SYMPOSIUM ON SEXUAL DEVIATION

Behavioural Approaches to the Management of Sexual Deviations

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The history of treatment approaches used to help individuals troubled by sexual deviation or variation is notable for the way it has reflected the changing attitudes of both society and medicine to such behaviour. In recent years the range of behavioural techniques has broadened considerably with the introduction of, for example, cognitive forms of treatment and a change in emphasis away from the suppression of deviant sexual behaviour and towards the positive development of desired behaviour. In addition, as with behaviour therapy in general, a more flexible approach to management has developed with much greater emphasis on designing treatment on the basis of each individual patient's needs. Furthermore, there has been a marked reduction in the number of requests received for help with deviant sexual interest. This reflects both the changes that are occurring in social attitudes to sexuality in general, and homosexuality in particular, which have reduced the pressures on individuals to abandon their personal styles of sexual behaviour, and the development of self-help groups and minority organisations.

In this paper, specific behavioural techniques that have been used with individuals who request help with regard to deviant sexual behaviour will first be considered. Subsequently a general approach to management in which a variety of behavioural methods can be integrated will be described. This paper is aimed primarily towards the clinical practice of the general psychiatrist. No reference will be made to treatment in forensic practice which is considered elsewhere (Chiswick, 1983).

Specific behavioural techniques used in the management of sexual deviance

Broadly speaking there are three approaches that have been used in the management of deviant sexuality. Firstly, there are procedures used to bring about a decrease in deviant sexual interest and behaviour. Secondly, there are treatment techniques directed towards increasing or improving non-deviant or desired sexual interest and behaviour; these include measures which can be used to assist an individual to improve his social and interpersonal adjustment. These two approaches usually should not be used in isolation from each other; the first approach in particular will often be unsuccessful if used alone (Barlow, 1973). Finally, there are procedures used with individuals who do not wish to abandon their deviant sexuality but who require help in adjusting to it.

It is difficult for three reasons to achieve a satisfactory overview of the relative efficacy of different behavioural techniques in this field. Firstly, the literature on behavioural treatment of sexual deviance has been notable for the disproportionate ratio of single case reports to controlled outcome studies. Although detailed single case studies can be very helpful, the natural tendency of both therapists and journals not to publish unsuccessful cases can give a very distorted impression of the efficacy of particular techniques. Secondly, individuals presenting with the same deviant behaviour are likely to differ on a very wide range of characteristics, including those concerning personality and non-deviant behaviour, and it is usually impossible to establish to what extent subjects in different studies are comparable. Thirdly, as will be discussed later, there are several ways of assessing changes in deviant sexuality, each of which may produce somewhat different results and each having its own drawbacks.

Methods for decreasing deviant sexual interest and behaviour

The approaches initially introduced to help reduce deviant sexual interest and behaviour were based on the theory that the deviant interest first develops because of positive conditioning between the object of the behaviour and early sexual arousal, possibly as a result in some cases of a chance association. A similar but more plausible theory is that repeated masturbation to a fantasy concerning a deviant experience, irrespective of whether the initial experience was associated with sexual arousal, is the means by which deviant sexual interest is developed, strengthened and maintained (McGuire *et al*, 1965). The drive in the deviant direction may be further strengthened because of fear of conventional sexual behaviour (heterophobia), or feelings of social or sexual inadequacy.

At one time, aversion therapy, involving external aversive stimuli, was the main technique used in the suppression of deviant sexuality. Less unpleasant approaches have been developed, particularly those based on helping patients alter their cognitions related to their deviant interest or behaviour.

1. *Aversion therapy*

First developed for the treatment of alcoholism (Kantorovich, 1930), aversion therapy has been used widely in the management of sexual deviance. The initial theoretical basis for aversion therapy was that induction of a conditioned anxiety response to a deviant stimulus by means of classical conditioning would result in reduction in the deviant interest. Evidence that aversion therapy worked in this way is weak. Thus Marks *et al* (1970) found that the usual response of patients who reported improvement was indifference to formerly attractive stimuli rather than anxiety, and came to the conclusion that changes in deviant interest were due to modification of attitudes.

The technique of aversion therapy involved the pairing of an aversive stimilus with actual deviant behaviour (e.g. cross-dressing), slides depicting the deviant stimulus, or fantasies of deviant behaviour. Chemical agents, such as apomorphine which induced nausea (e.g. McConaghy, 1969), were first used to provide the aversive stimulus. These were later replaced by electrical aversion, in which mild but unpleasant electric shocks were delivered to parts of the body, usually the forearm, in association with the deviant stimulus, (e.g. Marks *et al,* 1970). Aversion therapy has been used in the treatment of homosexuality (Bancroft, 1970; Feldman and MacCulloch, 1971), exhibitionism (Evans, 1970), transvestism, fetishism, paedophilia and sadomasochism (Bancroft and Marks, 1968).

Although Feldman and MacCulloch (1971) claimed a success rate of almost 60 per cent in eliminating unwanted homosexual arousal by aversion therapy, the success rates in other studies were more of the order of one-third (Bancroft, 1974). A 50 per cent success rate during the six months after treatment was obtained by Evans (1970) when using electrical aversion with exhibitionists. Marks *et al* (1970) found that patients with transvestite or fetishistic interest had a relatively good outcome in terms of change in deviant interest up to two years after electrical aversion, but little change in conventional heterosexaul adjustment.

Shame aversion, in which the patient performs the deviant sexual act in front of an audience, appears to be a variant of aversion therapy. Aversion is thought to arise from the embarrassment and anxiety that is induced (Jones and Frei, 1977). This approach has been used in the treatment of exhibitionism (Reitz and Keil, 1971; Jones and Frei, 1977) and transvestism (Serber, 1970).

In spite of all the attention that has been paid to aversion therapy in the past, a widely held current opinion, and certainly that of the author, is that because of its unpleasant nature, and the ethical problems it poses (Rachman and Teasdale, 1969), the use of aversion therapy can no longer be justified.

2. *Covert sensitization*

As aversion therapy seemed in some patients to induce changes in attitudes to deviant sexuality, it was argued that it might be possible to bring about such changes by a purely cognitive approach (Bandura, 1969). Although covert sensitization is a form of aversive procedure it should be considered separately. It is based entirely on the use of a patient's imagery or fantasies (Cautela, 1967; Cautela and Wisocki, 1971). Thus the patient imagines himself engaging in the deviant behaviour and when he has achieved a vivid image he is asked to imagine a highly unpleasant scene or event, such as vomiting or being caught in the act by a family member. Covert sensitization has advantages over aversion therapy in that it is more simple to implement, and can be used by the patient in his everyday life, not just in the clinical situation. Maletzky (1973) added a further ingredient, namely smell aversion, in which the deviant images are paired with the unpleasant smell of valeric acid. He has reported considerable success in the use of this method with a large series of exhibitionists (Maletsky, 1980).

Covert sensitization has been used in the treatment of a wide range of sexual deviations (Cautela and Wisocki, 1971), including obscene telephone calling (Alford *et al,* 1971), often in combination with other techniques such as orgasmic reconditioning (Brownell *et al,* 1977). Callahan and Leitenberg (1973) demonstrated that covert sensitization might be at least as effective as aversion therapy. Mastellone (1974) and Marks (1978) have suggested a simple additional procedure in which the patient wears an elastic band around his wrist which he pulls taut and then allows to slap back to sting his skin whenever he finds deviant sexual thoughts occurring. Although having a mildly aversive function, this probably acts primarily as a thought-stopping mechanism.

3. *Self-regulation or self-control techniques*

In these approaches the pattern of events and thoughts which precede the deviant act are first clearly established with the patient. The patient is then helped to find ways, such as switching thoughts or resorting to a well-rehearsed alternative behaviour, that would reduce the chances of his going on to carry out the

deviant behaviour. Rooth and Marks (1974) reported use of this technique in the treatment of exhibitionism, but found it was more effective if preceded by an aversive procedure. A modification of this procedure that has been employed in treatment by the author is to encourage the patient to masturbate instead of carrying out the deviant act. Gradual change in the fantasies associated with masturbation can also be suggested.

Methods for increasing/improving non-deviant sexual interest and behaviour

As was noted earlier, techniques aimed at decreasing sexual interest and behaviour are unlikely to succeed unless combined with attempts to develop alternative sexual behaviour. This will usually mean improving heterosexual adjustment, but in some cases modification of the nature of the deviant interest, such as paedophiliac homosexuality to satisfactory homosexual behaviour with adults (Kohlenberg, 1974), may be more feasible.

1. *Positive conditioning*

This includes procedures aimed directly at increasing heterosexual arousal.

(i) *Aversion relief.* This technique, which has usually been combined with aversion therapy, consists of pairing heterosexual stimuli with relief from a noxious stimulus (Thorpe *et al,* 1964). Thus following the pairing of a shock with a deviant fantasy or presentation of a slide, a non-deviant stimulus is presented in the form of words describing, or slides depicting, heterosexual behaviour. This approach has been described extensively in the literature with little evidence for its efficacy (Barlow, 1973). It is of interest that some workers have found an increase in heterosexual responsiveness after aversion therapy without aversion relief being used (Marks and Gelder, 1967; Bancroft, 1970).

(ii) *Fading or shaping.* In this procedure a deviant stimulus is gradually changed to a more conventional heterosexual stimulus. For example, in trying to modify homosexual interest, Barlow and Agras (1973) used slides showing attractive men which were gradually faded and replaced by those of women. The authors claimed the procedure had marked short-term effects. This approach can also be based on imagery by instructing an individual to gradually change the nature of his erotic fantasies (Bancroft, 1971). This has primarily been used in the management of homosexuality and paedophilia.

(iii) *Orgasmic conditioning.* This techique is based on the assumed role of masturbation and orgasm in the maintenance of deviant sexual interest (McGuire *et al,* 1965). The patient is instructed to switch his fantasy from a deviant to a more conventional one at the point of orgasm. The aim is to increase the attractiveness of the conventional fantasy by such association. Subsequently he is instructed to make the switch at earlier and earlier stages of masturbation. However, patients often find it difficult to voluntarily inhibit their deviant fantasies. Bancroft (1974) has suggested that gradual re-shaping of masturbation fantasies is more effective. Although widely used in clinical practice, there has been little systematic evaluation of orgasmic conditioning. Conrad and Wincze (1976) failed to demonstrate much effect when using it with homosexual males.

2. *Systematic desensitization*

Where anxiety about heterosexuality exists, as it is said to do in many homosexuals who seek treatment (Masters and Johnson, 1979), some workers have tried using systematic desensitization in imagination to heterosexual situations as a means of lessening heterophobia. There was little difference in effectiveness between systematic desensitization and aversion therapy in Bancroft's (1970) study of homosexual men. James (1978) found systematic desensitization plus encouragement of heterosexual arousal to be more effective than an aversive procedure in reducing homosexual interest and facilitating heterosexual adjustment both in those homosexual men with, and those without, heterophobia.

3. *Treatment of sexual dysfunction*

Some men with deviant sexual preferences experience sexual dysfunction (e.g. erectile impotence) during sexual activity with a female partner. Occasionally the patient's partner has such a dysfunction (e.g. sexual unresponsiveness). On the basis that sexual dysfunction may be an important factor in maintaining deviant sexual interest, and with the advent of effective means of helping couples with such sexual difficulties (Masters and Johnson, 1970), the dysfunction can be the focus of treatment. The author has had some success using a modified Masters and Johnson approach (Hawton, 1982) in the management of exhibitionists and fetishists who have partners. Reduction of deviant interest and behaviour can occur following successful treatment of sexual dysfunction without attention being paid specifically to the deviant sexuality.

4. *Methods for improving social skills*

Some workers have developed social skills programmes for patients whose deficiencies in skills in relating to women appear to be preventing them from establishing rewarding heterosexual relationships (Barlow, 1973). Sometimes social skills training is

carried out in groups including a female therapist so that members can practice behaviours, such as asking for a date, with a relatively non-threatening female before attempting to do this in the outside world (Cautela and Wisocki, 1969). Because many individuals with deviant sexual interest, especially exhibitionists (Rooth, 1980), appear to be deficient in the social skills usually involved in establishing relationships with women, this seems an obvious focus for help.

Methods used to provide help in adjusting to deviant sexuality

As social attitudes to deviant sexuality have changed, the role of the psychiatrist is now more often than in the past that of helping individuals achieve satisfactory adjustment without abandoning their deviant sexuality. Behavioural techniques have only a small part to play in such work. Counselling, psychotherapy, and referral to self-help groups, such as Friend (for homosexuals) and the Beaumont Society (for transvestites and transsexuals), will be the main approaches. However, mention should be made of two applications of behavioural methods. The first is in the management of homosexual couples with sexual dysfunction. Masters and Johnson (1979) have described in detail how their sex therapy approach can be used with homosexual couples who experience sexual difficulties such as erectile impotence. These workers claimed that only approximately one in ten of such couples failed to respond to treatment (they also reported considereable success in the treatment of lesbians with sexual dysfunction). The second application of behaviour therapy is in the management of transsexuals who are undergoing sex re-assignment. Transsexual men and women often show major deficiencies in the social and inter-personal skills of their preferred sex role. Yardley (1976) has described in detail a programme of social skills training that was used with apparent success to modify the sex role behaviour of a male transsexual. Treatment included such techniques as modelling by the female therapist, behavioural rehearsal of female social skills and videotaped feedback of practice sessions.

A general behavioural approach to management of sexual deviance

We can now consider a general plan of how to approach in routine clinical practice the treatment of individuals who seek help because of their deviant sexuality. For the practitioner likely to be involved in such treatment it must be emphasised that one should be prepared to be very flexible. In addition a treatment plan must be designed for the individual patient, but only after a careful assessment of the problem. Furthermore, it is usually inappropriate to use a single technique in isolation; a combination of procedures is nearly always needed. In this paper, attention is primarily paid to behavioural techniques, but other therapeutic approaches, including psychotherapy, social support and medication, can all have a role in management.

1. *Assessment*

A thorough assessment of the patient should be carried out first. In particular the clinician should determine precisely what the patient wants (e.g. removal of all deviant interest; improvement in heterosexual adjustment; adaptation to deviant role). He should then estimate the feasibility of achieving this goal. For example, the chances of reducing an individual's deviant interest will be related to several factors, including: the strength of his deviant sexual interest (Evans, 1970), reflected in the frequency of deviant sexual acts (including masturbation with deviant sexual fantasies); his age; the length of history of the deviant behaviour; the extent to which the behaviour is a source of gratification and of bolstering self-esteem; whether external pressures (Courts, family, spouse) have forced him to seek help, and whether his wish to rid himself of deviant interest is possibly only temporary because of a disturbance of mood. The patient's history with regard to conventional heterosexual interest and behaviour will be another important factor.

2. *Negotiate a contract*

As with psychological treatment for other problems, a clear contract should be established with the patient before commencing treatment. This should include the goals of treatment, the number, frequency and duration of treatment sessions, and precisely what will be involved. Often it is appropriate to make a limited contract, such as for four or five sessions of treatment, during which the possibility of successful treatment will become clearer. This might be the case where the patient's motivation is uncertain.

3. *Detailed behavioural analysis*

Before deciding on the specific approaches to be used in treatment, a detailed behavioural analysis of the patient's current sexual behaviour and attitudes should be carried out. This should include an assessment of (i) the patient's level of sexual drive (frequency of sexual acts, masturbation, and sexual thoughts); (ii) what stimuli the patient finds exciting, what potentially erotic stimulis he finds aversive, and the nature of his sexual fantasies, especially those associated with masturbation; (iii) the antecedents, content and consequences of a typical sexual incident;

it is important to obtain a precise description of the sequence of events, including especially what appears to initiate the sequence and how the patient feels afterwards; (iv) the patient's attitude towards the behaviour, particularly the extent to which he feels it is possible to change if that is what he has requested. It may be necessary for the patient to go away and keep records before proceeding further.

4. *Identify the initial focus of treatment*

As a general rule it is best with most patients to think first how the patient's heterosexual adjustment could be improved, before looking at possible means of reducing deviant sexual interest (Barlow and Abel, 1981). There will of course be different aims for the patient who does not want to give up his deviant behaviour, but who wishes for help in coming to terms with it, or in improving his deviant sexual adjustment.

5. *The treatment programme*

The essence of the behavioural approach is that once an initial focus for treatment has been established, the patient should always have tasks to practice between sessions. This should ensure active involvement with treatment and also enhances the chances of success. At each treatment session the therapist assesses the patient's progress. When the patient has been unsuccessful in carrying out the tasks the therapist's role is then to help the patient see what has prevented him from doing so. Where obstructive attitudes are the cause the patient should be helped to examine these attitudes to see whether they can be altered. The therapist must flexible, being prepared to change the approach if this becomes necessary.

The following three brief case examples illustrate the application of behavioural methods of treatment:

(a) An 18 year old garage worker was referred because of his persistent voyeurism, for which he had twice been convicted. He had little problem forming relationships with girls but had no girlfriend at the time of referral. His peeping occurred three or four times a week and always followed a regular pattern. After he had been out drinking with friends, he would start thinking about visiting his usual haunt, a local nurses' home. If he went ahead with the act he would usually try to peep on a girl undressing or a girl with a boyfriend. Afterwards he would masturbate using images of the scene. Although he usually found the urge to peep irresistable he experienced guilt afterwards.

Because of the regular sequence of events involved in his behaviour, means of self-regulation were suggested. However, he was unable to resort to one alternative pattern of behaviour (inviting a friend to his digs to have coffee) when the urge to peep occurred. Therefore it was suggested he go home and masturbate when the thoughts about peeping first occurred. Initially he used fantasies of peeping, but later, when he had been able to avoid peeping by this means on several occasions, he was instructed how to gradually modify the fantasies to one of him having a sexual relationship with a girlfriend. At this stage he commented that he had noticed that thoughts concerning peeping also occurred during the day time. He therefore started to practise covert sensitization when these thoughts arose, using the image of his being caught and ridiculed by a group of girls as the aversive thought.

(b) A 21 year old university student sought professional help because of anxieties about his homosexual interest, which he regarded as out of keeping with his religious beliefs. He had never been attracted to girls, although easily able to form platonic relationships with them, but had strong sexual feelings towards men including a current emotional attachment to a male friend. Nevertheless, he insisted he wished to try and develop heterosexual interest. After a thorough assessment, the psychiatrist explained that he thought this was probably not feasible, but, because of the patient's insistence, offered him a limited contract of four sessions during which this would be the goal. He was instructed in a gradual fantasy-shaping procedure to be used during masturbation. After four sessions he had made no progress at all in modifying his fantasies, finding any sort of heterosexual image non-arousing although not anxiety-provoking. By this stage he had accepted that his sexual orientation was likely to remain homosexual, but expressed anxiety as to how he could get involved in homosexual circles without becoming promiscuous. He was seen for three sessions of counselling in which he was encouraged to recognise that he was master of his emotions and his behaviour. Finally, he was encouraged to contact two university gay organisations, including a gay christian group.

(c) A 24 year old factory worker, who had been married for two years, was referred after being caught by the Police stealing ladies' underwear from washing lines. His fetishistic interest had first developed in his mid-teens but declined when he met his wife. Their sexual relationship had never been satisfactory because of her inhibitions about sexuality which caused her to be unresponsive. Gradually his fetishistic interest returned; often he would go out and try to find underwear after unsuccessfully attempting to make a sexual approach to his wife. He would masturbate with the underwear, but afterwards felt disgusted.

As the difficulties in the couple's sexual relationship appeared to be fuelling the fetishistic interest, and the wife was keen to do all that she could to help, it appeared that attention would best be directed to the

wife's sexual difficulties. The couple participated in a sex therapy programme, in which particular attention was paid to the wife's lack of sexual information and the need for her to be allowed more time to become aroused. In addition, she was helped to examine some of her attitudes and see how these had developed from her restricted upbringing and were at variance with what she really wanted. No direct attention was paid to her husband's fetishistic interest, which neverthless had disappeared almost completely by the end of successful treatment of the sexual dysfunction. After a further two years the couple's sexual relationship remained satisfactory and the husband no longer experienced any fetishistic interest.

6. *Monitoring progress*

Another important component of the behavioural approach is careful assessment of progress. There are three means of doing this:

(i) *Patient's self-report.* In spite of the development of what appear to be more sophisticated methods, the patient's account of his behaviour will remain the therapist's main source of information about progress. A diary in which the patient records his thoughts and acts, of both the deviant and the desired kind, can be a very useful means of obtaining such information. The therapist must bear in mind the possible falsification of information that can occur. The report by Rosen and Kopel (1977), of the outcome of treatment of a man who engaged in cross-dressing and exhibitionism, which had to be modified just before publication when his wife revealed that he had lied to the therapists about his progress, serves as a cautionary tale.

(ii) *Attitudes to deviant and non-deviant behaviour.* These have been assessed using, for example, a semantic differential technique (Osgood *et al*, 1957) in which deviant and non-deviant stimuli or behaviours are rated on a series of seven-point scales including sexual attractiveness, anxiety, approachability and general evaluation (Marks and Sartorius, 1968; Bancroft, 1974). Such techniques are also open to falsification.

(iii) *Psychological measures.* Where appropriate facilities exist a patient's physiological responses, including erections, to deviant and non-deviant slides, fantasies, or audio recordings can be obtained. These procedures have been described in full elsewhere (Bancroft, 1974). Even such an apparently objective approach to assessment can provide misleading results, should a patient use distracting sexual or other fantasies to modify his responses.

Most therapists will rely on the patient's self-report, possibly augmented by a pencil and paper method of assessment. Baseline measures should be obtained before treatment, and the measures should be repeated at regular intervals throughout treatment. Careful assessment measures obtained at appropriate times are particularly useful in determining the effects of introducing new procedures.

7. *Duration of treatment*

The management of patients requesting help with regard to deviant sexuality can often be fairly lengthy and should not be undertaken without recognition of this fact. However, the chances of success with a particular approach are usually apparent early in the treatment. There is no point in continuing with a line of treatment if no progress had been made after 10 sessions (Bancroft, 1974). Indeed it is often clear by session 5 or 6 whether it is worth proceeding. Should no progress be made the therapist must re-examine both the goals of treatment and the approach being used. One may need to continue seeing the patient for a considerable time after the main body of treatment has been completed in order to provide help in maintaining and consolidating progress, or in helping a patient come to terms with the fact that it has not been possible to assist him to achieve his original goal.

Conclusions

During recent years there has been a considerable change in the pattern of requests for help with deviant sexuality, with a great reduction in the demand for assistance with the suppression of deviant interest but with perhaps more patients wanting help with adjusting to their deviant sexuality. Furthermore, even with patients in the first category, many clinicians appropriately take the view that it is often best to concentrate on trying to facilitate desired behaviour, with attention to deviant sexual behaviour being very much a secondary consideration. However, whatever aspect of sexual behaviour is the main focus of treatment for an individual patient, the broad principles of the behavioural approach, including a thorough assessment, graduated behavioural tasks combined with careful examination of factors that interfere with progress, and the usual "non-specific" components of such treatment (e.g. general support and encouragement, acceptance, warmth and understanding), provide a very practical basis for trying to help many patients with problems concerning deviant sexuality.

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