mental Treatment* (London: Tavistock Publications, 1963)

Hadfield, J. A., 'Some Aspects of the Psychopathology of Sex Perversions', *Proceedings of the Royal Society of Medicine,* 29 (1933), 1021-1030

Hamblin Smith, M., 'Notes on 100 Mentally Defective Prisoners at Stafford', *Journal of Mental Science,* 59 (1913), 326-335

Hamblin Smith, M., 'The Mental Conditions Found in Certain Sexual Offenders', *The Lancet,* 203 (1924), 643-646

Hamblin Smith, M., *The Psychology of the Criminal*, 2nd edn (London: Methuen, 1933)

Hamblin Smith, M., 'The Psychopathic Personality', *Journal of Mental Science,* 71 (1925), 683-694

Hamblin Smith, M., 'Unfitness to Plead in Criminal Trials', *Journal of Mental Science,* 62 (1916), 763-774

Hardy, L. I., 'Homosexuality', *British Medical Journal,* 1 (1946), 291

Hemphill, K. E., and W. Grey Walter, 'The Treatment of Mental Disorders by Electrically Induced Convulsions', *Journal of Mental Science,* 87 (1941), 256-275

Henderson, D. K., and R. D. Gillespie, *A Text-Book of Psychiatry for Students and Practitioners*, 3rd edn (Oxford: Oxford Medical Press, 1932)

Henderson, David Kennedy, and R. D. Gillespie, *A Text-Book of Psychiatry for Students and Practitioners* (London: Humphrey Milford, 1927)

Ho, David K., 'Ineffective Treatment of Sex Offenders Fails Victims', *British Medical Journal,* 350 (2015), 24

Hobhouse, Stephen, and A. Fenner Brockway, *English Prisons To-Day* (Longmans, Green, 1922)

Hollander, Bernard, *The Psychology of Misconduct, Vice, and Crime* (London: George Allen & Unwin, 1928 [1922])

James, Basil, 'Case of Homosexuality Treated by Aversion Therapy', *British Medical Journal,* 1 (1962), 768-770

'J. D.', 'Prison and After', *The Howard Journal of Criminal Justice,* 9 (1955), 118-124

Krafft-Ebing, R. von, *Psychopathia Sexualis: With Especial Reference to the Antipathic Sexual Instinct*, trans. Franklin S. Klaf (New York: Arcade Publishing, 1998 [1965, 1902])

Landers, John J., 'Observations on Two Hundred Dartmoor Convicts', *Journal of Mental Science,* 84 (1938), 960-979

Landers, John J., D. S. Macphail, and R. Cedric Simpson, 'Group Therapy in H.M. Prison, Wormwood Scrubs: The Application of Analytical Psychology', *Journal of Mental Science,* 100 (1954), 953-960

Långström, Niklas, Kelly M. Babchishin, Seena Fazel, Paul Lichtenstein, and Thomas Frisell, 'Sexual Offending Runs in Families: A 37-year Nationwide Study', *International Journal of Epidemiology,* 44 (2015), 713-720

Leitch, A., 'The Open Prison', *British Journal of Delinquency,* 2 (1951), 25-33

Lombroso, Cesare, *The Female Offender*, ed. by W. Douglas Morrison, *The Criminology Series* (New York: D. Appleton, 1895)

Luff, Mary C., and Marjorie Garrod, 'The After-Results of Psychotherapy In 500 Adult Cases', *British Medical Journal,* 2 (1935), 54-59

Lumley, W., 'Homosexuality', *British Medical Journal,* 1 (1946), 369

Mackwood, John C., 'Male Homosexuality', *The Medico-Legal Journal,* 15 (1947), 14-18

Mackwood, John C., 'Psychotherapy in Prisons and Corrective Institutions', *Proceedings of the Royal Society of Medicine,* 47 (1954), 220-224

Maclay, David, 'Boys Who Commit Sexual Misdemeanours', *British Medical Journal,* 1 (1960), 186-190

Maclay, David, 'The Diagnosis and Treatment of Compensatory Types of Indecent Exposure', *British Journal of Delinquency,* 3 (1952), 34-43

Mannheim, Hermann, *Social Aspects of Crime in England between the Wars* (London: G. Allen & Unwin, 1940)

Mannheim, Hermann, and John C. Spencer, *Problems of Classification in the English Penal and Reformatory System* (London: Institute for the Scientific Treatment of Delinquency, n.d.)

Marsh Beadnell, C., 'The Interstitial Gland and Sex Problems', *British Medical Journal,* 1 (1922), 973

McKee, S. K., 'Homosexuality', *British Medical Journal,* 1 (1946), 503

Mercier, Charles, 'Psycho-Analysis', *British Medical Journal,* 1 (1914), 172-173

Mitchell, William, Murray A. Falconer, and Denis Hill, 'Epilepsy with Fetishism Relieved by Temporal Lobectomy', *The Lancet,* 264 (1957), 626-630

Mullins, Claud, *Crime and Psychology* (London: Methuen, 1943)

Mullins, Claud, 'The Twenty-Second Maudsley Lecture: Psychiatry in the Criminal Courts', *Journal of Mental Science,* 95 (1949), 263-274

Neustatter, W. Lindesay, *Psychological Disorder and Crime* (London: Christopher Johnson, 1953)

Neustatter, W. Lindesay, 'The Results of Fifty Cases Treated by Psychotherapy', *The Lancet,* 225 (1935), 796-799

Norwood East, William, 'An Inquiry into the Susceptibility of Criminals to Atmospheric Changes', *The Lancet,* 162 (1903), 211

Norwood East, William, *An Introduction to Forensic Psychiatry in the Criminal Courts* (London: J & A Churchill, 1927)

Norwood East, William, 'Crime, Senescence and Senility', *Journal of Mental Science,* 90 (1944), 835-850

Norwood East, William, 'Delinquency and Crime', *Journal of Mental Science,* 90 (1944), 382-398

Norwood East, William, *Medical Aspects of Crime* (London: J & A Churchill, 1936)

Norwood East, William, 'Observations on Exhibitionism', *The Lancet,* 204 (1924), 370-375

Norwood East, William, 'Physical and Moral Insensibility in the Criminal', *Journal of Mental Science,* 47 (1901), 737-758

Norwood East, William, 'Prostitution', *The Practitioner,* 158 (1947), 335-342

Norwood East, William, 'Psychopathic Personality and Crime', *Journal of Mental Science,* 91 (1945), 426-446

Norwood East, William, 'Responsibility in Mental Disorder, with Special Reference to Algolagnia', *Journal of Mental Science,* 84 (1938), 203-221

Norwood East, William, 'Sexual Offenders', in *Mental Abnormality and Crime: Introductory Essays*, ed. by L. Radzinowicz and J. W. C. Turner (London: Macmillan, 1944), pp. 177-207

Norwood East, William, *Sexual Offenders*, ed. by Vincent Long (London: Delisle, 1955)

Norwood East, William, *Society and the Criminal* (London: H. M. Stationery Office, 1949)

Norwood East, William, 'Some Cases of Mental Disorder and Defect Seen in the Criminal Courts', *Journal of Mental Science,* 66 (1920), 422-438

Norwood East, William, 'The Interpretation of Some Sexual Offences', *Journal of Mental Science,* 71 (1925), 410-424

Norwood East, William, 'The Modern Psychiatric Approach to Crime', *Journal of Mental Science,* 85 (1939), 649-666

Norwood East, William, 'The Non-Sane Non-Insane Offender', *Eugenics Review,* 39 (1947), 6-16

Norwood East, William, Percy Stocks, and H. T. P. Young, *The Adolescent Criminal* (London: J & A Churchill, 1942)

Norwood East, William, and Alexander Walk, 'Maurice Hamblin Smith', *Journal of Mental Science,* 82 (1936), 291-293

Osmond, Humphry, G. W. Fleming, Harold Burrows, W. W. Horton, and G. Orissa Taylor, 'Penalties for Sexual Offences', *British Medical Journal,* 2 (1951), 672-673

Pasmore, Edwin Stephen, 'Observations on the Classification of Insanity', *Journal of Mental Science,* 45 (1899), 70-78

Paterson, Alexander, *Paterson on Prisons*, ed. by S. K. Ruck (London: Frederick Muller, 1951)

Pentreath, E. U. H., and E. Cunningham Dax, 'Mental Observation Wards: A Discussion of Their Work and Its Objects', *Journal of Mental Science,* 83 (1937), 347-365

Radzinowicz, Leon, *Sexual Offences: A Report of the Cambridge Department of Criminal Science* (London: Macmillan, 1957)

Raymond, M. J., 'Aversion Therapy for Sexual Deviation', *British Journal of Psychiatry,* 115 (1969), 979-980

Raymond, M. J., 'Case of Fetishism Treated by Aversion Therapy', *British Medical Journal,* 2 (1956), 854-857

Read, C. Stanford, 'Homosexuality', *Journal of Mental Science,* 67 (1921), 8-12

Rees, J. R., *Mental Health and the Offender* (London: The Clarke Hall Fellowship, 1947)

Rees, J. R., 'Prognosis in the Sexual Neuroses', *The Lancet,* 225 (1935), 948-949

Rees, J. R., 'Sexual Perversions', *The Practitioner,* 137 (1936), 98-107

Rees-Thomas, W., 'Sadism and Masochism', *Journal of Mental Science,* 67 (1921), 12-17

Reid, R. D., 'The Case of the Homosexual' (Chiselhurst: Prison Medical Reform Council, 1944)

Roberts, Morley, 'Indirect Results of Prostatectomy', *British Medical Journal,* 2 (1922), 1048

Rooth, Graham, 'Exhibitionism, Sexual Violence and Paedophilia', *Journal of Mental Science,* 122 (1973), 705-710

Rosen, Ismond, ed., *The Pathology and Treatment of Sexual Deviation: A Methodological Approach* (London: Oxford University Press, 1964)

Sands, Dalton E., 'Further Studies on Endocrine Treatment in Adolescence and Early Adult Life', *Journal of Mental Science,* 100 (1954), 211-219

Savage, George, 'Case of Sexual Perversion in a Man', *Journal of Mental Science,* 30 (1884), 390-391

Savage, George H., and C. Mercier, 'Insanity of Conduct', *Journal of Mental Science,* 42 (1896), 1-17

Sessions Hodge, R., 'Medico-Legal Aspects of the Treatment of the Sexual Offender, with Discussion of a Method of Treatment by Gland Extracts', *Medico-Legal Journal,* 18 (1950), 130-144

Smith, Fred J., *Taylor's Principles and Practice of Medical Jurisprudence*, 6th edn (London: J. & A. Churchill, 1910)

Stanley-Jones, D., 'Homosexuality', *British Medical Journal,* 1 (1946), 179

Storr, Anthony, *Sexual Deviation* (London: Heinemann, 1965)

Strauss, E. B., *Reason and Unreason in Psychological Medicine* (London: H. K. Lewis, 1953)

Stungo, Ellis, and Eustace Chesser, 'Homosexuality', *British Medical Journal,* 1 (1946), 450-451

Sturrock, J. P., 'The Mentally Defective Criminal', *Journal of Mental Science,* 59 (1913), 314-325

Sutherland, J. F., 'Recidivism Regarded from the Environmental and Psychopathological Standpoints', *Journal of Mental Science,* 53 (1907), 568-590

Sutherland, Robert, 'Sexual Delinquency: Address to the 36th National Conference', *Probation Journal,* 5 (1948), 222-224

Sykes, Kathleen A. H., 'Homosexuality', *British Medical Journal,* 1 (1946), 409-410

Taylor, Alfred Swaine, *The Principles and Practice of Medical Jurisprudence* (London: John Churchill & Sons, 1865)

Taylor, Alfred Swaine, *The Principles and Practice of Medical Jurisprudence*, 2nd edn, vol. 2 (London: John Churchill & Sons, 1873)

Taylor, F. H., 'Homosexual Offences and Their Relation to Psychotherapy', *British Medical Journal,* 2 (1947), 525-529

Taylor, F. H., 'Observations on Some Cases of Exhibitionism', *Journal of Mental Science,* 93 (1947), 631-638

Walk, A., 'Review: A Text-Book of Psychiatry', *Journal of Mental Science,* 79 (1933), 173-174

Walker, Kenneth, and Eric B. Strauss, *Sexual Disorders in the Male* (London: Hamish Hamilton Medical Books, 1939)

Wells, Nesta H., 'Sexual Offences as Seen by a Woman Police Surgeon', *British Medical Journal,* 2 (1958), 1404-1408

Williams, Leonard, 'The Interstitial Gland', *British Medical Journal,* 1 (1922), 833-835

Woodward, Mary, 'The Diagnosis and Treatment of Homosexual Offenders', *British Journal of Delinquency,* 9 (1958), 44-59

Worthington, W. G., 'The Case for Probation', *Probation Journal,* 1 (1930), 65-66

## Newspaper articles

'15 Years' Sentence on Cole', *The Times*, 23 October 1947, p.2

'Accused Sheffield Man "Frantic with Distress"', *Sheffield Telegraph and Independent*, 19 August 1939, p.11

'After-Care of Offenders', *The Times*, 9 December 1952, p.3

'Alleged Attacks on Women', *The Times*, 17 October 1947, p.2

'Appellant to Continue Medical Treatment', *The Times*, 24 February 1942, p.6

'Back to Mental Home', *The Burnley News*, 8 May 1929, p.7

'Bishop Speaks for Accused Ex-Curate', *Sevenoaks Courier and Kentish Advertiser*, 4 March 1949, p.7

'Bishop's Brother to Be Examined', *Northampton Mercury*, 24 December 1941, p.3

'Bucks Autumn Assizes', *Bucks Herald*, 22 October 1927, p.4

'Central Criminal Court', *The Times*, 16 December 1901, p.13

'Charge against Ex-Mayor', *The Times*, 20 April 1928, p.5

'Charlton Man to Undertake Treatment', *Gloucestershire Echo*, 25 October 1949, p.5

'Conflict of Medical Evidence in Boy Murder Trial', *Manchester Guardian*, 5 July 1955, p.4

'Country Vicar's Lapse', *The Times*, 19 January 1922, p.7

'Curative Treatment of Crime', *The Times*, 7 January 1920, p.9

'Dangerous Mental Aberrations', *Dover Express and East Kent News*, 1 September 1939, p.14

'Dawlish Sensation: Wormwood Scrubbs Official Charged', *Western Times*, 21 September 1928, p.6

'Defence of “Partial Insanity” in Heath Trial: Killing of Two Women Admitted', *Manchester Guardian*, 26 September 1946

'Devon Assize: Judge on Unnatural and Sexual Offences', *Devon and Exeter Gazette*, 5 November 1926, p.12

'Devon Assize: P.S. for Plymothian', *Devon and Exeter Gazette*, 5 November 1926, p.12

'Ex-schoolmaster Sent to Gaol', *Yorkshire Post and Leeds Mercury*, 25 March 1955, p.4

'For Mental Observation', *Dover Express and East Kent News*, 20 January 1939, p.12

'Former Captain's Acquittal', *The Times*, 1 July 1920, p.13

'Former Captain's Defence', *The Times*, 30 June 1920, p.13

'General Messervy Bound Over', *The Times*, 11 September 1956, p.4

'Girls Complain of Railway-Man's Conduct', *Somerset County Herald*, 4 June 1949, p.3

'Indecency with Boys', *The Times*, 11 November 1953, p.11

'Judge Differs from Doctor', *Gloucestershire Echo*, 7 June 1924, p.6

'Kenilworth Magistrates' Court: To See a Doctor', *Leamington Spa Courier & Warwickshire Standard*, 10 December 1954, p.10

'Misbehaviour at Beachy Head', *The Times*, 28 August 1920, p.7

'Obscene Libel Charge', *The Times*, 28 March 1924, p.11

'On Medical Report', *Dover Express and East Kent News*, 15 April 1949, p.6

'On Probation', *Biggleswade Chronicle*, 11 May 1951, p.10

'"Painful Case" of a Cashier', *Derby Daily Telegraph*, 9 April 1941, p.6

'"Pest" Sent to Prison', *The Newsman*, 26 July 1924, p.3

'Prison for a North Lincs Vicar', *Hull Daily Mail*, 9 November 1926, p.9

'Probation for Ollerton Labourer', *Nottingham Evening Post*, 12 October 1949, p.5

'Probation for Teacher', *Yorkshire Post*, 27 September 1955, p.1

'Psycho-Analysts' "False Science"', *The Times*, 3 October 1922, p.7

'Punishment of Crime', *The Times*, 18 August 1925, p.5

'Put on Probation', *Nottingham Evening Post*, 29 August 1945, p.1

'Remitted from Lincoln: Youth Committed to Institution', *Nottingham Evening Post*, 18 June 1947, p.1

'Sapped His Own Mind: Judge and a Prisoner's Mentality', *Northern Daily Mail*, 17 November 1931, p.5

'The Hartlepools Day by Day', *Northern Daily Mail*, 8 November 1948, p.4

'Three Men Sent to Prison', *The Times*, 25 March 1954, p.4

'To Reside at Mental Hospital', *Biggleswade Chronicle*, 29 June 1951, p.3

'Wendover: Milk Roundsman Bound Over', *Bucks Herald*, 22 October 1948, p.8

'Worcestershire Rector Bound Over', *The Times*, 23 November 1929, p.9

'York Man's Record of Sadistic Acts', *Yorkshire Evening Post*, 20 July 1942, p.5

'Young Girls Assaulted', *Somerset County Herald*, 23 April 1949, p.3

Aikenhead, Decca, 'Chemical Castration: The Soft Option?', *Guardian*, 18 January 2013 <http://www.theguardian.com/society/2013/jan/18/chemical-castration-soft-option-sex-offenders>

Barrett, David, 'Number of convicted sex offenders in jail reaches record high', *Telegraph*, 30 April 2015 <http://www.telegraph.co.uk/news/uknews/crime/11573580/Number-of-convicted-sex-offenders-in-jail-reaches-record-high.html>

Camp, Ronald, 'Doctors Clash on Sanity of Heath', *News Chronicle*, 26 September 1946

Campbell, Duncan, 'Murder Most British', *Guardian*, 15 September 2013 <http://www.theguardian.com/uk-news/2013/sep/15/murder-neville-heath-fred-west>

Coddington, F. J. O., 'Factors in Petty Crimes', *Yorkshire Post*, 8 February 1939, p.3

Connor, Steve, 'Research Confirms "Gay Gene" Discovery', *Independent,* 31 October 1995 <http://www.independent.co.uk/news/research-confirms-gay-gene-discovery-1580244.html>

Dugan, Emily, 'Sex Offenders Freed from Prison without Treatment Will "Create More Victims"', *Independent,* 3 February 2014 <http://www.independent.co.uk/news/uk/crime/exclusive-sex-offenders-freed-from-prison-without-treatment-will-create-more-victims-9102847.html>

Hope, Jenny, 'Sex Crimes May Run in a Family's Male Genes: Brothers of Men Convicted of Offences Five Times More Likely to Commit Similar Crimes', *Daily Mail,* 9 April 2015 <http://www.dailymail.co.uk/news/article-3031261/Sex-crimes-run-family-s-male-genes-Brothers-men-convicted-offences-five-times-likely-commit-similar-crimes.html>

Johnson, Wesley, 'Sex Offenders Being Released from Prison without Accessing Treatment Programme', *Independent,* 12 January 2012 <http://www.independent.co.uk/news/uk/crime/sex-offenders-being-released-from-prison-without-accessing-treatment-programme-7843641.html>

Knapton, Sarah, 'Being Homosexual Is only Partly Due to Gay Gene, Research Finds', *Telegraph,* 14 February 2014 <http://www.telegraph.co.uk/science/science-news/10637532/Being-homosexual-is-only-partly-due-to-gay-gene-research-finds.html>

Sample, Ian, 'Male Sexual Orientation Influenced by Genes, Study Shows', *Guardian,* 14 February 2014 <http://www.theguardian.com/science/2014/feb/14/genes-influence-male-sexual-orientation-study>

## Radio programmes

*Inside the Sex Offenders' Prison*, Pres. Rex Bloomstein, Prod. Simon Jones, Unique production for BBC Radio 4, first broadcast 31 March 2015

## Unpublished papers

'Advisory Council for the Treatment of Offenders', The National Archives (London), HO 326/56

'Archives of Ismond Rosen', Wellcome Library (London), PP/ROS/C/4/1

'Archives of Ismond Rosen: Exhibitionism', Wellcome Library (London), PP/ROS/E/2

'Archives of Ismond Rosen: Sexual Deviation', Wellcome Library (London), PP/ROS/D/1

'Archives of the Howard League for Penal Reform', Modern Records Centre (Warwick), MSS.16B/1/1-4 and MSS.16C/3/MH/1-19

'Assizes: Oxford Circuit: Jones', The National Archives (London), ASSI 6/56/6

'Clarke, Sydney Joseph', The National Archives (London), DPP 2/2405

'Collection of Napsbury Mental Hospital, St Albans: General neurology and psychiatry', Wellcome Library (London), GC/135/B.3/2

'Committee on Sterilization', The National Archives (London), PCOM 9/123

'Defendant: DUTTON, John', The National Archives (London), CRIM 1/1227

'Defendant: GATZIAS, Samuel Harold', The National Archives (London), CRIM 1/475

'Defendant: GESSEY, Alan David', The National Archives (London), CRIM 1/2936

'Defendant: HARRIS, Frederick', The National Archives (London), CRIM 1/358

'Defendant: JAMES: Wynford Reginald', The National Archives (London), CRIM 1/3106

'Defendant: WYETH, James', The National Archives (London), CRIM 1/1415

'Evidence to the Departmental Committee on Assaults of Young Persons', The National Archives (London), HO 45/25434

'Father sentenced to seven years penal servitude for rape of daughter', The National Archives (London), MEPO 3/419

'Feversham Committee', Wellcome Library (London), SA/MAC/E.2/9

'Gross indecency with boys: conviction of an Indian Army Major (retired)', The National Archives (London), MEPO 3/404

'Harold Jones', The National Archives (London), PCOM 9/742

'HEATH, Neville', The National Archives (London), DPP 2/1524

'HEATH, Neville', The National Archives (London), HO 144/22872

'Hugh Chapman: persistent importuner', The National Archives (London), MEPO 3/992

'Indecent assaults on chambermaids in Regents Palace Hotel', The National Archives (London), MEPO 3/397

'Indecent notes and attempted larceny of schoolgirl's clothing', The National Archives (London), MEPO 3/945

'Medical Women's Federation: Home Office Committee to Enquire into Sexual Offences against Young Persons', Wellcome Library (London), SA/MWF/D.7

'Middlesex Assizes: Depositions', London Metropolitan Archives, MXS/B/01/004-006

'Minutes of the Prison Commissioners 1929-1947', The National Archives (London), PCOM 14/8

'Mitford Brice: attempting to procure a boy aged 15', The National Archives (London), MEPO 3/994

'Offers of evidence and suggestions from the public to the Advisory Council for the Treatment of Offenders', The National Archives (London), HO 326/55

'Papers of Sir Aubrey Lewis: correspondence, reports, copy minutes and papers', Bethlem Royal Hospital Archives & Museum (London), AJL-12

'PEAKE: A. J: Murder', The National Archives (London), DPP 2/408

'PEAKE, Arthur Jefferson', The National Archives (London), PCOM 9/809

'Psychological Treatment of Crime', The National Archives (London), PCOM 9/186

'Psychological Treatment of Crime', The National Archives (London), HO 45/18736

'Psychotherapy & Psychiatry in Prisons', The National Archives (London), PCOM 9/2178

'Recent Trends in Psychology: Lectures and Pamphlets', Wellcome Library (London), PSY/HEA/4/4

'Report on treatment of offenders with psychopathic characteristics, and background notes', The National Archives (London), HO 326/63

'Reports and minutes of meetings of the Institute for the Scientific Treatment of Delinquency', Archives of the Centre for Crime and Justice Studies (London) [uncatalogued]

'Transcripts of evidence hearings: Committee on Homosexual Offences and Prostitution', The National Archives (London), HO 345/12-15

'Venereal Disease: Women Prisoners', The National Archives (London), PCOM 9/413

## Secondary sources


Angel, Katherine, 'Contested Psychiatric Ontology and Feminist Critique: “Female Sexual Dysfunction” and the Diagnostic and Statistical Manual', *History of the Human Sciences,* 25 (2012), 3-24

Angel, Katherine, Edgar Jones, and Michael Neve, eds., *European Psychiatry on the Eve of War: Aubrey Lewis, the Maudsley Hospital, and the Rockefeller Foundation in the 1930s* (London: Wellcome Trust Centre for the History of Medicine, 2003)

Barham, Peter, *Forgotten Lunatics of the Great War* (New Haven: Yale University Press, 2004)

Bartrip, P. W. J., *Mirror of Medicine: A History of the British Medical Journal* (Oxford: British Medical Journal and Clarendon Press, 1990)

Bartrip, P. W. J., *Themselves Writ Large: The British Medical Association 1832-1966* (London: BMJ, 1996)

Bates, Victoria, '"Not an Exact Science": Medical Approaches to Age and Sexual Offences in England, 1850-1914' (PhD thesis, University of Exeter, 2012)

Bates, Victoria, '"So Far as I Can Define without a Microscopical Examination": Venereal Disease Diagnosis in English Courts, 1850–1914', *Social History of Medicine,* 26 (2013), 38-55

Bauer, Heike, 'Sexology Backward: Hirschfeld, Kinsey and the Reshaping of Sex Research in the 1950s', in *Queer 1950s: Rethinking Sexuality in the Postwar Years*, ed. by Heike Bauer and Matt Cook (Basingstoke: Palgrave Macmillan, 2012), pp.133-149

Bauer, Heike, and Matt Cook, *Queer 1950s: Rethinking Sexuality in the Postwar Years* (Basingstoke: Palgrave Macmillan, 2012)

Beard, John A. S., 'Dr William Sargant (1907-88) and the Emergence of Physical Treatments in British Psychiatry', *Journal of Medical Biography,* 17 (2009), 23-29

Beccalossi, Chiara, 'Madness and Sexual Psychopathies as the Magnifying Glass of the Normal: Italian Psychiatry and Sexuality c.1880–1910', *Social History of Medicine,* 27 (2014), 303-325

Bengry, Justin, 'Profit (f)or the Public Good?', *Media History,* 20 (2014), 146-166

Bergenheim, Åsa, 'Sexual Assault, Irresistible Impulses, and Forensic Psychiatry in Sweden', *International Journal of Law and Psychiatry,* 37 (2014), 99-108

Bewley, Thomas, *From Madness to Mental Illness* (London: Royal College of Psychiatrists, 2008)

Bingham, Adrian, *Family Newspapers? Sex, Private Life, and the British Popular Press 1918-1978* (Oxford: Oxford University Press, 2009)

Birmingham, Luke, Simon Wilson, and Gwen Adshead, 'Prison Medicine: Ethics and Equivalence', *British Journal of Psychiatry,* 188 (2006), 4-6

Bland, Lucy, *Banishing the Beast: Feminism, Sex, and Morality* (London: Tauris Parke, 2002 [1995])

Bland, Lucy, *Modern Women on Trial: Sexual Transgression in the Age of the Flapper* (Manchester: Manchester University Press, 2014)

Boswell, John, *Rediscovering Gay History: Archetypes of Gay Love in Christian History* (London: Gay Christian Movement, 1982)

Bourke, Joanna, *Rape: A History from 1860 to the Present Day* (London: Virago, 2007)

Bowden, Paul, 'Maurice Hamblin Smith: The Psychoanalytic Panacea', *Journal of Forensic Psychiatry,* 1 (1990), 103-113

Bowden, Paul, 'William Henry de Bargue Hubert (1905-47): Reformer and Expert Witness', *Journal of Forensic Psychiatry,* 7 (1996), 323-340

Bowden, Paul, 'William Norwood East: The Acceptable Face of Psychiatry', *Journal of Forensic Psychiatry,* 2 (1991), 59-78

Brady, Sean, *Masculinity and Male Homosexuality in Britain, 1861-1913* (Basingstoke: Palgrave Macmillan, 2005)

Braslow, Joel T., *Mental Ills and Bodily Cures: Psychiatric Treatment in the First Half of the Twentieth Century* (Berkeley; London: University of California Press, 1997)

Brennan, Toni, and Peter Hegarty, 'Who Was Magnus Hirschfeld and Why Do We Need to Know?', *History & Philosophy of Psychology,* 9 (2007), 12-28

Buckle, Sebastian, *The Way Out: A History of Homosexuality in Modern Britain* (London: I. B. Tauris, 2015)

Bullough, Vern L., *Science in the Bedroom: A History of Sex Research* (New York: Basic Books, 1994)

Byrne, Gerald, *Borstal Boy: The Uncensored Story of Neville Heath* (London: John Hill Productions, 1954)

Canguilhem, Georges, *The Normal and the Pathological*, trans. Carolyn R. Fawcett and Robert S. Cohen (New York: Zone Books, 1989)

Carlen, Pat, 'Psychiatry in Prisons: Promises, Premises, Practices and Politics', in *The Power of Psychiatry*, ed. by Peter Miller and Nikolas Rose (Cambridge: Polity Press, 1986), pp. 241-266

Carlston, Erin G., '"A Finer Differentiation": Female Homosexuality and the American Medical Community, 1926-1940', in *Science and Homosexualities*, ed. by Vernon A. Rosario (New York; London: Routledge, 1997), pp. 177-196

Chauncey, George, 'From Sexual Inversion to Homosexuality: Medicine and the Changing Conceptualization of Female Deviance', *Salmagundi* (1982), 114-146

Chauncey, George, *Gay New York: The Making of the Gay Male World, 1890-1940* (London: Flamingo, 1995)

Chenier, Elise, 'The Criminal Sexual Psychopath in Canada: Sex, Psychiatry and the Law at Mid-Century', *Canadian Bulletin of Medical History,* 20 (2003), 75-101

Chiswick, Derek, 'Use and Abuse of Psychiatric Testimony', *British Medical Journal (Clinical Research Edition),* 290 (1985), 975-977

Cocks, H. G., *Nameless Offences: Homosexual Desire in the Nineteenth Century* (London: I. B. Tauris, 2003)

Cocks, H. G., 'Saucy Stories: Pornography, Sexology and the Marketing of Sexual Knowledge in Britain, c. 1918-70', *Social History,* 29 (2004), 465-484

Cohen, Stanley, 'Social-Control Talk: Telling Stories about Correctional Change', in *The Power to Punish: Contemporary Penality and Social Analysis*, ed. by David Garland and Peter Young (London: Heinemann Educational, 1983), pp. 101-129

Cole, Simon A., 'From the Sexual Psychopath Statute to "Megan's Law": Psychiatric Knowledge in the Diagnosis, Treatment, and Adjudication of Sex Criminals in New Jersey, 1949-1999', *Journal of the History of Medicine and Allied Sciences,* 55 (2000), 292-314

Condrau, Flurin, 'The Patients' View Meets the Clinical Gaze', *Social History of Medicine,* 20 (2007), 525-540

Cook, Matt, *Queer Domesticities: Homosexuality and Home Life in Twentieth-Century London* (Basingstoke: Palgrave Macmillan, 2014)

Cooter, Roger, '"Framing" the End of the Social History of Medicine', in *Locating Medical History: The Stories and their Meanings*, ed. by Frank Huisman and John Harley Warner (Baltimore; London: Johns Hopkins University Press, 2004), pp. 309-337

Crozier, I. D., 'Becoming a Sexologist: Norman Haire, the 1929 London World League for Sexual Reform Congress, and Organizing Medical Knowledge about Sex in Interwar England', *History of Science,* 39 (2001), 299-329

Crozier, I. D., 'Taking Prisoners: Havelock Ellis, Sigmund Freud, and the Construction of Homosexuality, 1897–1951', *Social History of Medicine,* 13 (2000), 447-466

Crozier, I. D., 'The Medical Construction of Homosexuality and Its Relation to the Law in Nineteenth-Century England', *Medical History,* 45 (2001), 61-82

Crozier, Ivan, 'Nineteenth-Century British Psychiatric Writing about Homosexuality before Havelock Ellis: The Missing Story', *Journal of the History of Medicine and Allied Sciences,* 63 (2008), 65-102

Crozier, Ivan, and Gethin Rees, 'Making a Space for Medical Expertise: Medical Knowledge of Sexual Assault and the Construction of Boundaries between Forensic

Medicine and the Law in Late Nineteenth-century England', *Law, Culture and the Humanities,* 8 (2011), 285-304

Dale, Pamela, and Joseph Melling, eds., *Mental Illness and Learning Disability since 1850: Finding a Place for Mental Disorder in the United Kingdom* (London: Routledge, 2006)

Dally, Emma, *Claud Mullins: Rebel, Reformer, Reactionary* (Leicester: Troubadour Publishing, 2010)

David, Hugh, *On Queer Street: A Social History of British Homosexuality, 1895-1995* (London: HarperCollins, 1997)

Davidson, Roger, 'Psychiatry and Homosexuality in Mid-Twentieth-Century Edinburgh: The View from Jordanburn Nerve Hospital', *History of Psychiatry,* 20 (2009), 403-424

Davidson, Roger, and Gayle Davis, *The Sexual State: Sexuality and Scottish Governance, 1950-80* (Edinburgh: Edinburgh University Press, 2012)

D'Cruze, Shani, 'Crime', in *Women in Twentieth-Century Britain: Social, Cultural and Political Change*, ed. by Ina Zweiniger-Bargielowska (Harlow: Longman, 2001), pp. 198-213

D'Cruze, Shani, and Louise A. Jackson, *Women, Crime and Justice in England since 1660* (Basingstoke: Palgrave Macmillan, 2009)

D'Emilio, John, and Estelle B. Freedman, *Intimate Matters: A History of Sexuality in America* (New York: Harper & Row, 1988)

Dickinson, Tommy, 'Mental Nursing and 'Sexual Deviation': Exploring the Role of Nurses and the Experiences of Patients, 1935-1974' (PhD thesis, University of Manchester, 2012)

Dickinson, Tommy, Matt Cook, John Playle, and Christine Hallett, '"Queer" Treatments. Giving a Voice to Former Patients Who Received Treatments for Their "Sexual Deviations"', *Journal of Clinical Nursing,* 21 (2012), 1345-1354

Dicks, H. V., *Fifty Years of the Tavistock Clinic* (London: Routledge & Kegan Paul, 1970)

Doan, Laura L., *Disturbing Practices: History, Sexuality, and Women's Experience of Modern War* (Chicago: University of Chicago Press, 2013)

Doan, Laura L., *Fashioning Sapphism: The Origins of a Modern English Lesbian Culture* (New York; Chichester: Columbia University Press, 2001)

Downing, Lisa, 'Murder in the Feminine: Marie Lafarge and the Sexualization of the Nineteenth-Century Criminal Woman', *Journal of the History of Sexuality,* 18 (2009), 121-137

Downing, Lisa, *The Subject of Murder: Gender, Exceptionality, and the Modern Killer* (Chicago; London: University of Chicago Press, 2013)

Eigen, Joel Peter, *Witnessing Insanity: Madness and Mad-Doctors in the English Court* (New Haven; London: Yale University Press, 1995)

Emsley, Clive, *Crime and Society in Twentieth-Century England* (Harlow: Longman, 2011)

Fee, Elizabeth, 'Psychology, Sexuality, and Social Control in Victorian England', *Social Science Quarterly,* 58 (1978), 632-646

First, Michael B., 'DSM-5 and Paraphilic Disorders', *Journal of the American Academy of Psychiatry and the Law,* 42 (2014), 191-201

Foucault, Michel, *History of Madness*, trans. Jonathan Murphy (London: Routledge, 2006)

Foucault, Michel, *The History of Sexuality: An Introduction*, trans. Robert Hurley, vol. 1 (London: Penguin, 1990 [1976])

Freedman, Estelle B., '"Uncontrolled Desires": The Response to the Sexual Psychopath, 1920-1960', *The Journal of American History,* 74 (1987), 83-106

Garland, David, 'British Criminology before 1935', *British Journal of Criminology,* 28 (1988), 1-17

Garland, David, *Punishment and Welfare: A History of Penal Strategies* (Aldershot: Gower, 1985)

Garland, David, and Peter Young, 'Towards a Social Analysis of Penality', in *The Power to Punish: Contemporary Penality and Social Analysis*, ed. by David Garland and Peter Young (London; New Jersey: Heinemann, 1983), pp. 1-36

Gibbens, T. C. N., K. Soothill, and C. Way, 'Psychiatric Treatment on Probation', *British Journal of Criminology,* 21 (1981), 324-334

Goold, Imogen, and Catherine Kelly, *Lawyers' Medicine: The Legislature, the Courts and Medical Practice, 1760-2000* (Oxford: Hart, 2009)

Grosskurth, Phyllis, *Havelock Ellis* (London: Allen Lane, 1980)

Gunn, John, 'Future Directions for Treatment in Forensic Psychiatry', *British Journal of Psychiatry,* 176 (2000), 332-338

Hacking, Ian, *The Social Construction of What?* (Cambridge, MA; London: Harvard University Press, 1999)

Hall, Lesley, '"Disinterested Enthusiasm for Sexual Misconduct": The British Society for the Study of Sex Psychology, 1913-47', *Journal of Contemporary History,* 30 (1995), 665-686

Hall, Lesley, 'Heroes or Villains? Reconsidering British fin de siècle Sexology', in *New Sexual Agendas*, ed. by Lynne Segal (Basingstoke: Macmillan, 1997), pp. 3-16

Hall, Lesley, *Hidden Anxieties: Male Sexuality, 1900-1950* (Cambridge: Polity Press, 1991)

Hall, Lesley, *Sex, Gender and Social Change in Britain since 1880*, 2nd edn (Basingstoke: Palgrave Macmillan, 2013)

Hall, Lesley, '"Somehow Very Distasteful": Doctors, Men and Sexual Problems between the Wars', *Journal of Contemporary History,* 20 (1985), 553-574

Hall, Lesley, '"The English Have Hot-Water Bottles": The Morganatic Marriage between Sexology and Medicine in Britain since William Acton', in *Sexual Knowledge, Sexual Science: The History of Attitudes to Sexuality*, ed. by Roy Porter and Mikulas C. Teich (Cambridge: Cambridge University Press, 1994), pp. 350-366

Halperin, David M., *One Hundred Years of Homosexuality, and Other Essays on Greek Love* (New York; London: Routledge, 1990)

Harding, Christopher, '"The Inevitable End of a Discredited System"? The Origins of the Gladstone Committee Report on Prisons, 1895', *The Historical Journal,* 31 (1988), 591-608

Hare, E. H., 'Masturbatory Insanity: The History of an Idea', *Journal of Mental Science,* 108 (1962), 1-25

Harris, Ruth, *Murders and Madness: Medicine, Law, and Society in the Fin de Siècle* (Oxford: Clarendon, 1989)

Harrison, Tom, *Bion, Rickman, Foulkes, and the Northfield Experiments: Advancing on a Different Front* (London: Jessica Kingsley, 2000)

Hayward, Rhodri, 'Germany and the Making of "English" Psychiatry: The Maudsley Hospital, 1908-1939', in *International Relations in Psychiatry*, ed. by Volker Roelcke, Paul J. Weindling, and Louise Westwood (Rochester: University of Rochester Press, 2010), pp. 67-90

Hayward, Rhodri, '"Much Exaggerated": The End of the History of Medicine', *Journal of Contemporary History,* 40 (2005), 167-178

Hodges, Andrew, *Alan Turing: The Enigma* (London: Vintage, 1992)

Houlbrook, Matt, '"Lady Austin's Camp Boys": Constituting the Queer Subject in 1930s London', *Gender & History,* 14 (2002), 31-61

Houlbrook, Matt, *Queer London: Perils and Pleasures in the Sexual Metropolis, 1918-1957* (Chicago: University of Chicago Press, 2006)

Ignatieff, Michael, *A Just Measure of Pain: The Penitentiary in the Industrial Revolution, 1750-1850* (London: Macmillan, 1978)

Irvine, Elizabeth F., *A Pioneer of the New Psychology: Hugh Crichton-Miller* (Chatham: W & J Mackay, 1963)

Irvine, Janice, 'Regulated Passions: The Invention of Inhibited Sexual Desire and Sexual Addiction', in *Deviant Bodies: Critical Perspectives on Difference in Science and Popular*

*Culture*, ed. by Jennifer Terry and Jacqueline Urla (Bloomington: Indiana University Press, 1995), pp. 314-337

Jeffery-Poulter, Stephen, *Peers, Queers, and Commons: The Struggle for Gay Law Reform from 1950 to the Present* (London: Routledge, 1991)

Jones, C., 'Establishing a Sex Offender Treatment Programme within a Prison', *British Journal of Psychiatry: Bulletin,* 20 (1996), 261-263

Jones, David A., *History of Criminology: A Philosophical Perspective* (New York: Greenwood Press, 1986)

Jones, Edgar, 'War and the Practice of Psychotherapy: The UK Experience 1939–1960', *Medical History,* 48 (2004), 493-510

Jones, Kathleen, 'Law and Mental Health: Sticks or Carrots?', in *150 Years of British Psychiatry, 1841-1991*, ed. by German E. Berrios and Hugh Freeman (London: Gaskell, 1991), pp. 89-102

Jordanova, Ludmilla, 'Has the Social History of Medicine Come of Age?', in *Locating Medical History: The Stories and Their Meanings*, ed. by Frank Huisman and John Harley Warner (Baltimore; London: Johns Hopkins University Press, 2004), pp. 338-363

Laite, Julia, *Common Prostitutes and Ordinary Citizens: Commercial Sex in London, 1885-1960* (Basingstoke: Palgrave Macmillan, 2012)

Laqueur, Thomas, *Solitary Sex: A Cultural History of Masturbation* (New York: Zone Books, 2003)

Levenson, Howard, 'Legal Aid for Mitigation', *Modern Law Review,* 40 (1977), 523-532

Loughnan, Arlie, *Manifest Madness: Mental Incapacity in Criminal Law* (Oxford: Oxford University Press, 2012)

Loughnan, Arlie, 'The “Strange” Case of the Infanticide Doctrine', *Oxford Journal of Legal Studies,* 32 (2012), 685-711

Loughnan, Arlie, and Tony Ward, 'Emergent Authority and Expert Knowledge: Psychiatry and Criminal Responsibility in the UK', *International Journal of Law and Psychiatry,* 37 (2014), 25-36

Love, Heather, *Feeling Backward: Loss and the Politics of Queer History* (Cambridge, MA; London: Harvard University Press, 2007)

Mahood, Linda, and Barbara Littlewood, 'The "Vicious" Girl and the "Street-Corner" Boy: Sexuality and the Gendered Delinquent in the Scottish Child-Saving Movement, 1850-1940', *Journal of the History of Sexuality,* 4 (1994), 549-578

Marland, Hilary, *Dangerous Motherhood: Insanity and Childbirth in Victorian Britain* (Basingstoke: Palgrave Macmillan, 2004)

Marland, Hilary, 'Getting Away with Murder? Puerperal Insanity, Infanticide and the Defence Plea', in *Infanticide: Historical Perspectives on Child Murder and Concealment, 1550-2000*, ed. by Mark Jackson (Aldershot: Ashgate, 2002), pp. 168-192

Martinson, Robert, 'What Works? Questions and Answers about Prison Reform', *The Public Interest,* 0.35 (1974), 22

McAlinden, Anne-Marie, 'The Governance of Sexual Offending across Europe: Penal Policies, Political Economies and the Institutionalization of Risk', *Punishment & Society,* 14 (2012), 166-192

McIntosh, Mary, 'The Homosexual Role', *Social Problems,* 16 (1968), 182-192

McKenna, Neil, *Fanny and Stella: The Young Men Who Shocked Victorian England* (London: Faber and Faber, 2013)

McLaren, Angus, 'Exhibitionism and Deviance', in *Sexuality*, ed. by Robert A. Nye (Oxford: Oxford University Press, 1999), pp. 180-183

McLaren, Angus, *Twentieth-Century Sexuality: A History* (Oxford: Blackwell, 1999)

Meek, Jeffrey, *Queer Voices in Post-War Scotland: Male Homosexuality, Religion and Society* (Basingstoke: Palgrave Macmillan, 2015)

Meyerowitz, Joanne J., *How Sex Changed: A History of Transsexuality in the United States* (Cambridge, MA; London: Harvard University Press, 2002)

Milkins, Neil, *Every Mother's Nightmare: Abertillery in Mourning* (Abertillery: Old Bakehouse, 2008)

Milkins, Neil, *Who Was Jack the Stripper? The Hammersmith Nudes' Murders* (Abertillery: Rose Heyworth Press, 2011)

Miller, Ian, '"A Prostitution of the Profession?" Forcible Feeding, Prison Doctors, Suffrage and the British State, 1909-1914', *Social History of Medicine,* 26 (2013), 225-245

Moncrieff, Joanna, *The Myth of the Chemical Cure: A Critique of Psychiatric Drug Treatment* (London: Palgrave Macmillan, 2009)

Moore, Alison, 'Rethinking Gendered Perversion and Degeneration in Visions of Sadism and Masochism, 1886-1930', *Journal of the History of Sexuality,* 18 (2009), 138-157

Mort, Frank, *Dangerous Sexualities: Medico-Moral Politics in England since 1830* (London: Routledge & Kegan Paul, 1987)

Mort, Frank, *Dangerous Sexualities: Medico-Moral Politics in England since 1830*, 2nd edn (London: Routledge & Kegan Paul, 2000)

Myhre, Eivind, and Oyvind Thomassen, 'The Construction of an Accepted Masculinity: Castration in High Security Psychiatric Institutions in Norway, 1923-1945', in *Masculinities in the Criminological Field*, ed. by Ingrid Lander, Signe Ravn, and Nina Jon (Farnham: Ashgate, 2014), pp. 89-109

Neuman, R. P., 'Masturbation, Madness, and the Modern Concepts of Childhood and Adolescence', *Journal of Social History,* 8 (1975), 1-27

Nye, Robert A., 'The History of Sexuality in Context: National Sexological Traditions', *Science in Context,* 4 (1991), 387-406

Oosterhuis, Harry, *Stepchildren of Nature: Krafft-Ebing, Psychiatry, and the Making of Sexual Identity* (Chicago: University of Chicago Press, 2000)

Oosterhuis, Harry, and Arlie Loughnan, 'Madness and Crime: Historical Perspectives on Forensic Psychiatry', *International Journal of Law and Psychiatry,* 37 (2014), 1-16

Oram, Alison, *Her Husband Was a Woman! Women's Gender-Crossing in Modern British Popular Culture* (London: Routledge, 2007)

Parker, Tony, *The Frying-Pan: A Prison and Its Prisoners* (London: Hutchinson, 1970)

Parker, Tony, *The Twisting Lane* (London: Faber and Faber, 2013 [1969])

Petrunik, Michael, and Linda Deutschmann, 'The Exclusion–Inclusion Spectrum in State and Community Response to Sex Offenders in Anglo-American and European Jurisdictions', *International Journal of Offender Therapy and Comparative Criminology,* 52 (2008), 499-519

Pickersgill, Martyn, 'The Endurance of Uncertainty: Antisociality and Ontological Anarchy in British Psychiatry, 1950–2010', *Science in Context,* 27 (2014), 143-175

Porter, Roy, 'The Patient's View: Doing Medical History from Below', *Theory and Society,* 14 (1985), 175-198

Porter, Roy, and Lesley Hall, *The Facts of Life: The Creation of Sexual Knowledge in Britain, 1650-1950* (New Haven; London: Yale University Press, 1995)

Prosser, Jay, 'Transsexuals and the Transsexologists: Inversion and the Emergence of Transsexual Subjectivity', in *Sexology in Culture: Labelling Bodies and Desires*, ed. by Lucy Bland and Laura L. Doan (Cambridge: Polity Press, 1998), pp. 116-131

Ramon, Shulamit, *Psychiatry in Britain: Meaning and Policy* (London: Croom Helm, 1985)

Rapp, Dean, 'The Early Discovery of Freud by the British General Educated Public, 1912–1919', *Social History of Medicine,* 3 (1990), 217-243

Risse, G. B., and J. H. Warner, 'Reconstructing Clinical Activities: Patient Records in Medical History', *Social History of Medicine,* 5 (1992), 183-205

Robertson, Stephen, 'Separating the Men from the Boys: Masculinity, Psychosexual Development, and Sex Crime in the United States, 1930s-1960s', *Journal of the History of Medicine and Allied Sciences,* 56 (2001), 3-35

Robinson, Paul, *The Modernization of Sex: Havelock Ellis, Alfred Kinsey, William Masters and Virginia Johnson* (London: Elek, 1976)

Rooprai, Dharjinder Singh, and Tom Clark, *Practical Forensic Psychiatry* (London: Hodder Arnold, 2011)

Rosenberg, Charles E., 'Disease in History: Frames and Framers', *The Milbank Quarterly,* 67 (1989), 1-15

Rothman, David J., *Conscience and Convenience: The Asylum and Its Alternatives in Progressive America*, 2nd edn (New York: Aldine de Gruyter, 2002)

Rubin, Gayle S., 'Thinking Sex: Notes for a Radical Theory of the Politics of Sexuality', in *Culture, Society and Sexuality: A Reader*, ed. by Peter Aggleton and Richard Parker (Abingdon: Taylor & Francis e-Library, 2002), pp. 143-178

Schirmann, Felix, 'Badness, Madness and the Brain – the Late 19th-Century Controversy on Immoral Persons and Their Malfunctioning Brains', *History of the Human Sciences,* 26 (2013), 33-50

Scott, Joan, 'The Evidence of Experience', *Critical Inquiry,* 17 (1991), 773-797

Scull, Andrew, *Social Order/Mental Disorder: Anglo-American Psychiatry in Historical Perspective* (Berkeley: University of California Press, 1989)

Selwyn, Francis, *Rotten to the Core? The Life and Death of Neville Heath* (London: Routledge, 1988)

Sengoopta, Chandak, *The Most Secret Quintessence of Life: Sex, Glands, and Hormones, 1850-1950* (Chicago; London: University of Chicago Press, 2006)

Shapira, Michal, *The War Inside: Psychoanalysis, Total War, and the Making of the Democratic Self in Postwar Britain* (Cambridge: Cambridge University Press, 2013)

Shorter, Edward, *A History of Psychiatry: From the Era of the Asylum to the Age of Prozac* (New York; Chichester: Wiley, 1997)

Shorter, Edward, *Written in the Flesh: A History of Desire* (Toronto; London: University of Toronto Press, 2005)

Sim, Joe, *Medical Power in Prisons: The Prison Medical Service in England 1774-1989* (Milton Keynes: Open University Press, 1990)

Sim, Joe, 'The Prison Medical Service and the Deviant 1895-1948', in *The Health of Prisoners: Historical Essays*, ed. by Richard Creese, W. F. Bynum, and J. Bearn (Amsterdam; Atlanta, GA: Rodopi, 1995), pp. 102-117

Simmons, Harvey G., 'Explaining Social Policy: The English Mental Deficiency Act of 1913', *Journal of Social History,* 11 (1978), 387-403

Smart, Carol, 'Reconsidering the Recent History of Child Sexual Abuse, 1910-1960', *Journal of Social Policy,* 29 (2000), 55-71

Smith, Glenn, Annie Bartlett, and Michael King, 'Treatments of Homosexuality in Britain since the 1950s: An Oral History', *British Medical Journal,* 328 (2004), 427-429

Smith, Roger, *Trial by Medicine: Insanity and Responsibility in Victorian Trials* (Edinburgh: Edinburgh University Press, 1981)

Stone, M., 'Shellshock and the Psychologists', in *The Anatomy of Madness: Essays in the History of Psychiatry*, ed. by W. F. Bynum, Roy Porter, and Michael Shepherd (London: Tavistock, 1985), pp. 242-271

Szasz, Thomas, *The Myth of Mental Illness: Foundations of a Theory of Personal Conduct* (New York: Harper and Row, 1961)

Szreter, Simon, 'Victorian Britain, 1831–1963: Towards a Social History of Sexuality', *Journal of Victorian Culture,* 1 (1996), 136-149

Terry, Jennifer, 'Anxious Slippages between "Us" and "Them": A Brief History of the Scientific Search for Homosexual Bodies', in *Critical Perspectives on Difference in Science and Popular Culture*, ed. by Jennifer Terry and Jacqueline Urla (Bloomington, IN: Indiana University Press, 1995), pp. 129-169

Terry, Jennifer, 'The Seductive Power of Science in the Making of Deviant Subjectivity', in *Science and Homosexualities*, ed. by Vernon A. Rosario (New York; London: Routledge, 1997), pp. 271-295

Terry, Jennifer, 'Theorizing Deviant Historiography', *Differences,* 3 (1991), 55-74

Thane, Pat, *Foundations of the Welfare State*, 2nd edn (Harlow: Pearson Education, 1996)

Thomson, Mathew, *Lost Freedom: The Landscape of the Child and the British Post-War Settlement* (Oxford: Oxford University Press, 2013)

Thomson, Mathew, *Psychological Subjects: Identity, Culture, and Health in Twentieth-Century Britain* (Oxford: Oxford University Press, 2006)

Thomson, Mathew, *The Problem of Mental Deficiency: Eugenics, Democracy and Social Policy in Britain, c.1870-1959* (Oxford: Clarendon, 1998)

van der Meer, Theo, 'Voluntary and Therapeutic Castration of Sex Offenders in The Netherlands (1938–1968)', *International Journal of Law and Psychiatry,* 37 (2014), 50-62

Vernon, James, '"For Some Queer Reason": The Trials and Tribulations of Colonel Barker's Masquerade in Interwar Britain', *Signs,* 26 (2000), 37-62

Vickers, Emma, *Queen and Country: Same-Sex Desire in the British Armed Forces, 1939-1945* (Manchester: Manchester University Press, 2013)

Walker, Garthine, 'Everyman or a Monster? The Rapist in Early Modern England, c.1600–1750', *History Workshop Journal,* 76 (2013), 5-31

Walker, Nigel, and Sarah McCabe, *Crime and Insanity in England*, vol. 1 (Edinburgh: Edinburgh University Press, 1968)

Walker, Nigel, and Sarah McCabe, *Crime and Insanity in England*, vol. 2 (Edinburgh: Edinburgh University Press, 1973)

Walkowitz, Judith R., *Prostitution and Victorian Society: Women, Class and the State* (Cambridge: Cambridge University Press, 1980)

Ward, Tony, 'Magistrates, Insanity and the Common Law', *Criminal Law Review* (November 1997), 796-804

Ward, Tony, 'Psychiatry and Criminal Responsibility in England, 1843-1936' (PhD thesis, De Montfort University, 1996)

Ward, Tony, 'The Sad Subject of Infanticide: Law, Medicine and Child Murder, 1860-1938', *Social & Legal Studies,* 8 (1999), 163-180

Waters, Chris, 'Disorders of the Mind, Disorders of the Body Social: Peter Wildeblood and the Making of the Modern Homosexual', in *Moments of Modernity*, ed. by Becky Conekin, Frank Mort, and Chris Waters (London: Rivers Oram, 1999), pp. 134-151

Waters, Chris, 'Havelock Ellis, Sigmund Freud and the State: Discourses of Homosexual Identity in Interwar Britain', in *Sexology in Culture: Labelling Bodies and Desires*, ed. by Lucy Bland and Laura L. Doan (Cambridge: Polity Press, 1998), pp. 165-179

Waters, Chris, 'Sexology', in *Advances in the Modern History of Sexuality*, ed. by Harry Cocks and Matt Houlbrook (Basingstoke: Palgrave Macmillan, 2006), pp. 41-63

Waters, Chris, 'The Homosexual as a Social Being in Britain, 1945–1968', *Journal of British Studies,* 51 (2012), 685-710

Watson, Katherine D, 'Mental Disorder, Crime and the Development of Healthcare Systems', in *Healthcare in Private and Public from the Early Modern Period to 2000*, ed. by Paul J. Weindling (London: Routledge, 2015), pp. 58-81

Weeks, Jeffrey, *Against Nature: Essays on History, Sexuality, and Identity* (London; Concord, MA: Rivers Oram Press, 1991)

Weeks, Jeffrey, and Kevin Porter, *Between the Acts: Lives of Homosexual Men 1885-1967* (London: Rivers Oram Press, 1998)

Weeks, Jeffrey, *Coming Out: Homosexual Politics in Britain from the Nineteenth Century to the Present* (London: Quartet, 1990 [1977])

Weeks, Jeffrey, 'Invented Moralities', *History Workshop* (1991), 151-166

Westwood, Louise, 'A Quiet Revolution in Brighton: Dr Helen Boyle's Pioneering Approach to Mental Health Care, 1899–1939', *Social History of Medicine,* 14 (2001), 439-457

Whitehead, Philip, and Roger Statham, *The History of Probation: Politics, Power and Cultural Change 1876-2005* (Crayford: Shaw & Sons, 2006)

Wilson, David, 'Grendon: A Prison in Danger', *Inside Time* <http://www.insidetime.org/articleview.asp?a=843> [accessed 6 August 2013]