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The desensitization of a homosexual

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Ramsay and van Velzen (1968) made the point that, theoretically at least, desensitization therapy appeared to be the treatment of choice for homosexuality; yet they were unable to find a case where it had been used. They reasoned that if homosexuality was, even in part, a sexual adjustment necessitated by an irrational fear of the opposite sex, as many would claim, then desensitization of this phobia should open up the way to a more socially acceptable heterosexual adjustment.

From this same rationale, aversion therapy, which has recently proved very popular in the treatment of sexual deviations (cf. Feldman, 1966), would appear less appropriate. In aversion therapy with homosexuals the same sex is rendered fearsome too, leaving no interpersonal avenue open for sexual expression.

The following case shows in an objective fashion that, at least in this one instance, homosexuality was in some complex way functionally related to fear of the opposite sex, and further that when this fear was lessened by desensitization, heterosexual approaches began to be made.

CASE STUDY

Mr. J was an obese 19-year-old college student who complained of stage fright and of homosexuality. He said he would like to be heterosexual, but was simply not interested in women. I was able to convincingly demonstrate to him that he was indeed afraid of women rather than disinterested in them. This was done by having him close his eyes and imagine being in bed with a nude woman. To this he became very upset (sweating, tense facial expression) opened his eyes and said that he was so uncomfortable he was afraid he would have to leave the room. His homosexual behavior involved the masturbation of other adult males and self-masturbation to the fantasy of being a woman having sexual relations with a man. He did not engage in sodomy or fellatio although he was attracted to these activities with males.

The MMPI and the Leary Interpersonal Checklist were given both before and after desensitization. Figure 1 depicting the pre-therapy MMPI profile showed Mr. J to be very complaining and disturbed. Figure 2 provides Mr. J's placement of himself, his ideal self, his mother and father on Leary's Interpersonal Diagnostic Grid (Leary, 1958). As can be seen, prior to therapy (the circles) Mr. J thought of himself as shy, passive, weak and tended to be self-effacing. This was in marked contrast to his father. His mother (who had died when he was 12 years of age) was viewed as somewhat aloof and castrating. In general, he was not identified with either his father or mother, while idealizing his father and fearing his mother.

An anxiety hierarchy to physical intimacy with women was set-up and is presented in Table 1. This was accomplished in the first two therapy sessions at which time deep muscle relaxation was also taught (cf. Wolpe and Lazarus, 1966). Desensitization, following the procedure described by Wolpe and Lazarus, was begun to the lowest anxiety-provoking situation in the hierarchy at the third session. It took 18 more sessions and a total of 170 presentations completely to desensitize Mr. J to the complete hierarchy (a session usually lasted 30 min). The number of presentations required for desensitization of each scene is given in Table 1. Apparently most anxiety was associated with what is usually called petting, e.g. hugging, kissing, fondling breasts, with relatively less anxiety being associated with foreplay preceeding sexual intercourse and intercourse proper.

Mr. J was requested, at the beginning of therapy, to keep a day by day record of his sexual behavior, and preoccupations or fantasies. He was asked to keep a frequency count of (1) homosexual behavior (2) homosexual desires and/or preoccupations, (3) heterosexual behavior and (4) heterosexual desires and/or preoccupations. No elaborate definitions of these categories was provided. At the end of therapy, three weeks after the end of therapy, and for six weeks beginning five months after termination of therapy, these data were collected. To get an index of homosexuality, categories (1) and (2) were added together. The sum of (3) and (4) provided an estimate of heterosexuality. Since both homosexual and heterosexual behavior was so dependent on opportunity while fantasy and desire were not, this summing seemed reasonable. Figure 3 shows the frequency of homosexuality and heterosexuality from the beginning to end of therapy and for a three week follow-up (8 on the abscissa) and a six month follow-up (points 9 and 10 on the abscissa). Incidences occurring in therapy which were interesting are noted on the figure at the point in treatment at which they occurred. Generally, as therapy progressed homosexuality decreased while heterosexuality increased until the frequency of heterosexual behavior (dating females, etc.) and

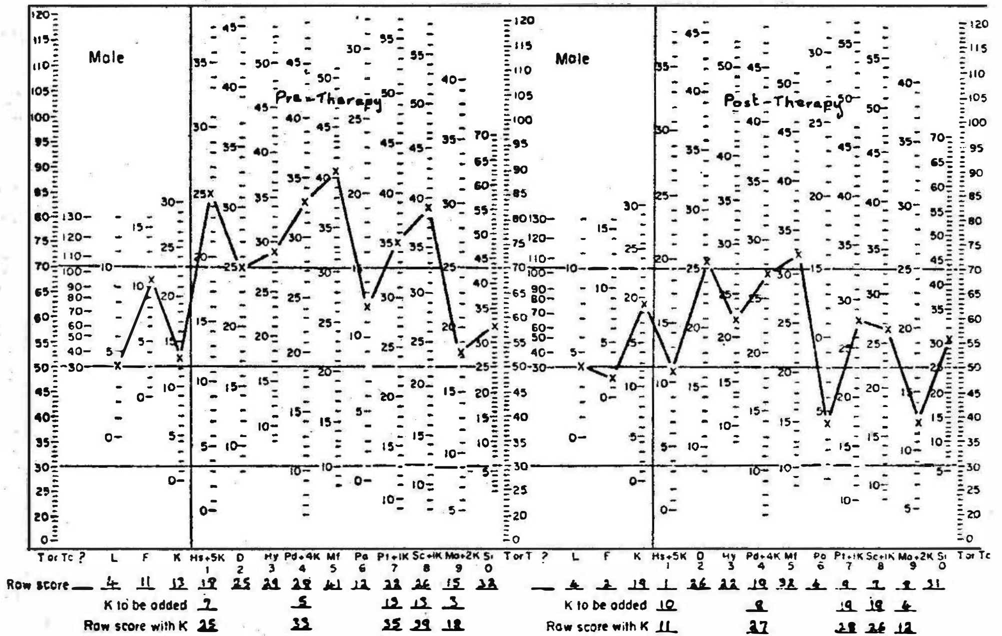

FIG. 1. Pre-and post-therapy MMPI profile.

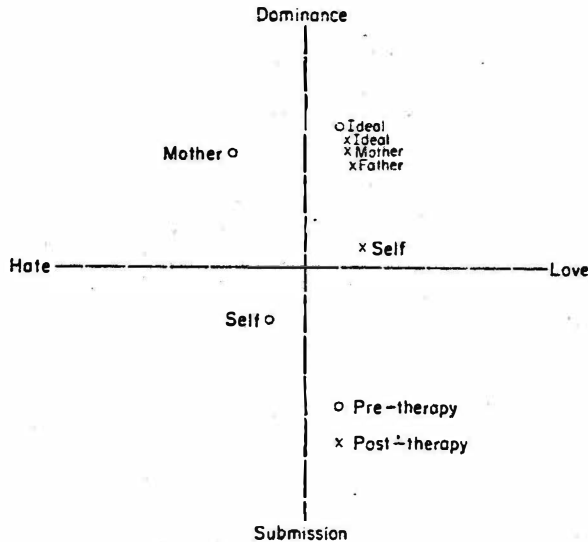

FIG. 2. Pre-and post-therapy typing of self and others on the Leary Interpersonal grid. Leary (1957) has developed a list of adjectives with which one describes oneself and specified others. The resultant data are converted into points in a two dimensional space. The dimensions are the interpersonal characteristics of dominance-submission and hate-love. Distance from the center represents the degree of possession of these characteristics.

TABLE 1. MR. J'S ANXIETY HIERARCHY TO INTIMACY WITH WOMEN (FROM LEAST AT BOTTOM TO MOST AT TOP; NO. OF PRESENTATIONS TO DESENSITIZE GIVEN IN COLUMN)

Situation	No. of presentations
16. girl moves while penis inserted	5
15. places penis in vagina	10
14. girl touches penis	6
13. nude, lying on top of girl	5
12. nude, lying beside girl	4
11. touching girl's mons, pubic hair	11
10. feeling girl's legs and thighs	5
9. fondling girl's breast	11
8. kissing girl on lips	11
7. kissing girl on forehead	22
6. looking into girl's eyes, tilting head up	21
5. hugging a girl	26
4. putting arms around girl	12
3. holding hands with girl	14
2. having a conversation with girl alone	4
1. having conversation with several girls	3
Total number to desensitize	170

fantasy became greater than that for homosexual behavior. It was interesting to note that during the therapy session just following when this occurred (6 on the abscissa) Mr. J reported that he did not feel as homosexual as usual. The scene to which he was desensitized at this point was fondling the legs and thighs of a woman. Beginning with the scene of lying beside a nude girl and for each scene thereafter,

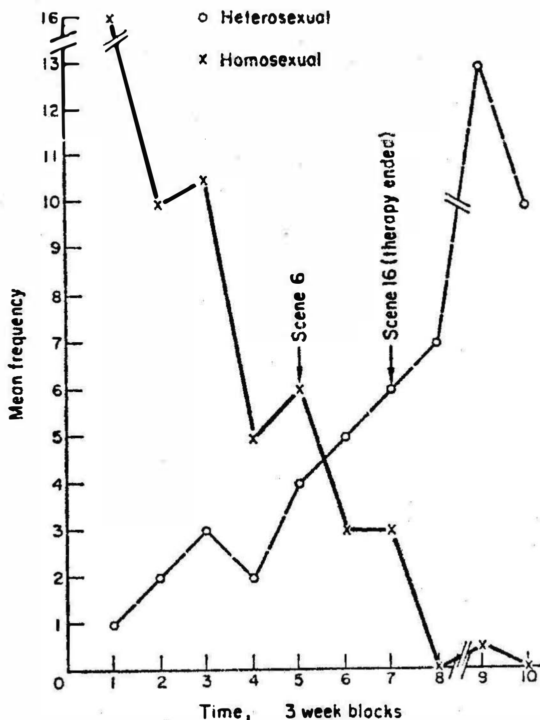

FIG. 3. Frequency of homosexual and heterosexual behavior/urges throughout therapy and for follow-up.

Mr. J reported that as anxiety diminished he would begin to feel "sexed up." Apparently this was the first time he had such feelings to fantasies of girls.

Mr. J had never dated prior to therapy and perhaps as a "flight into health" he began to date two girls three weeks after beginning therapy. These dates were primarily asexual, involving going to concerts and crowded public events with no physical intimacy. However, by the last six weeks of therapy Mr. J found himself wanting to be alone with his dates and also felt sexually aroused by them. Six month follow-up showed that his sexual interest in females has continued and increased (see Fig. 3, points 9 and 10 on the abscissa).

Figure 1 shows the MMPI profile after therapy and it was obvious that Mr. J felt less distressed. Figure 2 (the X's) shows that Mr. J's self-concept had changed considerably, coming closer to his ideal self-concept. His conceptualization of his mother had also changed from castrating, hostile to caring and instructive.

DISCUSSION

Apparently the desensitization procedure made women less aversive as sexual objects and as people from whom guidance, support, and comfort might be obtained. A definite freeing of sexual interest in women was noted. The changed view of mother from hostile and punative to supportive and loving suggests that all women were more positively valued by Mr. J. Here we have a change in attitude brought about by changing the emotional substrate of behavior. In verbal insight therapy the opposite is usually attempted, i.e. you try to change attitudes and then as a consequence emotional responding is altered. Insight which is considered the *sine quo non* of traditional psychotherapy was observed to follow desensitization or emotional change rather than precede it. Mr. J reported that he was afraid of women, an insightful statement, *after* the fear was neutralized by desensitization.

If we consider the recorded index of homosexuality (homosexual behavior plus homosexual desire) as an indication of the degree of aversiveness of women and the index of heterosexuality (heterosexual behavior plus heterosexual desire) an indication of their positive or approach value, then it will be possible to conceptualize Mr. J's therapy as the resolution of an approach–avoidance conflict. When the approach value of women became greater than their avoidance value, Mr. J reported he felt less homosexual and began to be sexually aroused to scenes presented in the desensitization session. It was as if homosexuality represented a compromise sexual adjustment rather than a free choice of equally available sexual objects. When the approach gradient was raised above the avoidance gradient then this compromise was no longer necessary and the selection of women as sexual objects was made. It is not known for sure why this selection was made. Desensitization just neutralized his reaction to women; there was no attempt to give them positive value. Did innate or social variables determine Mr. J's turning to women as sexual partners?

Rogers and Dymond (1954) maintained that in successful therapy the patient's self-concept and ideal self-concept become more alike. They attribute this to insight gained in a supportive, accepting interpersonal relationship. At the beginning of therapy Mr. J's self- and ideal self-concepts were very discrepant. When he was re-evaluated at the end of therapy, this large discrepency no longer existed. In other words, successful therapy, as Rogers would define it, was carried out but without the conditions he deems necessary, being met.

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