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HOMOSEXUALITY : TREATMENT BY BEHAVIOUR MODIFICATION

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SUMMARY

We present here the treatment of thirteen homosexuals by behaviour modification techniques. With classical electrical aversion and positive conditioning 8(61%) out of thirteen patients showed a change in orientation lasting on a six-month 1 year follow up. A marriageable age and indirect social pressures were positively correlated with improvement whereas the presence of a steady homosexual partner and habitual passive anal intercourse indicated a poor response. The techniques, the assessments, the onset and course of improvement and complications are discussed. Our results and techniques are compared with those of other workers.

Homosexuality in India, is illegal and the dominant cultural attitude is condemnatory. This has created an atmosphere of social ostracism and alienation. It is no wonder then that homosexuals are willing to have their sexual orientation modified. With the desire for social conformity and an increasing awareness of treatment facilities, the number of homosexuals approaching experts for relief from their distress has increased.

Beginning in 1895 with the attempts of Schrenck-Notzing to treat homosexuality with hypnosis (Bancroft, 1974), followed by androgens and psychoanalysis, the results of treatment have not been satisfactory. Recent reports highlight the role of behaviour therapy as a quick simple and effective solution of the homosexual's problem.

We are presenting here the treatment of thirteen cases by behaviour modification techniques.

MATERIAL AND METHOD

Thirteen patients diagnosed as suffering from homosexuality as defined in the I.C.D.-8., accepted treatment by behaviour modification. These patients were referred to the behaviour therapy clinic for psychiatric evaluation and behaviour therapy.

Pre-treatment polygraphic and psychometric investigations were carried out. During the initial interview a brief orientation regarding the treatment was given to the patients and the treatment strategy was worked out. All patients were taught relaxation initially. Albums of provocative male and female photographs were made to be used during treatment sessions.

Each session of behaviour therapy lasted about 20 to 25 minutes. Each patient received one type of aversion treatment for 10 minutes followed by one or more types of positive conditioning techniques for about 15 minutes. Behaviour therapy sessions ranged in frequency from two to five times per week. Evening sessions were arranged for working patients.

Techniques used :

Behaviour therapy consisted of the following treatments :

(1) Aversive deconditioning to homosexual stimuli in imagination by a pre-determined voltage of alternating current passed between two wet saline -soaked gauze electrodes tied to the left forearm for a duration of two to five seconds. The current strength varied from 50 to 75 volts.

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(2) Aversive deconditioning (electrical) to homosexual stimuli. in reality using provocative male photographs.
(3) Relief from electrical aversion by withdrawal of the electric current on seeing provocative female photographs.
(4) Positive conditioning to heterosexual stimuli by combining heterosexual fantasy with relaxation.
(5) Positive conditioning to heterosexual stimuli by combining provocative female photographs with relaxation.
(6) Positive conditioning to heterosexual stimulate at home by combining sexual excitation—stimulation of genitals even up to ejaculation—with hetero-sexual fantasies and with seeing provocative female photographs.

Evaluation and Follow-up :

Patients were evaluated before and after treatment on the Bancroft's (1974) scales for heterosexuality and homosexuality. Weightage was given to patient's subjective and the therapist's objective impression regarding progress. After achieving good/very good improvement patients were given once a week behaviour therapy sessions. Post-improvement polygraphic investigations were carried out and patients were followed up for a period between six months to one year.

Findings with Behaviour Therapy :

Eight (61%) of our thirteen patients showed very good improvement and of these four got married or engaged after treatment and had successful sexual intercourse with a female on a six month to one year follow-up.

Onset of Improvement :

The earliest signs of improvement were in the form of blockage of homosexual fantasies in the treatment situation or of erections to heterosexual fantasies and occurred only after about 15 sessions in the majority of patients. We feel that those patients who took more than 20 sessions showed a greater tendency to improvement.

TABLE 1—*Onset of Improvement*

Number of sessions of behaviour therapy required to achieve earliest improvement

	0—9	10—19	20—29	Total
No. of patients	2	2	4	8

Number of sessions and improvement :

Our patients received between 15 to 45 sessions of behaviour therapy. Of the 5 patients who did not improve 3 had taken less than 25 and 2 had taken more than 35 sessions. Of the patients who improved, 1 had taken less than 25, four more than 25 and three more than 35 sessions. Thus those who did not improve had taken a relatively lesser number of sessions.

TABLE 2—*Number of sessions and improvement*

No. of sessions of Behaviour therapy	15—25	26—35	36—45	Total
No. of patients improved ..	1	4	3	8
No. of patients *NOT* improved	3	0	2	5
Total ..	4	4	5	13

Duration of homosexuality and improvement :

Of the 2 patients with a duration of homosexual behaviour for 5 years or less one improved and one did not. Two out of 4 patients with homosexual behaviour between 5 and 10 years improved. Of the six patients with a duration of homosexuality between 10 and 14 years, 5 improved and 1

did not. The patient with a duration greater than 15 years did not improve. Thus duration of homosexual behaviour does not appear to be of much significance as a prognostic factor in behaviour therapy.

TABLE 3—*Duration of homosexuality and improvement*

Duration	0—4.9 years	5.0—9.9 years	10—14.9 years	15—19 years	Total
No. of patients improved ..	1	2	5	0	8
No. of patients not improved ..	1	2	1	1	5
Total ..	2	4	6	1	13

Severity of homosexual behaviour and improvement :

The rise in the scores on Bancroft's of heterosexuality scale and fall in the scores on Bancroft's (1969) homosexuality scale are shown in the following Table.

TABLE 4—*Ratings of Homosexuality and Heterosexuality on Bacroft's Scales*

	Homosexuality		No. of sessions of Beh. therapy	Heterosexuality	
	Initial score	Final score		Initial score	Final score
1.	6	1	45	0	8
2.	5	1	20	1	8
3.	8	1	35	1	9
4.	10	10	15	0	0
5.	6	½	27	1	5
6.	9	2	35	0	6
7.	9	7	40	0	1
8.	6	½	40	0	4
9.	6	6	15	0	0
10.	5	1	37	1	8
11.	6	6	40	0	1
12.	6	7	20	0	1
13.	6	½	28	1	5

As can be seen from the Tables, severity on the Bancroft's scale for homosexuality does not seem to affect response to treatment. Clinically, two of the five patients who did not improve had a steady homosexual partner compared to none in the improved group. Four out of five unimproved patients had indulged in passive anal intercourse compared to only three of the eight in the improved group. Probably factors other than severity are operating in determining the response to treatment.

Motivation and improvement :

All our patients had good motivation for treatment and had sought psychiatric help after becoming aware of treatments available for their deviation through lay or scientific literature. However some patients had an urgent and pressing need to get cured, e.g. impending marriage or engagement, indirect family pressures and an ardent desire to set up a house and settle down in life like other normal people. Of the six patients with such an urgent need 5 improved whereas only three out of seven without such an indirect social pressure improved. We feel that positive motivation with indirect social pressure played a significant role in the improvement of the patients and indicates good prognosis in behaviour therapy.

TABLE 5—*Motivation and Improvement*

	No. of patients improved	No. of patients not improved	Total
Good motivation with indirect social pressure ..	5	1	6
Good motivation without any pressure ..	3	4	7
Total ..	8	5	13

Observations during the course of treatment : (complications of changes in the process of recovery)

We observed the development of a depression in six of our patients. Similar observations have been reported by Bancroft, Marks, James *et al.*, and Mumford (Bancroft 1974). Bancroft maintains that this depression is an accompaniment of the change-over to heterosexuality. In five of our patients the depression was accompanied by an anxiety that they may lose their sexual drive totally and be neither homosexual nor heterosexual. One of our patients became depressed because his steady homo sexual partner went abroad deserting him. The depression was treated with anti-depressant drugs and behaviour therapy was continued in all cases.

COMMENTS

For the treatment of sexual deviation chemical, verbal and electrical aversive stimuli have been used and the most popular and most effective stimuli are electrical (Barlow, 1972). The importance of deviant masturbatory fantasies in the maintenance of deviant behaviour has been stressed by Evans (1968). In the present study positive conditioning was attempted for heterosexual fantasies to hasten the suppression of the deviant behaviour. We administered the aversive electrical stimulus when the patient indicated by raising a finger that he was able to imagine an exciting homosexual scene. This was not necessarily one of physical intimacy because, as Barlow's (1972) research indicates, behaviour early in the chain such as meeting and gaining consent from a prospective partner may be more pleasurable and may perpetuate the deviant behaviour. Whereas Wolpe (1973) has used only assertive training without any aversive procedure in the treatment of homosexuals and Bancroft (1974) has studied the effects of systematic desensitization on a hierarchy ranging from imagination of kissing to ejaculation inside the vagina.

We find that our patients on the whole require at least 30 sessions each lasting about 20-25 minutes spread over a period of about three months for improvement, whereas Bancroft (1974) has advocated 15 to 20 sessions at the rate of once a week or more followed by once a month sessions for approximately one year. The reason for this may be that Bancroft's sessions last for one year.

We have observed that all our patients were below 30 and had good prospects of marriage. The contribution of the need to improve due to indirect social pressures has been stressed in the motivation.

Factors indicating good prognosis have been age below 30, previous heterosexual experience and strong motivation (Feldman and MacCulloch, 1965). The presence of a steady homosexual partner and habitual passive anal intercourse were found to be factors of poor prognosis.

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