

Interview with Dr Neil McConaghy, 1927-2005

The following is an edited transcript of an interview recorded in March 2002 in Sydney, Australia

Dr Neil McConaghy was an advocate of treatments to change sexual orientation and published many papers on this subject and on sexuality in general from the 1960s onwards. He was essentially a behaviourist in his approach, who in the later years of his practice considered that such treatments might be most useful for changing behaviour in men whose strong homosexual interests led to poor impulse control and personal distress.

Neil McConaghy (NM)

I graduated from the University of Queensland in MBBS and I'd always been interested in psychiatry, largely feeling that it was a new frontier that was area of medicine that least was known and hopefully would be an area that would be open to scientific investigation. Once I had graduated, I started to get interested in psychiatry and after spending a year on this I went down to Melbourne and I was fortunate, from my point of view, that the training in psychiatry then was to do a diploma in psychological medicine which meant that you had to do, in addition to clinical psychiatry, work at Sydney university and Melbourne university, both which studied neuroanatomy and physiology and also studying psychology - so I focused on psychology. At that time the psychology schools in Melbourne were having a brief creative period where, for a variety of reasons, there was a lot of interest in the Pavlovian theory which for me linked brain function with behaviour. So it gave me this strong interest in trying to understand behaviour in terms of brain function. So, in addition to doing the Diploma of Psychological Medicine (DPM), I studied psychology. There was a teacher there who had a knowledge of a French psychologist (name not given), who had a Marxist approach to behaviour and incorporated a neo-Pavlovian kind of approach which again stimulated me and directed to try and understand behaviour from a physiological, brain function point of view. I completed my DPM and at that stage in Australia we felt that you had to go overseas to really get in touch with what was happening in the world. So I went and worked in Vancouver for a year and then I went on to London and, partly because of that interest in physiology, I trained in EEG work at the Maudsley Hospital. I didn't really enjoy the atmosphere at the Maudsley. I felt that the people there were very secretive. They seemed to be very frightened to talk about their ideas.

Michael King (MK)

It hasn't changed much!

NM

... for fear that you might use the ideas and steal them and so on. Also Aubrey Lewis was there at the time and I didn't see him as a very stimulating person. Everyone seemed to be terrified of going on his rounds where he'd quiz you about a patient. They would try and cover every possible detail like going to the occupational therapists to find out what kind of baskets the patient made and so on, for fear that he would ask them that, but if you said "Well maybe this patient is making baskets because they had a mother who was very interested in baskets" he would immediately jump on you and say - what evidence have you got of that? So you had to collect this enormous amount of information with which you did absolutely nothing.

MK

Why did you get interested in the sexual field?

NM

Having worked for a while in England I came back to Australia and a colleague of mine - a psychologist had worked with/had met with Freund in Prague - said how Freund had developed this penile plethysmography test. I was interested in a research approach anyway and having this sort of Pavlovian approach made more interested in a behaviourist approach to treatment; though at the same time I called myself not a behaviourist but a cognitive behaviourist because I was interested in Wolpe who emphasised the cognitive aspects of treatment as much as the behaviourist aspects. Anyway, given that at that stage I wanted to have an academic career, I was looking around for a research project. There was this measure of sexuality and a number of articles being published at the time claimed that you could change people's sexual orientation. At the same time the behaviourist literature said that you can't rely on self report, you have to have objective measures. I thought this is the way to

go, we could use this penile plethysmography and self report and see whether you actually could change people's sexual orientation by using these techniques.

MK

Was anyone in Australia doing this sort of work before you - or were you really a pioneer in this?

NM

Probably in Australia I would have been. Certainly there was no interest in Australia in behaviour therapy so in a sense I would have been a pioneer in introducing behavioural approaches to Australia. At that stage I grandiosely wrote an article I called 'A Year's Experience with Non Verbal Psychotherapy', which was really taken from (a similar title of) Pavlov's - 20 year's experience with something or other - it was a very grandiose...

MK

So your work then started with homosexuals at that point or was it....?

NM

Well that was part of it, I was using behaviour therapy generally but I thought this was a basis for research where you could not only have self-report but you could also have an objective physiological measure.

MK

Did you design your physiological measure?

NM

Yes, by talking to people about what would be the best way to measure this. Initially we looked at the penile circumference measure and we found that...

MK

Was that being used at the time overseas?

NM

Yes, I think it must have been. Anyway it didn't seem to be the right way to go, so I then used this other method which was much more based on Freund's volume measure - but we used a very simple form of that which was just a can with a finger stall pushed over the top - which I published.

MK

Just tell me again. It's a can, meaning like a tiny can?

NM

No it was a Largactil pill can - so it was a can....

MK

Like a small baked beans can? And you stretched a tip of a glove over that....

NM

That's right

MK

Where would the penis be?

NM

You cut off the finger of the glove. Then you took the finger stall and cut the end off and stretched the tip part of the finger stall round the can. Then you made a hole in the middle of the can and the person would stretch over the can put their penis in it and

MK

So it was almost like a drum, almost like a penis coming through the centre of a percussion ...

NM

Yes - we connected that to a pressure transducer and so it measured pressure changes in the can. Now, at the time everyone was very concerned to try and get a measure of the total penis, being unaware that half the penis was going back out the can anyway - but I always said it was irrelevant what was the actual baseline.

MK

Where was the base of the can? Was it against the pelvis?

NM

It was more or less against the base of the penis but we never worried too much to get all of the penis in, just as long as...

MK

And it would still measure the space occupied by the...

NM

...by the change in volume of the penis.

MK

So you and technicians obviously designed that apparatus. Was it ever commercially produced?

NM

No, because everyone liked the strain gauge which was mass produced and much simpler - and also about that time an American physiologist, whose name I forgot, decided that penile measurement was the way to go, that the can would stimulate the penis and could confuse the results. So he said the way to go was to use the circumference measure. I wrote a lot about this - but if you read what was happening, they showed that the circumference measure took much longer to respond and that it didn't separate out groups of homosexuals. So the evidence was that it was a very poor discriminator, but everyone ignored that. ...

MK

And presumably the men would get used to this being on anyway - habituate....

NM

Yes it was only a bit of rubber around the penis...

MK

So you developed this and then used it in what sort of studies?

NM

Almost exclusively in research studies randomly allocating people to different forms of treatment.

MK

What sorts of treatments did you study?

NM

The ones that were (already) in the literature. We started off comparing electrical aversion with apomorphine aversion; that was the very first study. The postulate was that if two treatments worked by conditioning they would have identical effects. The electrical aversion one used some hundreds of electric shocks associated with slides of phrases connected with homosexual activity.

MK

Phrases?

NM

Yes that was what was in the literature.

MK

Not pictures

NM

No they didn't use pictures.

MK

So were these sexually stimulating sentences or something suggestive?

NM

Yes we'd get the patients to say what they thought would be sexually arousing.

MK

I see - so you used the patient's own expressions and that would trigger off some sort of fantasy.

NM

It would just be what they said would be sexually stimulating for them. They were only put up for about ten seconds so they didn't really get much time to develop much in the way of fantasy.

MK

What would happen then - you would give the shock?

NM

In the initial study we followed what we called the aversion relief procedure which was that we would put up a series of phrases. Maybe we actually had the phrases on cards and got them to read the cards one after the other. We would randomly alter them each time and the last phrase was a heterosexual phrase like - make love to a woman - or something.

MK

And you wouldn't shock them (with that phrase)?

NM

Yes you wouldn't shock them - the theory was that that would give it a positive balance.

MK

And you measured penile volume as you went.

NM

We randomly allocated them into two groups - one half we tested them once for penile volume, tested them three weeks later, treated them for a week and then treated them again and compared that with another group that we didn't do the treatment.

MK

What did you find out?

NM

We found that they both (electrical aversion and apomorphine) had equivalent effects from a self report point of view. Not in three weeks but in a year and we made the point that we felt that three weeks was no time to do any evaluation anyway. You had to wait for people to have a long time to work out what happened. So we found out that the apomorphine seemed to be the equivalent to electrical shock, which suggested that the treatments weren't acting by conditioning. Because you would have thought that if they were acting by conditioning you'd expect one of them to be different from the other, given they were using different stimuli. For the apomorphine we used pictures and for the electrical one we used slides or phrases and we used totally different numbers of treatments. The apomorphine was about 20 and the electric shock would have been about a few hundred connections. So if your conditioning theory was right, you wouldn't expect both of those treatments to have equal conditioning value. So from the beginning we suggested that these treatments weren't acting by conditioning. Because the people - when you talked to them afterwards - said if they saw someone (of the same sex) attractive in the street they'd still feel a response to them but once they walked by them they wouldn't be preoccupied with that response. So didn't think we were producing a conditioned response - more of a negative response to the stimulus. And also a number of them were then saying that they could continue with the acceptable homosexual behaviour but stop the behaviour that they had found

compulsive. So from the beginning I was picking up that we were really altering the compulsive aspect of their behaviour.

MK

Rather than the underlying sexual orientation? So, did you always feel doubtful that this would ever change – sexual orientation – after those early tests?

NM

Well everyone else was saying that it *was* a change in orientation so ...

MK

You weren't sure....

NM

So I thought...it didn't seem to me that this was happening, but we did find minor changes in the measures of sexual ... physiological change. There was a bit of a shift in the heterosexual direction. So, my initial theory was that maybe it was producing this small shift in their sexual orientation..

MK

Who were these men generally, what sort of men?

NM

Quite a percent were married men who would spend hours going on to beats.

MK

Going to what?

NM

On to beats - in Australia we use that term for areas of public parks.

MK

Cruising...

NM

Yes – places where they cruise are called beats here.

MK

So going looking for anonymous sexual partners?

NM

Yeah, but a lot of them said that they were going to these places on the way home from work and that they'd spend a few hours there...nothing would happen...they'd feel that they'd just wasted their time.

MK

And were frustrated...

NM

And they felt that the next time they passed by a few weeks later they'd feel quite a strong urge to go again and so they were saying "can we change our sexual orientation so we can lose this behaviour?" Others of them were people who were being charged because at that time the police were acting as *agents provocateurs* in public lavatories. Going into public lavatories you could end up being charged and sent to jail but understandably the magistrates were impressed by something like this rather than psychotherapy. So if they said they were having this kind of treatment ...they would be much less likely to be sent to jail.

MK

So the courts preferred this more direct....

NM

At that time yes - but I used to say that if you don't want this treatment we'll try and organise for you to have other kinds of treatments. It sounds as if the treatment itself – the aversion or apomorphine treatment - was really unpleasant but the aversive electrical shock had to be at a level that was unpleasant, not upsetting. So they would have treatment for a week and they would come up three times a day voluntarily. As I said it (the discomfort) would be about the level of going to the dentist or something like that. So it wasn't as if they came along in a state of dread or anything.

MK

You'd admit them for a week and they'd have treatment three times a day for four or five working days?

NM

Yes - but a very high percentage of them would agree to come along for the three weeks follow-up and then the year.....I'd try and keep in touch with them every month or so just to see what was happening ...and then we would ask them to come.

MK

And what would you do? Would you do the penile plethysmography again at each of those follow up appointments - three and 12 months?

NM

Three months and then 12 months after the original treatment.

MK

And did you do any other assessments of them in terms of their own self-report or your clinical...

NM

Oh yes, we threw up a few (questions) – we asked them about what was happening and how their life was changing and that sort of thing.

MK

How was it generally did you think? How do you think these men - I know you feel that it didn't really change their underlying orientation - responded to it?

NM

Well, as I say, their main response was that they no longer had these urges to do things they didn't want to do. So a number of them did feel that that was a change in the heterosexual direction so the initial possibility was we *were* changing sexual orientation somewhat in the heterosexual direction and that's why, I suppose, we did some more studies to see just if that was the case or not.

MK

So that was the future direction of your work really - to look at this compulsive sexual behaviour?

NM

Well gradually I realised that - but it took me a few studies before I realised that the changes we were getting from penile plethysmography were really a placebo change and that they weren't very great anyway.

MK

Were you disappointed?

NM

No (laughs) because it did seem to be of value to give people control over compulsive behaviours and I suppose it led me on to a different theory about compulsive behaviourlike my so-called behaviour completion concept, which I then used also to treat other compulsions like compulsive gambling. So we did quite a lot of research following up compulsive gamblers to show that the new treatments we used, which were based on what I call 'imaginal desensitisation', was the way to go rather than using aversive therapy.

MK

Outside of your research studies how many men do you reckon, if you included all your research studies and all your clinical work, how many men do you reckon you treated with aversion therapies?

NM

Probably about 200 or something like that.

MK

And using desensitisation - imaginal desensitisation

NM

Probably....because I used that...

MK

More?

NM

If you count the sex offenders and...

MK

No – I was meaning more men worried about their sexual orientation.

NM

No, I would say less - because I guess with the earlier period a lot of men who came along were predominantly homosexuals who wanted to see if that could be changed. Certainly after 1975 when I would tell them that I didn't think it was possible to change their sexual orientation, the main people I treated were predominantly heterosexual, who felt their homosexual behaviours had become compulsive and they wanted to get them under control.

MK

How long did you go on treating them? Would that be through the 1980s (including) that latter group you mentioned?

NM

I switched over to using the imaginal desensitisation around about 1980.

MK

And do you still see men today? Would you treat some men worried about their homosexual inclination today?

NM

Yes.... married guys come along and say that they are involved in risky sex or they've let their wives know that they're involved in homosexuality. They want to stop it and their wives want them to stop it. They feel that it's got a compulsive urge. Then I would treat *them*.

MK

You do treat them - and that would be through using desensitisation in imagination?

NM

Yes - occasionally if the behaviour is sufficiently severe I have I suggested that they temporarily use methoxyprogesterone to lower their sexual drive.

MK

Did you follow up some of these men from the trials very long term; did they come back and see you many years later?

NM

Some of them did over some years but the majority of them ... you couldn't expect them after a year to keep on coming to see us....

MK

No I just wondered out of interest whether they come back.

NM

A percentage of them did for one reason or another keep in touch

MK

Did you ever treat heterosexual men with compulsive (opposite sex) sexual behaviour?

NM

The majority of heterosexual men I've treated was for things like sex offending – exhibitionism...

MK

Not just compulsively trying to find partners?

NM

Yes - a percentage would be for things like harassing sexual behaviour, which they felt was inappropriate or that their wives thought was inappropriate - or they felt they were excessively inappropriately preoccupied with heterosexual urges.

MK

That was all with imagination....not with aversion therapy?

NM

Well I think there would have been some who were treated with aversion therapy before I realised we could do better than aversion therapy.

MK

Did you ever use covert sensitisation?

NM

Only in research.

MK

Why was that, did you think it didn't work?

NM

Well we found it was no more effective than imaginal desensitisation and we thought it was more "down putting", getting the guys to imagine approaching guys ... pretty nasty (imagining being shamed)...if you could get the same results just by getting them to visualise being in a situation and leaving.

MK

More positive in a way.

NM

Yes – I thought it was less lowering of their self esteem.

MK

Did women ever come forward – lesbian women?

NM

Yes, but a very small number.

MK

Did you ever have lesbian women in any of your trials?

NM

Not in the research trial, only because the numbers were too small and we thought it would be confusing to mix up men and women.

MK

There was a study where they combined women and men – included two or three women, I think it was by John Bancroft.

NM

Perhaps

MK

But you would have seen women in ordinary clinical situations. Would lesbian women come to you, not for research, but to say “can you help me change to become heterosexual”?

NM

Yes

MK

What would you do?

NM

Well at the early stages we did the same type of thing, using the therapies in the same kind of way.

MK

How many women do you think you treated?

NM

Not more than ten I would say.

MK

And you didn't publish anything on that.

NM

No because it wasn't part of a randomised controlled trial.

MK

But you would have used exactly the same techniques, including apomorphine?

NM

By that time we had given away apomorphine because it seemed that it was much more unpleasant but not more effective.

MK

And what do you think happened with the women, did you know?

NM

Well it was the same kind of thing - with their sexual orientation...by that time I think I would be telling them that we can't change your sexual orientation but we can give you more control over it if you feel that it's damaging your life, sort of thing.

MK

Listening to you it sounds like you came to that conclusion relatively early on in your research. That you weren't going to change their orientation but you could try and help them with the behaviour.

NM

I published the first paper in 1969 and it wasn't until 1974 that I said that very clearly - along the way I was saying that for a percentage of people who weren't changing their sexual orientation – that although they were retaining some homosexual interest, they seemed to be getting control over aspects of it they didn't want. I think in the very first paper we published we said that this was true for a percentage of people.

MK

Can I just understand the theoretical underpinning of this? When you said (in your paper) 'is sexual orientation irreversible or is homosexuality irreversible?', did you have in mind a theoretical basis? I may be very bad at explaining this. Did you feel that even a very homosexual man if you like, would be able to move in a heterosexual direction?

NM

At the time in the paper *Is a homosexual orientation irreversible?*, the paper was saying yes – it's irreversible

MK

My interest in that word *irreversible* was more to do with – did you think it was irreversible back in the 1960s, because that paper was published in 1976?

NM

Before I started this research you mean?

MK

I take your point in that paper but I'm interested in the word *irreversible* because it implies that someone has been heterosexual (or had a heterosexual basis) and then became homosexual. Reversible implies you've gone from A to B and now you might be able to go back to A. It is the word that is interesting. It implies all people are basically heterosexual to start with.

NM

It was probably inappropriate...

MK

No I just wondered...

NM

At that time in the literature on treatment of homosexuality was this notion that homosexuality was some kind of developmental process that could be reversed and particularly the classical learning theory at that time, particularly in the 60s was that behaviour was determined by contingencies ...totally against biology in the 1960s. I suppose at that time, although I would have had a biological interest, I felt I was very much Pavlovian in my thinking.

MK

Because that was the paradigm you were working in?

NM

Yes, so the notion was somehow or other, because of various contingencies, people had been made homosexuals and therefore by unlearning they could...

MK

..go back to the substrate that was heterosexual. That's what I understood.

NM

That's why I was still in that paradigm of thinking.

MK

What is your thinking now?

NM

I think now that I have a much more dimensional approach anyway and certainly what I emphasise now is that the majority of people who have a homosexual component are predominantly heterosexual - and that this is a dimensional condition which I believe is determined either genetically or by exposure to different hormonal balances *in utero*.

MK

Can I just get this really clear? What you mean is that most men who have some homosexual feelings are predominantly heterosexual. Then a few men are very homosexual but they are the minority.

NM
Yes

MK
So the greatest *number* of men with homosexual inclinations are actually mainly heterosexual.

NM
And that shows up in several studies.

MK
Do you feel you were pilloried at times by the gay lobby even back in the early 1970s?

NM
The early 1970s was when I was still doing this research so it's understandable.

MK
What is your view looking back now on all of that? And what did you make of it at the time?

NM
I thought it wasn't unreasonable. I tried to say that we were very concerned to try and get rid of discrimination against homosexuals. I felt that it had to come from two directions, one from a scientific direction - trying to understand what causes homosexuality and determine whether it can or cannot be changed and so on. But at the same time there have to be activists who are passionately carrying on and are critical (which I don't agree with) of any attempts to try and understand homosexuality scientifically. I think, from a scientist's point of view, we have to try and understand everything about human behaviour...but I could sympathise with their attitude.

MK
Can I put to you though, that in the late 1960s or early 1970s the perception would not be so much of you trying to understand homosexuality as to change it?

NM
Yes, well in that case - in a sense I was, I suppose. As I see it - whether that's correct or not - there was this amount of research in the literature saying it could be changed - and I wanted to look at whether it really could be changed or not and - if it could be changed - to say well, it can be changed. Because at that time, those guys who did the homosexuality stuff in San Francisco....

MK
Bell and Weinberg?

NM
Yes - they were pointing out how the majority of the homosexual men that they studied would say if there was treatment that would reverse their homosexuality they would want it. So it seemed to me, well if there is a treatment and people want it, we should at least see whether there is or not. But it should be evaluated properly and not just claimed to have effects. So I suppose I was looking at whether it could be changed but at the same time saying that there was nothing wrong with it (homosexuality). But if people feel it's wrong and they want to change, then I feel that should be an option they have.

MK
Do you think that today? Do you think if a man is very concerned...?

NM
If there was a treatment that could change homosexuality for most people who wanted to have a change that wouldn't feel unreasonable to me. Because I still see guys who are predominantly homosexual but are really very uncomfortable with the whole gay scene. Their interests are entirely gender conformist. They want to be with the boys, drink beer, marry and all that kind of thing and they find the gay culture doesn't suit them. So I could see that, if there was a treatment to make them heterosexual, it wouldn't be unreasonable to give it to them.

MK

What do you think though, about the criticism back then that it was society's problem rather than the homosexuals and changing people into heterosexuals was simply conforming to society's stereotypes and going along with discrimination?

NM

Yes I can sympathise with that point of view. I did write an article on the ethics of homosexuality that was published in the Journal of Homosexuality in 1977 - about whether we should try and change the person or society and saying yes, we should try and change society. But in the meantime if we've got ways of helping the individual, we should do that too.

MK

You don't think the two are mutually opposed.

NM

They are to an extent but I think as a therapist you have to put your patient's interests as well.

MK

Can I put a parallel situation to you? In the 60s and 70s it was very difficult to be black in America. Would you have then said, if there was treatment to make someone white, you would have done it? It may not be very fair parallel.

NM

Yes - some people did try and change their skin colour. I wouldn't feel that they should be denied that possibility. I suppose a parallel I've got is pregnancy - that a lot of women who are single would not have children because of the social condemnation of being unmarried. But to deny them abortions simply because (their wish was the result) of the social pressure on them not to have children would be unfair to them. (Denying abortions) wouldn't help the prejudice against single mothers. I felt that you shouldn't deny them that option - of choosing to have an abortion.

MK

Tell me - what is your view on current genetic and biological research about homosexuality?

NM

As I said, I do think sexual orientation is determined by genetic factors and exposure to hormones in *utero*. But it does leave that unresolved problem that clearly some guys who are predominantly homosexual aren't very gender (discordant) in that they don't show much opposite sex gender feelings and so on. So, they've got the feelings of the football macho bloke and at the same time they've got some homosexual feelings. So I think they're in a real bind, just as heterosexual guys who've got involved with homosexual activities to the point where it's compulsive are in a bind. So I think there are people for whom just altering social attitudes isn't going to solve their problems.

MK

Do you think you've been unfairly criticised? Its quite obvious that the people I've spoken to here (in Australia), admire you. They see you as a very liberal man who, if anything, was battling for understanding of homosexual men and homosexual rights. And yet on the other hand because you were taking part in these treatments, you were misunderstood as someone who was terribly reactionary. It's a strange combination. Do you think looking back, because it sounded as if you had a bit of tough time sometimes with activists in meetings when people threw things at you....

NM

The big one was at the American Psychiatric Association where the meeting broke up into a great m el e sort of thing - but fortunately it was after I had read my paper! (laughs)

MK

You laugh when you say that. Do you view that as just par for the course, as being an experimenter, being a bit ahead of your field? Or is it just some of the flack you've got to take if you're in a certain field?

NM

I felt that homosexual activism was necessary and they needed targets – and I suppose I didn't ever feel that people shouldn't be allowed to say what they believed.

MK

Meaning you?

NM

Me, but even more so people who argue that, say, race could be associated with different IQ's. I think maybe it can and maybe it can't but at least they shouldn't be attacked physically for saying it.

MK

For even saying that?

NM

I was never – fortunately never - attacked physically. The worst that happened was that eggs were thrown and that sort of thing...I suppose I do feel that there should be freedom of speech, that people should be allowed to give evidence and the evidence should carry weight one way or the other.

MK

In of itself?

NM

Yes

MK

Do you think any harm came to the men from aversion or apomorphine therapy or any of these treatments?

NM

I didn't find evidence of that over the year that we followed them up anyway.

MK

John Bancroft in one of his papers writes about one man who became psychotic, one man became suicidally depressed. It's quite a graphic paper. But then he seems to conclude that there wasn't too much damage - it's a peculiar paper to read.

NM

Well I suppose the best indication I had was when we compared aversion therapy with a positive conditioned procedure where we showed guys pictures of men followed by pictures of women or the reverse, to see whether we could condition some degree of heterosexual arousal. And in the follow up we found – because in that case we did monitor their penile changes all through all of the treatments - we found that conditioning didn't occur. So we said that this is a placebo. But when we followed up these people we had maybe one or two who became depressed or something like that, but there were more people who had the placebo treatment who showed depression than the ones who had the aversion therapy. So given that you've got people coming along for treatment who are distressed anyway, I felt you couldn't attribute it (to the treatment). I think that was the group that just by chance had more negative responses than the earlier groups.

MK

Were the men quite distressed when they came along for help? You mentioned that the men were distressed anyway - were they very distressed, many of these men? It must have been quite a life event.

NM

Well, some of them were facing jail sentences. That can't be (pleasant).

MK

And coming into hospital for a week, how did they explain it to their families or their work?

NM

The majority of them would probably have had something happen and their problems would have been known to their families. But I think that some probably gave some reason...that they needed to come in to be treated for depression or something like that.

MK

Who actually undertook the treatments? You yourself obviously must have. Did you have other nurses and other staff on the wards doing it?

NM

With the apomorphine therapy we used ... they were treated by the nursing staff

MK

They'd be giving the injection of apomorphine - but you would still be there doing the pictures or would it all be done by the nursing staff?.

NM

No then we asked the patients to have the projector - and we asked them 10 minutes after the injection to put on the slides....

MK

So they would do it on their own then, in the room?

NM

Yes

MK

So they'd develop the nausea and vomiting at the time they were looking at the pictures of men. Then how long would that whole session last for? How long did the nausea last?

NM

Probably about 20 minutes or so.

MK

So they just had to keep changing the pictures themselves?

NM

No - I'd have to check that - they probably had a different picture for each session. I think they probably had 6 sessions a day for five days.

MK

It must have been quite unpleasant?

NM

Oh yes, that was a most unpleasant treatment.

MK

It surprises me today, because apomorphine is now a treatment for erectile dysfunction. It actually stimulates erections, it's called Uprima in England. I don't know if it's the same here.

NM

I hadn't actually heard they'd used that drug - I had read about it.

MK

It's just been released in America and Europe and it actually causes erections. It's curious when you think back to apomorphine treatments because they were probably having erections at the same time they were having vomiting.

NM

They were feeling some nausea - would that...?

MK

You probably don't know. The dosage you were giving would be higher than that used for erectile dysfunction, because nausea is a side-effect in only about 20% of people, but it's a paradox. No men reported that at the time though, I suppose they didn't know what they were getting erections for - the pictures or the apomorphine.

NM

You'd think some of them would have told me.

MK

But it is curious.

NM

Yes - I used it largely because of Freund. That's the treatment he used - therefore it was the beginning of the 1960's interest in aversive approaches.

MK

But you went off it?

NM

Yes - once we realised it was no more effective than electric shock aversion, which was much less unpleasant.

MK

Did men report that it was pretty nasty presumably, because the vomiting must have been difficult to contain.

NM

I think the majority didn't actually get to the point of vomiting but they would certainly get nauseous.

MK

To summarise: you read Freund's work with the apomorphine and then you tried it yourself - but then you put it into a trial and realised it was no more effective than the aversion therapy.

NM

I don't know whether we even tried it outside of a randomised, controlled trial.

MK

So it wasn't a treatment you used very much?

NM

We would have used it, I think, on 40 people altogether.

MK

You mentioned earlier that you sometimes used intramuscular injections of progesterone in men with compulsive sexuality. Is that in all men?

NM

Yes, homosexual and heterosexual.

MK

So it's to do with compulsive sexuality rather than anything else?

NM

Yes, yes.

MK

What do you think compulsive sexuality is?

NM

Well I suppose - my theory is based on that behaviour completion mechanism concept that I put forward.

MK

Could you explain that?

NM

When we found that people seemed to get control of their behaviours without altering their sexual orientation, it made me feel that this must be a different process. I suppose I put forward an idea about anxiety - and particularly conditions like agoraphobia - that the first attack of agoraphobia commonly is in a situation of 'delay' - in a supermarket queue or on a public transport when they feel held up. I experienced it myself personally that at times being trapped - in England (even) when you're not *really* in a hurry to get home - when you got home you'd feel more tense? So it made me feel that here was a mechanism; that if you started a behaviour you didn't complete, this would produce arousal. I was stimulated by the work of a Russian physiologist that I got exposed to after the Sputnik went up and the Americans got interested in Pavlovian theory. They produced two volumes of Russian research - one of them was by Sopolov about the neuronal model and the other one was by Nopen about what he called the acceptor of the action. And so it was brain theories about behaviour. This meant when you are setting up behaviours the brain sets up a model of the behaviour through to its completion, but if it isn't completed correctly, this produces a sense of arousal which sort of (I suppose evolutionarily) encourages you to drive on and complete that behaviour.

MK

So you think there is a physiological model to this compulsive sexual behaviour?

NM

Yes.

MK

Do you think though, that it could arise because of social disapproval of homosexuality? That people couldn't express their ordinary sexual inclination and so became obsessed and ruminated about it?

NM

We used the same model for compulsive gamblers but also for things like exhibitionism, paedophilia, shoplifting and hair-pulling. So, it seems in my experience to work for that entire range of behaviours. So, what I thought is, if you go by the "beat" (cruising area), in the case of the gay guy, and you've got this urge to go in, that if you don't follow that urge you tend to get aroused - and people have said that. I suppose the most dramatic one is the guy who used to go to places to watch couples having sex in cars. And he would say how he would get so aroused that he would sweat profusely and get a bad skin rash and so on. But if you asked them, a number would say that - that prior to the behaviour - they would get very aroused and be conscious that their heart was beating very fast and so on.

MK

To go back to one thing earlier in our discussion: was it just fortuitous, or was there any influence in your professional or personal life that got you into the field? You mentioned you were very interested in behaviourism and schizophrenia, so I wondered how you got into the field. Was it simply that here was a situation in which you could test out your behavioural ideas? That's what you seemed to say.

NM

I think so at the time. I think it was the knowledge that you could measure a change physiologically as well as by self-report. At the time that was so important with the behaviours.

MK

And still is a problem in mental health isn't it?

NM

Yes, but I suppose right now self-report is not rubbished the way it was in the 1960s.

MK

Do you ever regret getting into the field? Are you glad you did? What are your feelings looking back now?

NM

No - I think from my point of view it was productive. I feel that I've been able to help a lot of people through the ideas and treatments that they allowed me to develop.

MK

(In this interview) we've concentrated on homosexuality but actually your work's covered a huge range of sexual problems hasn't it?

NM

Yes - initially I did a lot of work which I didn't publish on obsessive-compulsive neurosis and anxiety states. My initial interest was in behaviour therapy generally, but also a big area initially was schizophrenic thought disorder and the notion that this was also a dimensional condition. So a strong theme in my work was to emphasise the dimensionality of human behaviour rather than its categorical nature.

MK

Do you have any thought on the future? What do you think the future will bring in terms of research into sexuality?

NM

I am optimistic that we will develop a biological understanding of sexual orientation. At the moment I am working on writing a book in relation to what I call the "homosexual heterosexual" because I think that the term bisexual has lost currency. The majority who label themselves bisexual have a reasonable number of heterosexual partners, whereas I think that anyone who is truly bisexual is likely to have more heterosexual partners because it's much more socially approved and so on. And the people who are predominantly heterosexual but have a homosexual component are the majority of people with homosexual feelings. They are a lost link in society. I think an understanding of them, how it affects their lives and to what extent there is a link between sexual orientation and sex and gender, and hormones and behaviour is terribly important in understanding human behaviour. I have suggested in my book that maybe the reason we've got this dimension of sexual orientation is so that we produce people who have some degree of opposite sex dimorphic behaviours to give them much more of a mix of behaviour and creativity. Presumably women and men who are predominantly heterosexual but with a homosexual part are going to have a different slant on life and perhaps a different type of creativity.

MK

They're neither completely heterosexual nor completely homosexual. You want to draw attention to that point?

NM

Yes - and hopefully to get more to study. At the moment there are only studies in terms of men who have sex with men, a lot of whom would be in that group but no-one's interested in anything else but their AIDS problem.

MK

Yes - it's got completely preoccupied. Do you have any thoughts about the whole subject looking back on that area of work? I know that you felt you weren't always interpreted correctly or that you didn't have much influence in England. Am I right in saying that?

NM

I suppose I feel that working in Australia one's not going to have much of an influence overseas. Even if you do some original work here, it is rapidly replicated in North America and then your contribution is forgotten.

MK

(A colleague) gave me your paper in which you mentioned you felt that some of your positive, some of your good work that was only published in Australia was ignored overseas.

NM

Well I was quite annoyed that it was ignored in Australia, I don't mind being ignored overseas....

MK

Do you think that other academics in your field have done the same thing?

NM

Well there was a tendency in Australia, being a small country, to be a bit more concerned, competitive. Whereas in England people realise that they boost English psychiatry by citing each other and in America they boost American psychiatry by citing each other. I think there's a strong tendency in Australia not to cite other Australians but to cite English or American people.

MK

In a sort of credibility stakes or something?

NM

I think it is more competitive. Being a small country, competition couldn't be more intense. They don't appreciate each other's work all that much.

MK

Do you have any other thoughts in general? I've asked you lots of things but any other thoughts about the whole field. You must have reflected a lot about it over the years and I know you're writing a book with some of those reflections in mind.

NM

I suppose ...much of it is pointing out what we don't know and what we ignore rather than what we do know. I remain disappointed with the quality of scientific thought and the need for scientific analysis and particularly for randomised trials. I find that they way that they have gone about it – they have possibly gone to too big an extreme of setting up such high criteria for the trials. So few get scored that they more or less end up saying there is no evidence that anything works!

MK

When they ignore the partial evidence that could be helpful?

NM

Yes, so in the meantime they should be relying also on sensible, critical analysis of the literature.

MK

Do you think that the "homosexual's lot" is any happier and more satisfying today than it was when you started in the 1960s?

NM

In Sydney it must be - because some of the young registrars now are quite openly gay and I think they don't suffer any negative things, whereas when I was starting out, or perhaps even in the 1970s, some of the registrars who would be pretty obviously gay would go to great lengths to hide.

MK

So it would be unthinkable to be open then. Why? Because they might not get advancement or..

NM

Yes - some of them would say that their likelihood of getting through the College exams would be reduced. Some of the people, like David Maddison who was quite a power at the time, would have been quite prejudiced.

MK

Who was he?

NM

He was "President of the psychiatrists". Professor of Psychiatry at Sydney University and a very powerful influence in the College. Probably an examiner.

MK

Was he anti homosexual – homophobic?

NM

Well, that was certainly what was being said. People would have to conceal any potential homosexual inclinations to get through the exams.

MK

Just one more question. Psychoanalysis in Sydney - do you know much about how their approach to homosexuality was or has been?

NM

Not really

MK

Had many of the men coming through your hands been to see analysts?

NM

Actually, one of the people who's quite psychodynamically orientated is in the gay and lesbian psychiatry group.

MK

He's gay himself?

NM

Well he's married but indicates he's gay.

MK

Any other thoughts?

NM

I hope that I've put most of my thoughts into print.

MK

It's been very helpful. Thanks very much.

Treatmentshomosexuality