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CASE CONFERENCE: BEHAVIOR THERAPY IN A PATIENT WITH HOMOSEXUAL FANTASIES AND HETEROSEXUAL ANXIETY*

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Summary—The case history of a patient with homosexual fantasies and heterosexual anxiety is presented. A variety of behavior therapy techniques were employed in flexible fashion and marked improvement resulted.

THE CASE presented here was treated by a psychiatric resident† at Hahnemann Medical College under my supervision. Since the resident had had no practical training in behavior therapy, I started the therapy while he observed. As the weeks passsed, I had him do more and more, until finally he was doing the bulk of the therapy. We saw the patient for twenty-one sessions. Remarkable was the fact that improvement at first moved slowly and then suddenly became much more rapid.

The patient, Paul, a 4th year student at an art school, 22 years old, tall and rather good looking, but slightly effeminate in gesture and speech, feared physical contact with women and was troubled by homosexual fantasies. He had lived in his own apartment for 4 years but his parents were largely supporting him financially.

A girl named Helen, also 22 years old, was his partner in a rather strange relationship that had gone on for about 3 years despite minimal sexual contact. She had pursued him and he had been quite passive, allowing her to stay over at his apartment occasionally. She would buy him gifts and drive him around. It was the reverse of the case of the kept woman; she was, in a sense, keeping him, giving him money, food and clothing. She was a college graduate and a school teacher. When staying over at his apartment she did not sleep in the bed with him because this made him quite anxious. He was unable to fall asleep with Helen in the bed although it was a double bed and she would not touch him. Consequently, she would sleep on the floor—which she accepted without protest.

When the patient came for treatment, he was quite depressed and had begun to have crying spells and difficulty in sleeping. This was attributable to a minor homosexual experience. At a party where everyone had had too much to drink, a young man, a friend of his, had kissed him on the lips. He had allowed this and enjoyed it, but had become very anxious afterwards. Helen, having witnessed the incident, had begun to pressure Paul toward treatment.

There had been only one other homosexual experience—when he was in the 8th grade. He had allowed a boy to finger his genitals for perhaps half a minute. He spoke of having had heterosexual fantasies in early adolescence which had later gradually given way to almost totally homosexual fantasies. He would observe young men and boys on the street and admire them and

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sometimes become aroused by them. On the other hand, looking at young women did not arouse him. Pictures from magazines such as *Playboy* 'did nothing' for him. He said he had been labeled as a 'queer' by his peers in adolescence but I assume that this was from his somewhat effeminate manner rather than because of any overt activity.

With regard to heterosexual experience, he had once felt Helen's breasts and her vaginal area through the clothing. He had not been aroused by this but had done it to give the appearance of heterosexuality. Six months before therapy started there had been one occasion when he had touched Helen's leg around the knee and had begun to get aroused, but as he moved his hand up her thigh and felt the warmth of her body he had become disgusted and developed a feeling of nausea.

In spite of the lack of sexual contact, Paul and Helen were more or less planning to marry. She wanted him at all costs, she said. He wanted to marry her to cover up his 'homosexuality'. Currently, Paul was not aroused by Helen at all. In fact, to stand next to her and think about sex would make him anxious. After the *sud* scale* was described to him he said that standing next to Helen would rate zero *suds* unless he was thinking about sex, when it went up to 15 or 20.

For Helen the attraction must have been a husband. She was a rather unattractive girl, and Paul was someone she was quite fond of and a fellow she could perhaps eventually marry. She had anxiety about sex too, but while Paul was anxious even at holding hands, she reported that she would only become anxious at the point of intercourse. She had never had intercourse. So this relationship was one which, being non-sexual, did not make her anxious.

At first my recommendation to Paul was gradually to stand closer to Helen while talking to her about pleasant things. The idea was that pleasant emotions would inhibit anxiety if the latter was relatively weak. Whenever he became anxious in her presence he was to tell her to leave or else move away from her. This plan resulted in his being able to get closer and closer to her, still without sexual arousal, but with less anxiety. Eventually he was able calmly to hold her hand and to walk out of doors with his arm around her shoulder.

In this first phase of desensitization when we were trying to use non-specific emotions associated with pleasant activities, things moved rather slowly but his anxiety did diminish. However, as there was still no sexual arousal with Helen by the 12th session, I decided to make use of sexual arousal as a counter-anxiety agent. Paul was instructed to use his fantasies of other heterosexual situations for sexual arousal that might counter his anxiety responses to Helen. With that things moved more rapidly.

I now introduced masturbation as a conditioning agent as suggested by Thorpe *et al.* (1963, 1964). Paul had been masturbating at the rate of 3 times per week for the past 4 or 5 years to fantasies which had been almost totally homosexual. Fortunately, he reported that he could be 'turned on' by some heterosexual fantasies as well, usually those associated with certain books he had read or motion pictures he had seen. I recommended that he continue to masturbate as he had been doing, except at the moment of orgasm he switch his fantasy to a heterosexual one. I explained that the orgasm would be pleasurable no matter what he was thinking of. He was able to do the switch, at first with difficulty, but later quite easily. I then asked him to cut down the homosexual fantasies. By about the 15th session he was able to masturbate exclusively with heterosexual fantasies, while homosexual fantasies rarely intruded.

At this point I felt that his masturbating might be interfering with our efforts to change his responses to Helen. Assuming that a person who has no sexual outlet would become sexually aroused more easily than one who is frequently having intercourse or masturbating, I told Paul to discontinue masturbation.

Because he reported that he felt no sexual arousal at all after masturbation, I instructed

*The patient rates his anxiety level on a 100-point subjective scale.

him to think about the young men he was attracted to for a few minutes after masturbation in order to associate these non-sexual feelings with men. He was to think about the fellow who was most appealing to him at the time.

Another technique was also used against his homosexual fantasies which occurred between 10 and 25 times a day, usually while observing a young man in a public place. I asked him to recall some nauseating scenes. He described an occasion when the blood from a cut on his father's hand had gelled together like jello. He also thought of spit on the street and dog feces. I used this material to train him in covert sensitization for later use *in vivo*. He was told to think of these disgusting scenes whenever he began to have homosexual thoughts.

I also told him to begin to observe women and to undress them mentally. He had never been a girl watcher and said he derived no pleasure from observing women on the street. He was told to try to imagine girls naked or partially naked and try to evoke some sexual pleasure while observing attractive girls. At first he would dutifully do this without pleasure or sexual arousal, but in time began to admire various physical characteristics of specific women. He would describe the girl of the week to us and we would congratulate him for carrying out the assignment.

Finally, I recommended some erotic literature. *Sexus*, *Candy*, *Lady Chatterley's Lover* and *I Am Curious Yellow* were four books which 'turned him on'. He was persuaded to read and re-read them.

At the beginning of therapy I had given him Bentler's Heterosexual Behavior Scale (Bentler, 1968) which consists of a list of 21 sexual activities ranging from kissing for 1 min to mutual oral genital intercourse. The means of two groups of several hundred male students were 11·1 and 14·5 respectively. Paul's score at the beginning of therapy was 3. He had manipulated the genitals of a female with his hand over her clothes; a female had done the same to him and he had manipulated the breasts of a female with his hand over her clothes, as mentioned above.

Helen, seen at Paul's 3rd session, reported that she too had sexual anxiety but did not feel anxious until a much later phase in foreplay than Paul. She felt that sex was relatively unimportant and she was rather comfortable in this asexual relationship, but said she wanted to help Paul. I made it clear to both of them that therapy and marriage should be considered two different things and that successful therapy didn't necessarily mean marriage. By the 8th session Paul had been able to hold Helen's hand during the movie 'I Am Curious Yellow' without anxiety. He had become somewhat aroused during the movie. They had not yet held hands at home however. Nevertheless, they were now sleeping in the same bed almost every night. Paul was continuing the use of *in vivo* covert sensitizetion although he felt that it was a strain sometimes. I continued to encourage him in mental undressing and girl watching as a substitute for homosexual fantasies while he was in the street or on the subway. He had masturbated twice, to heterosexual fantasies both times, thinking of Helen on one occasion, and of 'I Am Curious Yellow' on the other. There seemed to be a change in that he was now thinking of Helen more during the masturbation and of other things less. By the 9th session he had been able to hold Helen's hand indoors for a total of 75 min. Helen had now more or less moved into his apartment.

Before the 9th session there was an unfortunate sensitizing event. Paul and Helen had gone to the beach with a group and they were crowded in a car. There were four of them in the back seat with Helen next to Paul. On the way home she had fallen asleep so that her head fell on to his shoulder and her hand on to his thigh. This made him exceedingly anxious and yet he was too embarrassed to do anything about it. Consequently, he remained highly anxious for an hour or so.

Since Paul was now able to hold Helen's hand for long periods indoors with very little anxiety, a new assignment was given. He was to lie in bed with her, clothed and without touching, and try to become sexually aroused. Since he could

not easily arouse himself by thinking of Helen, I told him at the start to think about any heterosexual scene that would sexually arouse him. At the 11th session, Paul reported that he had been able to lie in bed next to Helen and become sexually aroused 7 times in 2 weeks.

He was now instructed to lie on the bed next to Helen and when sexually aroused to hold her hand. If he lost his erection, he was to take his hand away. As he had not been able to carry out the new assignment we returned to the previous one. After he had had erections on several occasions, I gave him the assignment once again of touching Helen's hand while aroused, first one finger and then the rest of the hand. He had masturbated twice this week to heterosexual thoughts. It was at this point that I recommended that he stop masturbating in order to maximize arousal while lying next to Helen. He reported in the 15th session that he had been lying in bed with Helen but could not become aroused. Helen was aware of what he was doing and was at times becoming sexually aroused herself. (She knew there was a program, but she didn't know in detail what he was doing at a given time.) He was now lying in bed thinking of other girls and passages from books, etc., and she was gradually becoming aware of this. During this week however they had been at a party and had danced slow dances together and he had probably been resensitized to a certain extent by the physical contact.

At the 17th session Paul reported that he had been able to lie in bed with Helen, hold her hand, and remain sexually aroused four times. Therefore, he was told to lie in bed facing Helen and put his hand on her shoulder while sexually aroused. This evoked 10 or 15 *suds*. The following week he was able several times to touch Helen's shoulder while remaining sexually aroused for 15 or 20 min. He felt no anxiety. Helen too was becoming increasingly aroused. He did not look at her during this assignment because that made him anxious.

He was now asked to lie on his back with his arm around Helen's back and his hand on her far shoulder. This at first evoked about 25 *suds*.

By the following session, Helen had masturbated Paul and he had enjoyed it tremendously. It was a spontaneous event. By the next week they had attempted intercourse. He had entered her about 2 in. and then had withdrawn. He spoke of a number of fears and misgivings he had about pregnancy, disease and contraception. Dr. Melchiode gave Paul some instruction in contraceptive methods, and corrected his misconceptions that one contracted veneral disease by too much intercourse and that vaginal fluid was dirty.

There was only one more session since by then Paul and Helen had had intercourse numerous times. The homosexual thoughts had not completely vanished, but had decreased considerably. In addition Paul was getting along much better with Helen; they were arguing less although they had not yet decided to marry.

A short time later, I sent Paul a second copy of Bentler's Sexual Behavior Scale. The quantitative difference between the pre-therapy and post-therapy scores really did not reflect the extent of change that took place. His score had only gone up from 3 to 7, but he was now checking such items as "I've engaged in sexual intercourse with a female". He had not engaged in many foreplay activities or the variety of intercourse positions which are listed in Bentler's scale.

DISCUSSION

Wolpe: Well, it's an interesting case that was very skillfully handled. I have a few questions. With respect to the development of the condition, what was the reason for the transition from heterosexual to homosexual fantasies during his teens?

Gray: There was that one homosexual experience of sorts, when a boy touched him for just a few seconds until he pushed him away. He was also labeled a homosexual by his peers. I don't think that these two bits of information explain the transition.

Wolpe: What I think is interesting here is that we see once again that homosexuality can be multifactorial. Of the three definable factors two are often present and frequently, three. I think in this case, there is evidence of all three. These factors are, first, a positive 'valence' to men—being aroused by men; second, anxiety responses to women at least in a sexual context; and third, frequently related to the second, general interpersonal anxiety. Paul had the first two, very clearly indeed, and you correctly attacked them both. But there is also some evidence of general interpersonal anxiety—for example, when he became increasingly anxious when Helen's hand slipped on to his thigh and he was unable to take it away because of the reaction he was afraid this might produce. So the question is whether the job has been finally done, even though the sexual problem has, as far as one can see, been cleared up. There may be other areas that need therapeutic attention.

Gray: Yes, I agree. I described him as a rather passive individual and I am sure he is going to run into difficulty through his lack of asserton and other kinds of interpersonal anxiety. He wasn't motivated at this time for anything more than to become heterosexual however. He had a very clear goal, and once that was reached, there didn't seem to be any question of continued therapy.

Gershman: In your programming, did you at any time consider making use of the aversive shock technique?

Gray: No, but I could have used it instead of covert sensitization.

Gershman: I'm very curious whether you did use it and then discarded it.

Gray: No, I felt that covert sensitization was a much more flexible technique. It can be used less conspicuously and in a wider variety of situations.

Goldstein: I find it instructive that you took the covert sensitizing material from his past history—which I had not heard of before.

Muldawer: I don't quite understand why you had him think of homosexually attractive men after masturbation.

Gray: I had first asked him whether he felt any sexual feelings after having an orgasm and he said that he was quite devoid of any sexual feelings at such a time. So I had him think of men he found attractive at this time in an attempt to associate the absence of sexual desire with these men.

Muldawer: At the termination of treatment, was he still 'turned on' by men?

Gray: Yes, but much less frequently; as heterosexual desire increased, homosexual desire decreased. Homosexual impulses were still present, but less frequently and were much less upsetting.

Wolpe: I think there's still a question about this tactic. Although after orgasm he had no sexual desire, he might have had pleasant or satisfied feelings and it's possible that their effect might have been positive rather than negative. It's an empirical question. Does your data suggest that this specific technique was helpful?

Gray: No, I really couldn't disentangle this particular technique from the others. If he had said that he continued to have sexual desires or sexual pleasure after having had an orgasm, I wouldn't have used it. I think that the pleasant feelings he had were non-sexual, so if he were to associate these various men with them, I wouldn't be too worried about it.

Wolpe: Another thing that occurs to me relates to the controversy recently about the choice between desensitization and flooding types of techniques. It really seems incredible that flooding would have been effective in the treatment of this particular case, or in this class of case. Apart from the fact that you can make some patients worse by flooding, it seems that in working with sexual disorders quite a lot of finesse is needed. You must not merely remove anxiety towards females, but also decrease sexual responding to males and enable sexual responding to females. It is difficult to see how simply flooding the case could be effective.

Gershman: Has Stampfl ever described a case in which he has used flooding for sexual anxiety? I don't recall ever having come across such a case.

Gray: I generally would attempt desensitization as a first technique, since it is less risky than flooding. In addition, flooding would require greater control over the patient. We saw him for just a half hour a week.

White: Flooding requires that the patient is not able to escape. If you tried flooding, if you got Helen to flood, then there would be an immediate escape response available.

Wolpe: As a last resort you could have got them to engage in an extricable mutual embrace.

Edwards: I think we should note the distinctive feature of the situation in which flooding works. It works where the patient expects an aversive condition to ensue in the presence of a given stimulus; not where he's afraid of failure of a positive endeavor.

Wolpe: That does raise an important question. What was the stimulus antecedent of his anxiety towards contact with Helen? Had it anything to do with fear of failure or was it an immediate conditioned response to contact with female flesh?

Gray: I think the latter—just looking at her sometimes produced fear.

Goldstein: One thing in your presentation suggested to me the fear of failure; the fact that he was able to hold hands outside but not inside. It seems to me that some of the anxiety might have been caused by the thought that he would not be able to carry out the final step.

Gray: That could be true though he never verbalized a fear of failure, but rather a fear of intercourse and of whatever might lead to it. There was a limit to what was socially permissible out of doors. His anxiety increased indoors where intimate sexual contact was more likely.

Wolpe: From the facts available you can make no confident deductions. Perhaps he was afraid of physical contact because of fear of intercourse. Therefore he felt safer outside and could go further. However even there for quite a while he could not make an approach response. Perhaps it was the female stimulus configuration, both tactile and visual, that raised his anxiety level. Then if he were outside it would be easier for him to find an excuse not to touch her.

Edwards: Why do you think there was such a sudden improvement between sessions 18 and 19? At the time of the 18th he was anxious about putting his hand on her shoulder while lying next to her, and by the next session she had masturbated him.

Gray: There was some verbal exchange. His anxiety was apparently sufficiently reduced and they were able to talk while carrying out the assignment. There had been a gradual build-up to this. A few sessions before, Helen had been asleep or half asleep while Paul was carrying out the assignment. But toward the end, because of the increased physical contact, Helen was awake and occasionally becoming aroused herself.

Goldstein: Sudden changes of this sort are not unusual.

Woodham: The thing that's striking is that Helen was a remarkable partner for this guy. I don't know where you would find somebody else for a program like this except maybe in a marriage. How would you treat a guy who didn't have a girlfriend but who had similar problems?

Gray: I'd focus on the anxiety associated with finding a partner and would use some combination of desensitization and assertive training. It can be a very long process. Helen was ideal in some ways, in other ways she wasn't. She was available and quite cooperative in the program, but she was relatively unattractive sexually.

Goldstein: In answer to the question Dr. Woodham raised, I've often thought we ought to solicit, if I can use that word, the aid of some sympathetic prostitute. Many people come in with just these kinds of problems and there is no cooperative partner available.

Wolpe: On the other hand, it's not so infrequent to find girls who are prepared to cooperate. You quite commonly find a girl who is emotionally involved with a man who has a homosexual or impotence problem for whom she cares enough to be prepared to cooperate even if she is not married to him. Helen was able to go through the early phases of the program without any sense of deprivation at all. There are women who would go through such a program even though it was difficult and frustrating.

Piltz: Did you consider using systematic desensitization with relaxation as the inhibitor?

Gray: Yes I did consider it at the beginning and I think it would have worked in the early phase of treatment as an alternative to the *in vivo* desensitization with Helen. But I decided that since there was a partner available, things would be expedited if she were used. I could have used relaxation as an inhibitor, however, until he was able to become sexually aroused with Helen.

Muldawer: I find it interesting that in the end Helen was able to have intercourse so easily when the evidence seems to suggest that she had chosen Paul specifically because he was a very 'safe' partner. I wonder whether she was desensitized somewhere along the way while she was becoming aroused without her feeling any danger of having intercourse. From what you know, did she enjoy the program and do you think it was therapeutic for her also?

Woodham: It sounds as if you were treating more than one person.

Gray: Early in the program, Helen had told us that she had anxiety about intercourse with Paul but not about foreplay. She did become sexually aroused at times during the program. In the sense that she lost her fear of intercourse she was desensitized during Paul's treatment.

White: Concerning the evaluation of the

effectiveness of imagery, I don't know if you have any particular techniques for doing this. Do you accept the person's verbal report as entirely adequate?

Gray: With some reservation, I accept the verbal report and ask if there is a physiological response which accompanies the imagining. In this case Paul reported an actual feeling of nausea when he began to imagine blood, spit, etc., during the covert sensitization. I took this as a sign that he was imagining well.

White: Have you used penile volume measures for evaluating response to homosexual and heterosexual stimuli?

Gray: No.

Wolpe: There have been two recent studies in which penile measurements played an important part in the treatment of sexual deviations. Bancroft (1969), treated one group of homosexuals by aversion therapy, and another by desensitization of anxiety toward females. Each method was successful in a substantial proportion of cases. It seems likely that a very high success rate would have attended the use of both methods in all patients since each might have been relevant in different cases. The other study, by Abel, Levis and Clancy (1970), concerned the treatment of exhibitionism and other deviations. In research in male sexual problems penile volume measures are an enormous help to objectivity. In routine clinical practice they would be something of a luxury at present; but the day may come when no self-respecting therapist will treat such patients without their aid.

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