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A MULTIPLE BEHAVIORAL APPROACH TO MALE HOMOSEXUAL BEHAVIOR: A CASE STUDY

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Summary—Attempts to modify homosexual behavior usually require several behavioral techniques to deal adequately with the multiple components that are typically associated with the problem A 23-yr-old homosexual male was treated by a combination of systematic desensitization, electrical aversive counterconditioning, masturbation training, and practice in heterosexual social skills. After 14 weeks of treatment, the client reported a marked increase in heterosexual arousal, marked reductions in homosexual arousal and heterosexual anxiety, and exclusively heterosexual behavior. A follow-up after 6 months indicated that the changes had been maintained.

ATTEMPTS to modify homosexual behavior have utilized such techniques as electrical counterconditioning (Bancroft, 1969; Feldman and MacCulloch, 1965; Larsen, 1970; McGuire and Vallance, 1964; Thorpe and Schmidt, 1964), chemical aversive counterconditioning (Freund, 1960; James, 1962), counterconditioning by aversive pictorial stimuli (Mandel, 1970), or aversive imagery (Barlow, Leitenberg and Agras, 1969; Cautela, 1967) systematic desensitization (Kraft, 1967; LoPiccolo, 1971), and orgasmic reconditioning (Marquis, 1970). A survey of these reports indicates that one may have to deal with multiple components of homosexuality: reducing the attraction value of homosexual stimuli, increasing the attraction value of heterosexual stimuli, reducing heterosexual anxiety, and helping the client establish new heterosexual social skills. Dealing with any one of these aspects without regard to the others, may well limit the probability of success for the treatment. The following case report illustrates a multiple-treatment approach to a client's homosexual behavior patterns.

CASE STUDY

History

The client was a 23-yr-old single, male, hospital employee with a history of homosexual involvements beginning in early adolescence and continuing through 4-yr in the military service. His only sexual experiences with females were two abortive attempts at intercourse with prostitutes.

Treatment

Phase one: assessment. During this phase an attempt was made to determine the exact nature and history of his problem, to obtain a general sex history, and to estimate his motivation to change and his intellectual ability. He was given several questionnaires to assess his heterosexual anxiety, the extent of his sexual experience and the degree of arousal associated with a variety of sexual activities (Hanson, 1972), his general heterosexual and homosexual orientation (Feldman *et al.*, 1966), the extent of his fears (Wolpe and Lang, 1964), and his level of assertiveness (Wolpe and Lazarus, 1966). The

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results indicated extensive heterosexual anxiety, an inability to relate to females on an intimate level, very little sexual attraction to females and considerable sexual attraction to males. In contrast, the questionnaires did not suggest any significant lack of assertiveness or fears outside the problem area. A score of 119 on the Shipley Hartford Institute of Living Scale placed him in the bright-normal range of intelligence.

Phase two: Preparation for treatment. After he was accepted as a suitable candidate for therapy, he was given a thorough explanation of the treatment procedures and their rationale. He was also asked to obtain medical clearance for electrical aversion. The client was then instructed to begin making a daily record of his hetero- and homo-erotic thoughts and given training in deep muscle relaxation.

Phase three: Application of systematic desensentization, aversive counterconditioning, and masturbation training. The responses of the client to the Fear Survey Schedule (Wolpe and Lang, 1964) and the Sexual Orientation Inventory (Feldman *et al.*, 1966) suggested that the first priorities in treatment were to reduce the attraction value of homosexual stimuli and to abate his heterosexual anxiety. He was seen twice a week to allow an alternation between desensitization and aversion sessions. The desensitization dealt with a hierarchy of 22 items, developed from his responses to the Fear Survey Schedule and a heterosexual behavior anxiety scale (Hanson, 1972). The items ranged from holding a girl's hand to engaging in complete sexual intercourse. Desensitization of the hierarchy was completed in five sessions.

In the aversion sessions he was shown pictures of nude males and asked to fantasize one of four scenes which depicted homosexual behaviors that were problematic for him, including: masturbation or performing fellatio on the subject in the picture or having the subject masturbate or perform fellatio on him. When he had a clear image of the prescribed scene, he signaled to the therapist and received a painful 5-second shock to one of his forearms. After only four aversion sessions he reported an inability to imagine the prescribed homosexual activities, despite earnest endeavours.

Since the client's responses to the Feldman *et al.*, (1966) questionnaire and his own reports of the frequency of his homo- and hetero-erotic thoughts had indicated that heterosexual stimuli had little erotic value for him, he was given masturbation instructions in order to increase the valence of hetero-erotic stimuli. These instructions were only given 2 weeks after desensitization and aversion had begun; nevertheless, the standard instructions (Marquis, 1970) were employed. Specifically, he was told to obtain an erection by any means, even if it required a temporary reversion to homosexual fantasies. Just before ejaculation, he was to switch to a heterosexual fantasy. He was then gradually to switch earlier to heterosexual fantasies. However, since the client claimed to be unable to sustain homosexual fantasies after his aversion sessions, he was advised to use pictures of such nude females as he found attractive to facilitate the development of heterosexual erotic fantasies.

After 8 weeks of therapy, he was able to imagine himself engaging in previously feared heterosexual activities. Although, as previously stated his tests did not show deficient assertiveness, the client was somewhat hesitant to assert himself in heterosexual social situations. Therefore, *in vivo* training was instituted.

Phase four: In vivo training. Most homosexual clients possess a limited repertoire of heterosexual social skills. The client was given training in conversing with girls and asking them for dates, by verbal instruction, modeling, and behavior rehearsal with two female assistants. He was then given graded behavioral assignments. The first assignment was to find a suitable dating partner, which he managed within a week. He was instructed to go no further sexually than he could with comfort. Therapy sessions were then devoted to discussing his dates, the extent of his sexual activity, how he felt about it, and what to do next. His girl friend knew nothing about his problem, and fortunately was quite receptive to his amorous advances.

Results

After 4 weeks of *in vivo* training, he was able to engage comfortably in heavy necking with his girl friend. After 2 more weeks he was able to engage in complete sexual intercourse for the first time in his life. At this point he considered himself 'cured' and therapy was terminated. Altogether, his treatment took 14 weeks.

The assessment questionnaires were re-administered after 8 weeks (before *in vivo* training) and at the end of therapy. After 8 weeks he reported a decrease in heterosexual anxiety, no change in actual heterosexual experience, a slight decrease in heterosexual arousal and a marked decrease in homosexual arousal. There was also a decrease in fears. His hetero-erotic thoughts showed little change in frequency during the first 8 weeks, going from three during the first week to six during the eighth week. The frequency of homo-erotic thoughts decreased from 38 during the first week to 12 during the eighth week. At this point, the client felt that he was in a 'sexual limbo'—no longer attracted to males, but still not attracted to females.

At 14 weeks he reported a continued reduction in heterosexual anxiety, an increse in hetero-sexual experience, and increase in heterosexual arousal, no change in homosexual arousal (continued at a very low level), no change in the extent of general fears and an increase in assertiveness. The frequency of hetero-erotic thoughts had increased markedly to 36 during the final week, whereas his homo-erotic thoughts had dropped to three.

The client, contacted 6 months after terminating treatment, reported that he was continuing to enjoy heterosexual activity and that his homosexual inclination was negligible.

This case involved multiple behavioral treatments for homosexuality. Aversive counter-conditioning was used to reduce the positive arousal to homosexual stimuli. Masturbation training and *in vivo* practice were used to increase the positive valence of heterosexual stimuli and to facilitate approach behavior to these stimuli. Finally, systematic desensitization, *in vivo* training and graded behavioral assignments were used to reduce heterosexual anxiety and develop heterosexual skills.

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