Eugene-Thorne-FAIR Examination

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SPEAKERS

Dr. Eugene Thorne, Steve Densley

S **Steve Densley** 00:00

This is FAIR Examination on the Mormon FAIRcast. Very examination takes a close look at interesting and sometimes difficult issues facing the Church of Jesus Christ of Latter-day Saints and its members. Dr. Eugene Thorne was a member of the Psychology Department at BYU during the 1970s and was involved with studies into what is called "aversion therapy." In this interview, Dr. Thorne explains the studies that were done, and helps clear up some of the misperceptions, false innuendo and outright lies that have been told regarding aversion therapy. Dr. Thorne, welcome to FAIR Examination.

D **Dr. Eugene Thorne** 00:40

Thank you.

S **Steve Densley** 00:41

Why don't we start by you telling us a little bit about yourself and your background with respect to the subject we're talking about today?

D **Dr. Eugene Thorne** 00:49

Okay. My name is Gene Thorne. I'm a clinical psychologist. I was a faculty member on the Department of Psychology at Brigham Young University. I started there in 1966, I believe and was a faculty member till somewhere around 1980, 79-80. And I while I was there, at that time, in the early 70s, from somewhere around 1970 to 73, I had become quite interested in publications that were occurring regarding aversion therapy, in a variety of places throughout the world, in laboratories and in, in various other settings hospitals and otherwise, and their impressive, positive effect on changing the attraction of persons who had same sex attractions. And I thought that it may be worthy of doing further research, it showed some promise. And I thought that it would be worthy of my efforts along with others. In trying to find how to improve

this kind of therapy. I conducted a couple of researches that I reported on at the time, and probably prior to 1974. And then I turned to a different subject almost all together, and became totally focused on that. Since that time, I've been contacted by people in your organization. And they've let me know that there are a number of publications, some of which I saw, that make outlandish claims about research and therapeutic applications of aversion, in some sort of compulsory fashion, to those who were identified or identified themselves as homosexuals. This was never the case. While I was there, I didn't know anybody that was ever forced or compelled in any way, by anyone, including the university or the church to take part in such research or therapy.

S Steve Densley 03:20

Let's back up a little bit and talk about what we mean when we're talking about aversion therapy.

D Dr. Eugene Thorne 03:25

Sure. A version of course means is something that is contrary to you, against you or something of this nature, it means it -- generally in therapy, it means it's unpleasant. Some, some kind of therapeutic stimulus is used that is experienced as unpleasant. And it's placed in the order of things, that it follows something that previously was attractive. And if the aversive stimulus follows the attractive stimulus, over a period of time the attractive stimulus -- the valence attraction -- seems to decay and sometimes disappear. Obviously, this looks like it would be very useful for those who wish to change their orientation or their attraction to people like same sex individuals.

S Steve Densley 04:21

So aside from homosexual attraction, what other ways has aversion therapy been applied in clinical practice?

D Dr. Eugene Thorne 04:32

Well, there are a variety and and then like I say, it's been a number of years, several decades, since I've been involved, but I know that it was used with a variety of things like cessation of smoking, eating disorders, attraction to inappropriate foods, addictions, thought processes that we're seen at the time to be inappropriate, either by the person himself or both the person and society.

S Steve Densley 05:08

We're talking about when you say 'at the time' when you were doing this research back in the early 70s. At that time, how was homosexuality viewed by the psychological community?

D Dr. Eugene Thorne 05:20

It was clearly included in the Diagnostic and Statistical Manual of psych, psychiatric disorders, as a disorder, an abnormality. And so it was certainly an objective of most therapists to assist anybody who wanted to alter that designation to himself, him or herself.

S Steve Densley 05:46

Now, my understanding is that the DSM classification was changed in I think, 1973, to declassify homosexuality as a mental illness.

D Dr. Eugene Thorne 05:57

Yes.

S Steve Densley 05:57

But that, at the time, it was replaced with ego dystonic homosexuality, which remained on the books as a mental illness, I think, until 1983. Does that ring a bell?

D Dr. Eugene Thorne 06:12

Well, kind of I know that the DSM went through several revisions. And in each subsequent revision from the one that was current in 1970, let's say,

S Steve Densley 06:26

and again, the DSM, the diagnostic, statistical, manual, physical manual psychiatric disorders. And that's what psychologists and psychiatrists use as the criteria to diagnose mental illness. Is that right?

D Dr. Eugene Thorne 06:39

It's one, it's one of many.

S Steve Densley 06:41

Okay,

D Dr. Eugene Thorne 06:41

and it's, it's commonly used.

S Steve Densley 06:44

All right. And, and so what were you saying about the development of the use of homosexuality in the DSM?

D Dr. Eugene Thorne 06:50

Over the period of time that you've suggested from 1970 to the 2000s, it underwent several revisions. And in those revisions, the abnormality of excuse me, of homosexuality was altered, and was given different names. I can't even remember them now. But it was clear to me, and this is just my impression that they were that is the APA, the American Psychiatric Association, was under great stress from a variety of groups, including the gay, lesbian, transvestite/transsexual groups -- who were becoming much more politically powerful -- to accept, to get the psychiatric association in the Psychology Association, to accept homosexuality as being normal, or at least find ways of protecting them, because I'm sure some of them were abused, or misused or something. Nobody that has a psychiatric classification feels...there's a stereotype that starts to occur, and some of them are negative. And so I'm sure they, they felt very badly about being considered abnormal. And so they wanted this changed. And without research -- that any that I know of -- without a review, sort of laying claim to knowledge or understanding, or to information that was considered scholarly: they voted, it just appears straight on vote, let's take it out of the field of abnormality or out of the area of abnormality, and it is no longer it's no longer in the DSM as an abnormal behavior.

S Steve Densley 08:56

So when things were reclassified, they're sort of an evolution, the DSM went through and at one point, then ego dystonic homosexuality was considered to be appropriate and appropriate area of treatment.

D Dr. Eugene Thorne 09:10

Right.

S Steve Densley 09:12

What does ego dystonic mean?

D Dr. Eugene Thorne 09:14

Well, I don't have that particular definition in my head or even accessible at the moment, but sort of, like somebody putting themselves down. That's ego dystonic.

S Steve Densley 09:26

Right. So it's the kind of experience someone's having where they are not happy with...

D Dr. Eugene Thorne 09:34

Precisely.

S Steve Densley 09:35

...the kinds of feelings that they're experiencing and they want to change.

D Dr. Eugene Thorne 09:38

Yes, right, they're unhappy with themselves as they, as they view themselves being abnormal, quote, unquote.

S Steve Densley 09:44

Right. So during that time period, the DSM recognized that would be a legitimate area for a counseling psychologist to help someone who is experiencing homosexual feelings that they wanted to change.

D Dr. Eugene Thorne 09:57

Well, not the DSM, the DSM only gives you the criteria for being ego dystonic. But, yes, ego dystonic persons who were seeking treatment -- it was seen to be quite appropriate for therapists, psychiatrist, psychologist, psychotherapist where to apply various therapeutic modalities to helping this person change and become happier with himself.

S Steve Densley 10:24

Was BYU the only place in the world that was conducting studies into aversion therapy at that time?

D Dr. Eugene Thorne 10:31

Boy, as far as I knew, I was the only one at BYU that was even interested in that topic. And I was made interested in by reviewing the literature, from a number of different places and countries that were claiming to have very promising data that showed that aversive conditioning, was able to improve an ego dystonic person's feeling about themselves, for example.

S Steve Densley 11:04

Right, I came across one study that was done by Feldman and McCoy in 1965. You're familiar with that?

D Dr. Eugene Thorne 11:11

I remember that name. Yes.

S Steve Densley 11:13

The study found that the success rate for aversion therapy was approximately 60%. With their patients,

D Dr. Eugene Thorne 11:21

Which would be amazing. That's pretty good.

S Steve Densley 11:23

Yeah. And so. So this is the type of research that you are coming across. And so then at BYU, you're deciding to perform your own --

D Dr. Eugene Thorne 11:33

If I could, yeah. Improve the status of the, the that approach, the effectiveness of it.

S Steve Densley 11:41

Right. You know, as we were talking about this, before we started our recording, you gave me an example in your personal life, of, you know, sort of an aversion experience that I think we can all relate to? You talked about eating Fig Newton cookies? Can you relate that experience again?

D Dr. Eugene Thorne 12:00

Yes, I'd be glad to, I had to be about 10 or 11, I suppose. At any rate, we were on a family picnic. And when they everybody had abandoned the car to the picnic place, I remained back. And I noticed that there was a still a bag of Fig Newtons, a complete bag. And I decided, well, I have the piece and I didn't stop until I ate the whole bag by myself. It wasn't very long thereafter that I became deathly ill. And I have never been able to find attraction to a Fig

Newton, since. I don't even like to think about them. They make me queasy. Other people have had food that's been bad, bad taste or bad experience. And it's left them with a lasting impression. Those are all what we'd call in the realm of aversions, aversive experiences.

S Steve Densley 12:52

Right. And so with the aversion therapy that you were investigating, there are different ways of developing an aversion in someone: one way, like you said, maybe somebody's made nauseous because they're eating so many Fig Newton cookies. What are some of the various ways in which clinical psychologists will try to induce an aversion towards some kind of stimulus?

D Dr. Eugene Thorne 13:21

Sure. Take a smoker who wants to stop smoking. One of the ways that has been used with some success, or at least reported success, is by what's called flooding, that's flooding proceedure. That is have them smoke and smoke and smoke as much as they can until a taste becomes just awful to them. And they subsequently don't lose or become sated with their need for for cigarettes, it's not as much so, that they obviously are getting sick or sated with the smoke and that particular aversive experience diminishes or the attraction of cigarettes.

S Steve Densley 14:08

Alright. What other kinds of treatments are used in aversion therapy?

D Dr. Eugene Thorne 14:13

Well, there are people who have reported the attractions to certain kinds of foods: chocolate, I don't know something like chocolate and they may use a hypnotic or visualizing experience where they, they they try to think of chocolate in its best form: in a big kettle with a person stirring it while the dandruff and the hair from his head fall within the within the cauldron and the chocolate and they get such an image of that that it seems to do, well remove or deplete or eliminate or reduce the attraction to chocolate.

S Steve Densley 15:03

Right. And so it's sort of a hypnotic process.

D Dr. Eugene Thorne 15:06

Well, or they don't even have to be hypnotized, but they use it as just visualizing.

S Steve Densley 15:12

Okay. A cognitive treatment.

D Dr. Eugene Thorne 15:14

There you go. See that's aversive: that's not attractive, to think of somebody's scabs or or dandruff, or hair falling into the food you're about to eat.

S Steve Densley 15:24

Right. Now, I've heard some reference to using chemicals to help induce vomiting. Are you aware of chemicals being used?

D Dr. Eugene Thorne 15:37

Yeah, I'm aware of it. It could be that somebody is attracted again to something, some activity or some substance that really creates problems in our lives, I recall reading one where a person literally found attraction to fecal material. That's obviously considered abnormal. And so when he went to the bathroom, he would hold until he could receive a shot of some sort of let's see what do they call it a medic, I think a medic, it causes nausea, within seconds or minutes, I don't know. And so that he just could not look at any of these saw almost was negative, maybe the bathroom itself or the toilet. But he was to think of the fecal material in the toilet, or his elimination of that fecal material. And that's what you're trying to create the aversion to, it's sort of, I want to come back to homosexuality, it's not like you want to have them averse to pictures of males or females, or even masturbating, or even finding a same sex person attractive. That's not its thinking. It's the thinking process, you're trying to create an aversion to, "I want to sexually be involved with that person." And I think of myself involved in that while I'm getting a nausea producing substance, or while I'm getting shocked, or some other aversion. And the hope is that, like with the Fig Newtons, I no longer want Fig Newtons. And this person no longer finds pleasure in thinking of sexual interaction with another person, you're trying to reduce the ability to cognitively become aroused. You can't become aroused without thinking. And it includes, it includes experience. An 11, well, an eight year old, has all the equipment, but he's he or she is not able to become aroused. Even by looking at a nude. Most most people I'm assuming. But as they reach puberty, and as they're encouraged by their fellows, to Oh, wow, look at this, they begin to acquire an attraction to that stimulus. Most of the young men I was associated with, you know, they found pictures, you know, girls or something in National Geographic as being different. And they found their friends were found that attractive. And as they teased themselves with it, they then became attracted to these things. Well, that's not so abnormal, I would imagine every heterosexual has had some experience, he can remember how he suddenly became aware he had these attractions towards a female in the case of a male or vice versa for that female.

S Steve Densley 18:54

Alright, I guess what you're saying is that a typical young man, as he reaches puberty is going to start noticing that he's experiencing some kind of reaction when he sees some of these pictures or when he sees young women. You know, as they're, as they're, as young women's

bodies are starting to develop, and he starts to notice that and as he starts to act on that, that it starts to ...

D Dr. Eugene Thorne 19:18

Pleasure himself with the thinking, right, it's the the stammering and stuttering procedure. At six years old, most people don't stutter. Suddenly, by 12, their stuttering it's just a happenstance. That's all it is. There's nothing physiological it's changed. In most cases. It's there -- something happens in their head. They tease themselves with the idea. I- I may stutter, and they do. And that reinforces I'm a stutterer. And so now whenever they have a time they think about stuttering, they stutter. That's what the "I find a girl attractive." Ooh, The more it is myself that it's suddenly girls become start to become more and more attractive. It's a process that goes through in a very important time -- usually puberty, and it has long lasting effects, stutterers have always been difficult to treat. And yet you can treat them. And speaking of aversion, aversion has been used for stuttering. So we didn't mention that with, at any rate...so the stuttering kind of thing is what I believe, is what we're trying to change. Not -- I don't change anything about their tongue, their lips, their throat, their vocal mechanisms, what we're trying to change is their belief that they're going to stutter. Because as long as they have that in their mind, they stutter. If you get them to recite a poem, or sing a song, they do not stutter, because they're thinking of the words, or what it is, the rhythm. And that's, that should tell you something about how we set ourselves up to have certain reactions. In this case, we're talking about arousal. If I don't become aroused by animals, or by doorknobs, or socks, or shoes, or some fetishistic kind of object. If I don't learn something by some mistake, perhaps, that these are sexually attractive, I'll never have an attraction to these things. But I've treated people who are actually turned on and follow people by looking at their shoes. Others by -- I'd mentioned doorknobs --grasping a doorknob.

S Steve Densley 21:43

And they found grasping a doorknob sexually exciting?

D Dr. Eugene Thorne 21:46

yes. Wow. I'll give you an instance one of my patients. One of my patients came to me and when I finally got it clear what happened, he said that he was masturbating in his upper room, it was kind of a loft. And he had no door. There was no lock on his door, but he would hold on to the handle, make sure nobody could walk in on him. He did this while masturbating and becoming aroused. Soon he found when he taught touched other doorknobs -- especially ornate doorknobs -- he became even more aroused. This just shows me the conditioning process, and how the mind begins to, if you let the mind think about these things, as some of our General Authorities have indicated, then you're in trouble. If you keep yourself from thinking about them, you have no problem.

S Steve Densley 22:46

Right. Now, you're not saying, I assume, that we're all completely blank slates. That we do have, you know, young men tend to be attracted to young women and young women tend to

have, you know, young men tend to be attracted to young women and young women tend to be attracted to young man. But then, like you said, as they're socialized with other young men, as they start pursuing certain thoughts, or certain activities --

D Dr. Eugene Thorne 23:07

They're reinforced for it.

S Steve Densley 23:08

Right. And so there's sort of a positive reinforcement toward what they may be naturally inclined to do. And in some cases, there may be positive reinforcement toward something that they may not have been naturally inclined to do.

D Dr. Eugene Thorne 23:20

Not even a part of the sexual experiment. What a doorknobs or shoes boots have to do with a sexual experience? Would none of us even think of that. But by chance, I've told you about two people who developed those kinds of attractions.

S Steve Densley 23:35

Wow, that's fascinating. So let's go back then to the aversions; we've talked about some of the different types of aversions that are used. One of them, then, is electrical shocks, right?

D Dr. Eugene Thorne 23:49

It's the most easily controlled. If you do use an emetic, how do you know when it's going to come and how forcefully? Now, doctors may be able to decide that -- maybe they have a down precisely, it takes 15 seconds and bang it hits or something? I don't know. But, and if you use obnoxious smells, how intense is it? How fast does it dissipate, you have no control over that.

S Steve Densley 24:15

So you can you can measure a little better exactly how much the shock is going to be .

D Dr. Eugene Thorne 24:20

How strong it is and how long it lasts.

S Steve Densley 24:21

Yeah, when it when it arrives and when it ends

Yeah, when it when it arrives and when it ends

D Dr. Eugene Thorne 24:25

Precisely.

S Steve Densley 24:26

Now. Let's distinguish now between the electric shocks that are used in aversion therapy, and the electric shocks that are used as treatment for things such as severe depression.

D Dr. Eugene Thorne 24:40

Oh, ok, electro convulsive therapy.

S Steve Densley 24:43

Okay. So sometimes people will call that electric shock therapy, but I think more recently, it's been reclassified or the term has changed to electro convulsive therapy. Is that right?

D Dr. Eugene Thorne 24:53

Correct.

S Steve Densley 24:54

What is electro convulsive therapy?

D Dr. Eugene Thorne 24:56

Well, I've never used it. Mostly only physicians can But I've observed it. And it usually is an apparatus that allows the physician to put electrodes on close to the temples have a, say a depressed patient, somebody who's a little more than comatose, but just really does almost deadly depression and allow an electric current to go between the two leads, and then stop it. And they usually are knocked unconscious. They had to be take care of that it'll bite their tongues, a variety of things were done. And then they're allowed to sleep it off. And in most cases, it is not even registered in their memory. They can't remember just how being in the room where they had the the AECT and how it was delivered to them.

S Steve Densley 25:55

And this is a currently accepted practice for treating people with severe depression?

D Dr. Eugene Thorne 26:01

Well, I I think it's still used. I don't know how popular it is. I think it's lost some of this depression because we've learned, you know, the pharmaceuticals have have learned of medicines that are very effective, and probably better controlled. And so I think most physicians use psychometric obviously psychometrics, but I mean, psycho pharmacology, right, and

S Steve Densley 26:32

Xanax Zoloft. But I mean, the point is, is that electroconvulsive shock therapy is still used today.

D Dr. Eugene Thorne 26:41

I think so I, I haven't been in, in the practice where I've seen it, but...

S Steve Densley 26:46

But what it does is it causes convulsions, right?

D Dr. Eugene Thorne 26:51

Yes.

S Steve Densley 26:51

Okay. And that is absolutely not what we're talking about when we're talking about aversion therapy?

D Dr. Eugene Thorne 26:56

None that I'm aware of.

S Steve Densley 26:58

Right. What you're talking about then is what -- what kind of shock would be used?

D Dr. Eugene Thorne 27:03

A shock that is DC, direct current, not AC, and which is usually placed on the ankle, or on the arm, perhaps.

S Steve Densley 27:14

At what point on the arm? bicep?

D Dr. Eugene Thorne 27:16

Oh, probably the bicep, it could be the wrist.

S Steve Densley 27:17

Okay.

D Dr. Eugene Thorne 27:19

Usually you let them choose, but I think most of my subjects had it on the bicep part of their arm. And they -- let's see, I've forgot the rest of your question. But that's where it's placed. And nothing goes through the head and it does not cause convulsions. I take that back -- on some instances if they've got the electrode right over the bicep muscle, it, sometimes you can see the muscle jerk because it creates a movement of the muscle, but nothing dramatic, you can see a little flinch or something and that's about it.

S Steve Densley 28:01

Right. And so the type of shock that is used is there enough juice to cause any kind of damage to the skin?

D Dr. Eugene Thorne 28:15

I only can presume it could be, like an electric fence around a jail or prison I'm sure that's really hot. So that perhaps could injure the skin. I've never seen that so I don't know, but that which we were using was so minute compared to that kind of thing that the most it would do is as I say if it was on the muscle itself it may get a reaction, a jerk reflex.

S Steve Densley 28:43

So you may make you may see a little bit of a jerk in the the muscle to which the apparatus is attached to the so the arm or or maybe the leg but not the whole body?

D Dr. Eugene Thorne 28:53

Indeed.

S Steve Densley 28:55

Also, at no time when you were at BYU Did you ever see anyone skin damaged from shock aversive therapy?

D Dr. Eugene Thorne 29:04

Never. Never saw anything. Not even a red spot. If anything maybe with a cuff was there might be a mark, but within a moment or two that disappeared.

S Steve Densley 29:15

Did you ever see anyone have such a reaction to the shock treatments that they did induced vomiting?

D Dr. Eugene Thorne 29:24

Never, never.

S Steve Densley 29:26

okay.

D Dr. Eugene Thorne 29:26

Nor did any of my subjects ever record repeat or report should say that they ever felt sick, or that they felt in any way that it was frightening to them. And they always knew in my research that if they ever had anything that made them feel that it was too much or it was not doing what it was supposed to be doing. Or they wanted to stop for one reason or another they could turn it right off right then.

S Steve Densley 29:56

What is it that's attached, that delivers the ...

D Dr. Eugene Thorne 29:58

Just, well it's a cuff with two electrodes about, I'd say an inch to an inch and a half apart.

S Steve Densley 30:05

Okay, we talked about how those would be attached maybe to the bicep or maybe the ankle. So far as you know, did anyone at BYU ever use those attached to the genitals?

D Dr. Eugene Thorne 30:19

That would be totally inappropriate. You're not trying to condition the way the genitals work: they're working perfectly properly. What you're trying to condition is the arousal, the thing that arouses them, and allows them to reach climax or have ejaculation. If they had even a bad, decent amount that's never been reported, not not even a change of thoughts or panic or something. I mean, to this sense that they became frightened. If they did, they were to let me know, they just turned the switch. Shut it off.

S Steve Densley 30:19

Right. So are you aware of anyone at BYU ever attaching electrolytes to the...

D Dr. Eugene Thorne 30:25

This was the question I was trying to get back to. And I'm sorry, I forgot. No, it shouldn't be on any sensitive part of the body at all. The arm, the lower arm, the wrist, the the ankle, maybe even the calf. Those are very simple. And I've never seen anything occur of a an abrasive reaction.

S Steve Densley 31:31

Okay. And so when you decided to further research aversion therapy, how did you go about it?

D Dr. Eugene Thorne 31:42

Well, I don't remember from the start, I remember that I had another psychologist from Salt Lake who had a machine that would deliver shock. And they asked me to consult with him for a person who had chronic sneezing, and another one who had chronic hiccups. And we, we designed a way of delivering the shock. We figured it was a sort of neural circle that, because it was constant, you could time it. And so we wanted to interrupt the circle with a shock. And both of us received national press, by the way, the shock stopped these two people -- not that they were together, but at different times. And so I that was my first I think exposure with shock itself. And I found it very easy to work into a therapeutic kind of a scheme.

S Steve Densley 32:41

Okay. And so how did you go about accepting subjects for your research?

Okay. And so how did you go about accepting subjects for your research?

D Dr. Eugene Thorne 32:47

Well, most of the time, I taught a lot of the advanced Well, the both undergraduate and graduate learning, excuse me and advanced therapy courses. And while I was doing so, I would always but not always, but generally talk about those things that were interesting to me about learning theory and application of the principles, etc. And it was almost I almost always said, part of my practice, or part of my interest was in helping those who were homosexual. And that I was thinking about starting a research. So if anyone were interested in that and had this problem, they could come to me anonymously, and I would keep their name anonymous.

S Steve Densley 33:34

So the people that participated in your study, were all self referred.

D Dr. Eugene Thorne 33:39

Yes. And I should point out, not all of them were from the class people in the class knew of people who were, who had these attractions, these same sex attractions, and and probably told them, Do you know about Thorne, and his research? Would you want to be in one? So I didn't, these weren't people just out of my classes. I think they were people who people in my classes, had let them know that I was doing this research. But I had, I wouldn't even accept anybody from the BYU police, or the ecclesiastical leaders from the administration. No one ever approached me from any of those.

S Steve Densley 34:21

Right. There are some allegations that the BYU Standards Office was threatening people that, you know, if you don't go and participate in this aversion therapy, treatment that we're going to kick you out of the university. You didn't get any kinds of referrals like that.

D Dr. Eugene Thorne 34:37

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

S Steve Densley 34:51

Right. You're not aware of anybody from the BYU administration. You're not aware of anyone from the church, who was, I guess rounding up homosexuals and sending them out for aversion therapy?

D Dr. Eugene Thorne 35:04

No. But I do remember that the church was beginning to -- church. By that I mean, leaders of the church and stake conference

S Steve Densley 35:12

about bishops.

D Dr. Eugene Thorne 35:13

Yeah, bishops and General Authorities were beginning, more than I recall before, talking about homosexuality and how that this was a problem in the church, in the world, and that they -- people who had this problem should really try to repent, or change their lives. And I thought, well, this is a contribution I can make and helping those who might want to do it. Now, no one, none of the General Authorities or bishops ever came to me, but I know that that was becoming an open topic.

S Steve Densley 35:47

Right. And so that would, of course, encourage subjects to come to you.

D Dr. Eugene Thorne 35:52

yes.

S Steve Densley 35:53

And say, you know, I would like help with this. This was all anonymous. You --

D Dr. Eugene Thorne 36:00

Well, I, I had a couple who were students of mine, who were wives of people who were having this problem. Their husbands had the problem.

S Steve Densley 36:11

Right. You're not though, turning in the names of people who, who you are seeing to the university? Is that right?

D Dr. Eugene Thorne 36:22

Dr. Eugene Thorne 36:22

Never did.

S Steve Densley 36:23

You're not, you're not consulting with their bishops or their stake presidents.

D Dr. Eugene Thorne 36:28

No.

S Steve Densley 36:29

So, aside from maybe a spouse that knew that someone was participating in this type of study, they were anonymous. The subjects were not published.

D Dr. Eugene Thorne 36:40

Yes, right. Only their spouse would know that.

S Steve Densley 36:43

Right. Now, they were then to come to this study, and they would be shown pictures.

D Dr. Eugene Thorne 36:52

No. Well, they were. It was almost hilarious. I thought, well, now what would attract a male homosexual? And in my mind, I thought, well, now what is really manly, and it occurred to me, football players, people in the muscle magazines and things like that with these huge bulging biceps, that that would be what they would really be attracted to. And I showed these to a couple of my first subjects saying to them, would any of these pictures arouse you if you...? They laughed at me. I mean, I was embarrassed. They just says this, these turn me off. And so I said, Well, I don't know what turns you on. I only you do. So can you get me some slides made of pictures that would be of males and females that are attractive and could maybe even be used to arouse or stimulate sexual interaction thoughts with the pictures, and I says, but they cannot be prurient, they can't be salacious. They must be... if it's a nude, for example, It'd be like something like the statue of David. I mean, you know, it's a piece of art or something like that.

S Steve Densley 38:17

So you're distinguishing between nude and pornographic?

D Dr. Eugene Thorne 38:20

Yeah. If it was pornographic, it was never used.

S Steve Densley 38:24

Okay. And so you asked them to bring in pictures of males?

D Dr. Eugene Thorne 38:31

And that was so that was such a an enlightening for me. I mean, I finally realized, we don't know what it turns these people on. We think we know what turns them on. They know what turns them on, what gets them to think about approaching somebody for an interaction or something that's inappropriate. And so I finally awakened to the fact that, you know, it's not just a muscley, manly looking man, if -- most of the pictures that they had were like college freshmen, dressed neatly and cleanly, and they and they had nothing to do with the kind of thing I thought was, what would attract them.

S Steve Densley 39:14

Were there any movies used?

D Dr. Eugene Thorne 39:15

Never a movie, never ever used a movie. We didn't have facilities, and I don't think I would have used one. Well, I don't know that I wouldn't have, if it was an appropriate subject and and you could decide on the place that and allow them to deliver the shock to themselves as they observe the movies.

S Steve Densley 39:36

So in any event, there wouldn't have been anything pornographic.

D Dr. Eugene Thorne 39:40

No.

S Steve Densley 39:41

Describe for me then the process that they went through, you're attaching some type of apparatus to an arm or a leg that would deliver a shock. How did they decide? How did you decide how high the level of electricity would be?

D Dr. Eugene Thorne 39:56

Well, we didn't. The most I would do is help them put the cuff around wherever part of their arm or their leg that they wanted to, where they wanted it placed. Some of them would do it on their own. And their leg was very easy, it was hard for them to do it on their arm. And the cuff was like a blood pressure cuff. I mean, you know, it looks like that. And as far as the intensity was concerned, they were instructed, "alright, now, turn this knob, red knob, and you deliver it, it will deliver to you a shock, that will increase as you increase the rheostat in movement, and you stop where you find it uncomfortable or barely tolerable." So they had total control of the intensity.

S Steve Densley 40:45

Not, not intolerable. So something short of intolerable.

D Dr. Eugene Thorne 40:49

No, no, they wouldn't have stayed in research, I don't think, if it had been intolerable. But at any rate, and then the duration in some of the trials were like being a split second. So you didn't make it very long. I think the longest shock was on would be maybe a 10th of a second, I suppose, if I guessed. So ...

S Steve Densley 41:15

Nobody was strapped down to a table?

D Dr. Eugene Thorne 41:17

No no no, they were sitting in a chair, the only thing was on them, was the cuff. And they had little controller by their hand. And they had a switch to turn up the or down the intensity and to turn off the shock altogether.

S Steve Densley 41:31

Okay. And so did you use any kind of apparatus to measure their physiological response to the photographs?

D Dr. Eugene Thorne 41:44

No, I didn't. I asked them at the end of each session, the aversion session, to go through the slides, and give them a rating as to how attractive they, how easy they could find these thoughts of interacting with these subjects in them pictures -- attractive. And instead of 10 or

nine, they were beginning to report three, two, even none. I even find it aversive. I mean it's negative.

S Steve Densley 42:15

So there's just a subjective report.

D Dr. Eugene Thorne 42:17

Right. And then later, some of my graduate students had acquired I think it's called a plethysmograph. And they described to me, they allow the subjects to place this on -- the male subjects -- on their penis. And it was -- the more the penis engorged, was a direct demonstration of arousal. The more the attraction was there, then no matter what number they gave us, those numbers gave them you know, something about engorgement. That doesn't happen unless you're becoming aroused, at least as far as I know.

S Steve Densley 42:58

Right. But this was an apparatus that was attached by the subject.

D Dr. Eugene Thorne 43:02

Yes.

S Steve Densley 43:03

And to your knowledge was any subject that was involved in any kind of aversive therapy at BYU ever asked to disrobe?

D Dr. Eugene Thorne 43:11

No, no, I guess to put that apparatus on, that plethysmograph, they would have to, you know, unzip or whatever, but...

S Steve Densley 43:19

Right, but presumably, they would do that in private, and...

D Dr. Eugene Thorne 43:21

There was a screen.

S Steve Densley 43:22

Right.

D Dr. Eugene Thorne 43:23

There was a screen, like in a in a clinic, that they could step behind.

S Steve Densley 43:27

Right. So they're given privacy. And so the therapist was not involved in placing that apparatus?

D Dr. Eugene Thorne 43:34

Not that I'm aware of. I never have been aware of anything like that, and the people that I worked with, I just think had too good of ethics to do anything like that.

S Steve Densley 43:45

All right. And so, describe for me again, then the what once each apparatus was attached, and the photographs were collected, how did the procedure commence?

D Dr. Eugene Thorne 44:06

Well, the apparatus I was telling about that finally, we arrived at, was able to -- we had a tray of slides from them, they maybe had 10 to 30, I suppose, of males, for example. And and then another slides of females, which we used in the assertive training that followed the aversive training. But anyway, so when the, when either tray was there, it would, once we turn on the apparatus, it would bring up the slide and show it on a screen in front of them. And I think it would last probably about 10 or 15 seconds, and then the next one would come up. And the shock would be given by the subject. You know, two or three times while they were watching each male slide. While they were watching the female slides, they were to be thinking about things that were pleasant and, and wouldn't it be nice to be accepted by everybody and you know, things that were not ego dystonic.

S Steve Densley 45:07

Right. So positive reinforcement.

D Dr. Eugene Thorne 45:09

Yeah.

S Steve Densley 45:11

Were there any instances in which, to your knowledge therapists conducting this type of research would verbally abuse the subjects?

D Dr. Eugene Thorne 45:21

Oh, that would really turn me off, if that occurred. These are people that we've been instructed by our religious leaders to treat with kindness and love and support. They're human beings, their brothers and sisters. They have a condition that they -- there's no fault on their part, they didn't set out at 12 anymore than we did a 12 to become homosexual, or us to become heterosexual. It happened, whatever happened to them. And so they need all the support. I'm there trying to create a more efficient approach to helping them. To call them names or to demean them in any way?

S Steve Densley 45:27

Well, there was one individual reported that he was being, you know, somebody was swearing at him. Is there anything like that you've ever heard?

D Dr. Eugene Thorne 46:18

Well, that would be aversive, I suppose I hadn't thought about that. But I just can't imagine anybody doing that.

S Steve Densley 46:25

...and you're not aware of it ever happening?

D Dr. Eugene Thorne 46:26

Because that's coming from the therapist. And that's now creating an aversion to the therapist. So I just can't imagine it would be used.

S Steve Densley 46:36

And so the shocks, then, when you were performing your studies, were administered by the subject himself.

D Dr. Eugene Thorne 46:44

In most cases; in some cases, they came about two or three within the 10 second interval, they never knew where. In the interval there's what's been called variable response. So it might be a 10th of a second, or maybe two seconds. So they never knew what was coming. But they were instructed, now keep looking at the picture and trying to imagine yourself interacting sexually with the subject of that picture, you won't know when the shot came. And that was more towards the end of my involvement, where we use that on a variable schedule, because in learning theory, that particular schedule is much more effective than a fixed schedule.

S Steve Densley 47:32

So partly, what we were trying to do here is figure out what works.

D Dr. Eugene Thorne 47:36

Yes. And let me say one more thing about the reason that we changed. If they have to think about okay, now I got to shock myself, their mind is not on the sexual thought. If they if it's coming, when-- by an automatic process, the machines that we had, they can still try to be thinking while they're viewing their subject, the picture of what they're not supposed to be thinking about, and trying to get themselves aroused. And ultimately, while those thoughts are there, aversive things are happening to them in an unpredictable fashion within a, say, a given interval. And so it just, I thought, made it even more effective. And they reported it was too, because if they had to give themselves a shock, which is what they did at first, they had their mind was on something else, turning it on and off.

S Steve Densley 48:30

And however, the shock was administered, the subject is the one that determined how severe the shocks would be?

D Dr. Eugene Thorne 48:39

What the intensity was, and they could turn the whole sequence off. I mean, if they were saying, I suppose, they thought it hurt, I mean, more than they thought it would, they could turn it off.

S Steve Densley 48:40

At any time, they felt that this treatment was not having the desired effect, they were allowed to quit.

D Dr. Eugene Thorne 48:56

That's correct

That's correct.

S Steve Densley 48:57

Okay. Was there ever a time I guess, in a sequence of treatments, where the setup was such that the subject was supposed to push the button to cause the shocks? If there were that type of procedure set in place, would the administrator push the button if the subject refused to?

D Dr. Eugene Thorne 49:19

No, no, however, not in the research, but in a few that I took on as patients of mine, I gave them a self -- what's called a self stim, and they would administer the shock to themselves at home. They would take this home, and they would find whatever they found attractive, but inappropriately so, and would have to deliver the shock at the intensity they set. Now, most of them reported that helped but it wasn't, it wasn't something that was prominent. Let me give you an example of just how we learned in this process, this is what research is all about. I had one very tall, attractive, blond haired fellow who was very manly, but he crossed dressed -- which is different from a homosexual. And so, behind the screen I mentioned, he would dress like a female. He even put curlers in his hair. And while he was doing this, he would be giving himself shock. And I, he said it was hard to do in the laboratory. And so I said, Well do this at home. And that didn't work too well, either. And so I said, well, take a video camera, and videotape yourself getting dressed and undressed inappropriately. And then we'll use that, so that you're not having to worry about changing the slides and that sort of thing. He came to back to me and he says, I'm cured. And I was very happy to hear that. But I said, why? He said, it had nothing to do with the shock, the shock had helped. But when I saw how stupid I looked on that film, I can't get that out of my head. Now there's a aversion that's real aversion that stayed right in his head, that teaches us something. That's why we need to do research on it. This was a big fellow, strapping young man. Can you imagine him in a dress and rollers and lipstick? He saw how silly and stupid he looked, and with that, that was more than the shock itself could do.

S Steve Densley 51:41

What was the result of the trials that you performed with respect to homosexual aversion therapy? What were the subjects reporting by the end of the treatments?

D Dr. Eugene Thorne 51:50

Well, of course, I always hoped they'd say, Wow, am I cured. There were some who said, I have better control of now I don't find this boyfriend of mine pretty attractive, or these pictures don't do anything for me anymore, or whatever. But I still feel I am a homosexual or whatever. And but I appreciate what you've done. It's helped me a lot. And, you know, I I'd be glad to be a subject of yours again, if you develop this further. So, you know, that was, those kinds of things happened. I have many, by many, I mean, of the total number of probably over half of the subjects who I who reported decay or diminishment of their homosexual attraction. Not not that all of them said, I don't have anything anymore. No, no attraction. And most of them, well, I can't say: probably 40% I'm just guessing, now, I'd have to look at my data if I had it. Probably

40%, somewhere thereabouts were reporting, I now feel comfortable dating this girlfriend of mine. And I've even had feelings like I would like to not only date but kiss or embrace or do things like that, perhaps even have intercourse in a proper way. Because they were instructed that like heterosexuals, if they become heterosexual, they have to control that behavior. I can't go out and just have sexual experiences with anybody I find attractive. I have to be able to control myself there.

S Steve Densley 53:27

So along with the aversive therapy, there was also assertive therapy. How did that work?

D Dr. Eugene Thorne 53:33

assertive Well, but just as I described it, at the end of the aversion event, then I mean, they're uptight, you know, these are not feeling good, these are the shocks, etc. And so then we have a period of least 10 minutes and usually longer than that, where they totally relax, think of all kinds of pleasurable things while observing the slides that they find at least attractive. And I don't remember any of those being nudes. They were probably in, some were in sort of a, I don't know, what do... poses or something that were evocative.

S Steve Densley 54:20

They were they were sexy, but not pornographic.

D Dr. Eugene Thorne 54:22

You see them in every magazine. I mean, they're just they're attractive girls, or whatever, but nothing of a, any kind of pornographic, nature.

S Steve Densley 54:31

But something that would help to develop a sense of attractiveness or attraction toward females.

D Dr. Eugene Thorne 54:39

Same as the mentioned before the stuttering.

S Steve Densley 54:42

Okay.

D Dr. Eugene Thorne 54:43

Once the stutter begins to believe, I can find, I can control my stuttering, they control their stuttering and it increases because they get reinforcement from that. And this is same thing with the pictures at once they find I'm hey, I'm finding women, girls, attractive now. I can't be homosexual if I'm finding girls attractive. So it's sort of begin to-- needs a lot more work. But they began to get them moving in the right direction.

S Steve Densley 55:14

With respect to any individual that participated in aversion therapy at BYU that you're aware of, were there any suicides that resulted from involvement in this therapy?

D Dr. Eugene Thorne 55:26

I never heard of the suicide at BYU. Except in the years that I was there, maybe one or something, I -- seems like somebody had jumped off one of the cliffs. I think it was a girl. Maybe it was in Rock Canyon, or something like that. But

S Steve Densley 55:44

And totally unrelated to aversion therapy.

D Dr. Eugene Thorne 55:45

Unrelated to therapy. I never, I mean, I've never heard of anybody in therapy ever even suggesting they were interested in that. Well, or, I mean, unless that was what they were there for therapy for: they were thinking of suicide. But that wouldn't be aversion therapy, you're trying to work them through that.

S Steve Densley 56:01

Well, the people who are coming to you for treatment are distressed, about about their condition, they're ego dystonic with respect to homosexual feelings. And so before they come to you, they're already in some state of distress. Having said that, you're not aware of anyone who committed suicide that participated in these these types of studies? In fact, you're not aware of anyone who committed suicide at all, during your years at BYU aside from this woman, that your recall, okay.

D Dr. Eugene Thorne 56:32

I've never heard of negative...Yeah, I mean, it's just it would be amazing to me if there were. now, could they lie to me? Sure. They say, Oh, yeah, I really feel like a heterosexual now. I suppose they could, but what was the purpose of their coming? Or why did, you know? Why

would they go around telling everybody, oh the BYU made me do this, or I didn't do this voluntarily. He surprised me with this. These were people who are really, really serious about wanting to change their life. If they were disappointed, maybe it didn't work as well as they wanted to be, I guess they would go away a little bit depressed or discouraged. But never to a point where I sensed I had to worry about this person. They were saying, Well, you know, I still live with myself and you know, go on. And I would be, you know, disappointed that they weren't totally changed. But after all, we're we're right at the -- in those days,. we're right at the basic elementary stages of treatment programs for these people. We can't promise anyone that they will be completely cured.

S Steve Densley 57:44

Everyone who was involved in aversion therapy BYU was a BYU student?

D Dr. Eugene Thorne 57:50

I can't recall anyone that was in research that wasn't a BYU student.

S Steve Densley 57:57

They were all college age.

D Dr. Eugene Thorne 57:58

Yeah. It could have been one of the husbands of ...

S Steve Densley 58:02

Oh, I see

D Dr. Eugene Thorne 58:03

...a wife that had recommended their husband come in. It may be they weren't members. I don't know. I can't remember that.

S Steve Densley 58:12

Okay. Nobody that was under the age of 18.

D Dr. Eugene Thorne 58:14

No.

S Steve Densley 58:15

Were you aware of anyone who threatened a lawsuit against you or BYU or any other research?

D Dr. Eugene Thorne 58:21

No BYU student, no other therapist, no other faculty member, not even the school. I don't know that BYU was ever, you know, sued.

S Steve Densley 58:30

There was one claim that the reason BYU stopped doing conversion therapy research was because of threats of lawsuits. Do you have any information that would substantiate that claim?

D Dr. Eugene Thorne 58:41

No firsthand information. I mean, it's possible. BYU is like any other organization, they don't want to be sued. If they thought something was out of character, or was creating a vulnerability for them, I would guess they would be in would only be smart of them --their attorneys would recommend to them, We, we'd better avoid this unless it's critical. I mean...

S Steve Densley 59:05

is there anything else that you would like people to know about the aversion therapy research that went on at BYU while you were there?

D Dr. Eugene Thorne 59:14

Well, I'm glad I did it. I learned a lot about it. I still meet people who are struggling with a variety of kinds of problems. I'm not a clinician right now. I don't do that. So I can, but I can sympathize with them. I would like people to know that, if I understand the Church's position, there's no vendetta or no interest, I don't think, on the church's part to bother these people or harass them or harangue them. At most, I suspect that their their ecclesiastical leaders would do their best to encourage them to try to control it. Get it under control. And even if they have to go through life with this orientation or attraction, do it without acting upon it. And I think people that think otherwise are not, I just...I'm floored that people would think that they that the church or BYU, or even BYU faculty members would be interested in doing things to hurt homosexuals, even the California movement of the gay rights and marriage. It's not done in a belligerent way. They have a belief about marriage and the sanctity of it, and it doesn't include homosexuality. And they can't, they don't even have the right to say, well, we can wink at this. They have to try to help people change if they want to change -- you can't force anybody to. The other thing is, it's my belief -- I don't know that every therapist, I'm sure that there are

some that would differ with me. I believe homosexuality, fetishism, transvestism, sadism, beastiality, whatever is learned. And heterosexuality is to, and it can be unlearned. And it's so there's, it's promising, even with what little we learned. We found we were helping and others that were publishing at the same time, found they were helping people. For us to be precluded from trying to develop something that would help those who want to be helped is as discriminating and wrong as what they are claiming of BYU, or the church or anybody else. I mean, it's pretty narrow minded for them to decide that other people who have this problem, I'm not going to let them have any, any treatment, they should never try to change. That's, that's not the case. They can change. And we'll get better at changing them if people will give us the chance.

S Steve Densley 1:02:13

Did you ever have people come to you and say, I no longer experienced same sex attraction after having been treated by you?

D Dr. Eugene Thorne 1:02:20

Yes.

S Steve Densley 1:02:21

How often did that happen?

D Dr. Eugene Thorne 1:02:23

Well, I've never kept score. But for those who directly came to me, and talked to me, perhaps six months a year, maybe five years after -- probably 20 came to me with more than just, thank you, Dr. Thorne. They said, I want you to know, I would like you to meet my wife and my children, I want you to know, I am a member in solid standing with the church, I finished my degree or I'm working at a good place or that my life is satisfying. And I attribute some if not all, of their effect to some of the aversive things that they underwent with me and that that wouldn't include just homosexuals. And I say 20, I could probably name you, or I could probably list another 20 or 30, who had bizarre kinds of attractions such as the door handle

S Steve Densley 1:03:30

Yeah, different fetishes --

D Dr. Eugene Thorne 1:03:31

Cross dressing and fetishes and a variety of others who have also said that.

S Steve Densley 1:03:37
Do you have an estimate on how many people you've worked with total?

D Dr. Eugene Thorne 1:03:41
I would guess a couple of 100.

S Steve Densley 1:03:44
Okay,

D Dr. Eugene Thorne 1:03:44
As a clinician, but not in research at BYU.

S Steve Densley 1:03:48
Okay, so so maybe 10% of the people that you work with, came back to you and said...

D Dr. Eugene Thorne 1:03:54
I'm talking about 20 people who were involved in the research, have said things like that to me,

S Steve Densley 1:04:02
Right.

D Dr. Eugene Thorne 1:04:02
You introduce the fact that I treated others and a lot of problems.

S Steve Densley 1:04:08
Right. But I mean, if you were you estimating that you work with about 200 people who were trying to overcome same same sex attraction?

D Dr. Eugene Thorne 1:04:17
People have a tendency to overestimate so as to be careful, let me say 150.

S Steve Densley 1:04:23

Okay.

D Dr. Eugene Thorne 1:04:24

It could be more now. I don't count them.

S Steve Densley 1:04:27

Of the 150 or so that worked with you on overcoming SAME GENDER attraction feelings, you estimate that maybe 20 of those came back two years later, and said, Thank you, I no longer experience same sex attraction?

D Dr. Eugene Thorne 1:04:41

No. Again, 20 of those that were in the research,

S Steve Densley 1:04:45

the aversion therapy research,

D Dr. Eugene Thorne 1:04:46

Aversion therapy research at BYU. Of those that I treated as a clinician in private practice, I would say that would be another --How do you estimate? I would say probably another 20 or 30. Maybe more.

S Steve Densley 1:05:05

Wow. And so, aside from your clinical practice, are you aware maybe from other practitioners or from what's been reported in the research that people do report that they indeed have changed their orientation?

D Dr. Eugene Thorne 1:05:23

Well, I was really up on this research years ago. And at that time, there were people reporting, I mean, people of high reputation with good credentials, that were believable, reporting that their subjects or their, their clients, or patients, whatever they call them, were changed, that

they were now better that they didn't have as much or even any same sex attraction. I've read those things right now. Recently, I just haven't been in that part of the world of research. I don't know what's being written now.

S Steve Densley 1:06:08

So to summarize, you worked with how many people with aversive therapy at BYU?

D Dr. Eugene Thorne 1:06:16

Well, probably 30, maybe, maybe 40? Yeah.

S Steve Densley 1:06:25

So the 30 or 40 people that you worked with, in aversive therapy studies at BYU, about 20 of those came back to you later and said, I no longer experience same sex attraction?

D Dr. Eugene Thorne 1:06:37

Well, I'll try to back off that a little bit to be sure I'm safe. I would guess at least half of them -- 15 at least, that actually came to me directly and said, and I didn't hear it from somebody else. If I say, I heard it from somebody else or read it, it would be higher.

S Steve Densley 1:06:54

That's not quite as good. But it's not far off from what Feldman and McCulloch reported from their 1965 study where they said that 60% were reporting that they were having success with same sex attraction.

D Dr. Eugene Thorne 1:07:11

I just happen to remember that set of researchers and that was one of the reasons I became even more interested in trying to improve this approach to helping homosexuals. And I, I think I was impressed at the time of the research with them, that I was doing even better. But I don't know. Well, I got patting myself on the back.

S Steve Densley 1:07:42

Well, you know, I guess we'd have to go back and look at how they were counting success and and how many years or how many months have passed?

D

D Dr. Eugene Thorne 1:07:51

Right, right.

S Steve Densley 1:07:51

In your case, I guess you're saying that a number of years would pass where people came back to you with marriages and children and said, Thank you.

D Dr. Eugene Thorne 1:08:00

Yes. Yes, either on BYU campus. That was a small number, but meeting them in different cities, California cities or Nevada that are close by where I was. They recognized me, and came to me. I didn't seek them. Said, do you remember me? Sure. I remember you Joe. How are you doing? Let me tell you, I really am happy. And I said, to what do you attribute that? -- words to that effect? And they said, much to what you did there at BYU for me.

S Steve Densley 1:08:43

Dr. Thorne, thank you for joining us on FAIR Examination.

D Dr. Eugene Thorne 1:08:46

You bet. Thank you.

S Steve Densley 1:08:49

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