PARADIGM LOST OR PARADIGM REGAINED? BEHAVIOUR THERAPY AND HOMOSEXUALITY

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This paper examines some ethical, ideological and practical considerations in attempts to change sex orientation through behaviour modification methods. Possible outcomes are examined and responsible alternatives suggested which are ideologically, ethically and clinically acceptable.

There is considerable danger that behaviour therapists will attempt to apply their techniques to the change of many unconventional behaviours, whether they require it or not. This may well occur regardless of whether that change is ethically or ideologically justified in the circumstances. In our eagerness to make use of our behavioural technology, it would appear that total change has become of paramount importance, rather than adaptation through its less spectacular use.

Male homosexuality is a case in point: a large body of literature dealing with behaviour therapy as a method of change exists. Yet the ideologies behind the use of behaviour therapy, the dangers of misuse and attempts at total changes, the ethics of the situation, and above all the alternatives, have been virtually ignored up to the last two or three years.

Wolfenden (1957) concluded with this comment:

> We were struck by the fact that none of our medical witnesses were able . . . to provide any reference in medical literature to a complete change. Our evidence leads us to the conclusion that a total reorientation from a complete homosexual to a complete heterosexual is very unlikely indeed.

In spite of the application of behaviour modification techniques, this would still appear to be true. Why, then, has there been such an effort to "cure" homosexuals?

Ideological Considerations

In order to examine the motivations of behaviour therapists it is essential to examine the ideologies and beliefs behind these efforts. Bell (1960) defines ideology as "the conversion of ideas into social levers". In the case homosexuality, the ideology of behaviour therapists refers primarily to the transfer of the idea that homosexuality is an "illness" or sufficiently non-conforming to be dangerous, to action to remove the homosexual behaviour.

Central to any attempt at "cure" is the belief that homosexuality is an "illness". Szasz (1960) comments:

> Mental illnesses are, for the most part, communications expressing unacceptable ideas, often framed in an unusual idiom. . . . The psychologist is committed to some picture of what he calls reality, and to what he thinks society considers reality, and he judges the patient in the light of these beliefs.

It becomes clear that one cannot deny the moral aspects of psychology and suggest that medical concepts, especially in the case of homosexuality, are value-free. In fact, given the large body of experimental evidence that has demonstrated that homosexuality cannot be considered an "abnormal practice" (summarised by the American Psychiatric Association on its decision to remove homosexuality from its list of mental disorders, April 9, 1974), it would seem fair to conclude that "Men make the definition of 'crazy' or 'not crazy', and then set themselves up as the saviours" (Miller, 1970), if the use of behaviour therapy for homosexuals is applied on the basis of its designation as a "deviation".

However, the most common basis for the use of behaviour modification techniques is that those who are not content with their orientation have the right to change. Nevertheless, their motivation of change will stem from the "illness" label for so many years placed on homosexuality, and the "abnormality" label still prevalent in public opinion. To go along with the suggestion that pressure for change in an individual results from social pressure is to admit that "Psychotherapy serves the function of maintaining the status quo of society . . ." (Winkler, 1972). The implication inherent in the former view is that social change is unnecessary, and that the status quo must be maintained. And to accept this is to suggest that either the present form of society is the ideal, or that society is unable to cope with even a moderate range of behaviours. If it is to be that all within a society must fit within a narrow range of "accepted" or "normal" behaviours, then the social evolutionary implications are enormous. Rohmer (1972) has suggested that homosexuality is part of a wide range of human behaviours which are necessary to provide sufficient range for evolutionary adaptation to whatever social or environmental changes may occur in the future. While homosexuality could not have been considered an adaptation in the past, the wide range of sexual behaviours of which it is a part, could.

Ultimately, the proscription of any behaviour must come down to the level of its effects on the life and welfare of others. If there is a deleterious effect, a society is justified in negative sanctions or proscription. But if this is not the case, then the ideological and practical implications of maintenance of the status quo are far worse than those of maintenance of individual freedoms.

The point has been made by Popper (1950) that individualism and collectivism are antagonistic principles. However, a critical difference between the two is that in an individualistic society, people are not prevented by force from forming voluntary associations: in a collectivistic society, people are forced to participate in certain organizational activities and are punished for pursuing solitary or non-conforming existences. Simply individualism seeks to minimise coercion and fosters a pluralistic society, whereas collectivism regards coercion as necessary for achieving it goals and leads to a singularistic society.

Szasz (1970) has commented that a human being is a person to the extent that they make free uncoerced choices. Given the distinctions made by Popper, the ideology of behaviour modification as it is currently used with homosexuality, is distinctly collectivistic (or socialistic). However, this need not necessarily be the case.

The ideological implications of behaviour therapy for homosexuality are important, too, in terms of current concepts of freedom. Sennett (1970) sees freedom as the "right to accept and live in disorder if one wishes". He suggests that community health will be based on individual health rather than the socialistic ideal of common social good, with a single overall pattern and limits for society. Thus rigid maintenance of norms and roles would tend to be typical of an extreme socialistic, repressive or totalitarian society and idealogy, and the converse would suggest some degree of anarchism in community development. If one is to take the view that community health is a function not so much of the common good for the general society but of the sum of the health of individuals in the community, then the healthiest society will be one in which the individual is able to express himself without fear of being forced within the narrow limits of the norm.

Davison (1976) describes the vast amount of literature on helping male homosexuals change their sexual preference, and the almost complete absence of work aimed at helping the labellers change their prejudicial biases and encouraging the homosexual to develop as a person without undergoing change. He goes on to quote Silverstein (1972):

> To suggest that a person comes voluntarily to change his sexual orientation is to ignore the powerful environmental stresses, oppression, that has been telling him for years that he should change.

While the ideological aspects of change are still important, on the patient side the ideological pressure inherent in the prevailing social norms is a complicating factor. Coleman (1971) concludes that:

> If there is no positive value on the dominant pattern, then homosexuality is a manifestation of a pattern which might, in the absence of social pressures, be as fulfilling as, or more fulfilling than, the dominant one.

Thus, he suggests, a person should be encouraged to see social norms as their problem, rather than their expression of their sexuality. With all the forces of society acting against the homosexual: family, friends, law, some churches and medical practitioners, is it any wonder that when asked if he wants to be homosexual or heterosexual, a patient wishes to change? It may be argued that it is easier to change an individual than society, but apart from the ideological implications, one must ask just how far the process can go. Social attitude change is possible, if one can regard the actions of publicly homosexual groups as "education" or "community systematic densitization". Law changes and attitudes of public figures and institutions also have their effects. To attempt to change an individual, a therapist is acting as an agent

of a society which could possibly better justify the label "maladjusted" than the patient.

We have already referred to attempted change of sexual orientation as impractical and impossible. However, this is not related to the separate issues involving ethical and ideological considerations: we must not confuse these aspects with practical applications of behaviour modifying procedures. As Davison (1976) has pointed out:

> Even if one were to demonstrate that a particular sexual preference could be wiped out by a negative learning experience, there remains the question as to how relevant this kind of data is to the ethical question of whether one *should* engage in such behaviour change regimens.

Practical Limitations

It would be instructive to examine briefly a couple of the better documented studies in the area of modification of homosexual behaviour in order to satisfy ourselves that there is a strong case to be made for discontinuation on both issues. Probably one of the more thorough works on aversion therapy (behaviour modification using aversive stimuli) is that of Feldman and MacCulloch (1971). They reviewed seventeen previous studies of application of aversion therapy to homosexuals and concluded:

> The review . . . has revealed a lamentable lack of information both on patients and treatment. Nor is there a single instance of a controlled trial in which . . . techniques are systematically compared. The impression gained is that for over ten years, treatment went on without adequate details on efficiency and effects.

Feldman and MacCulloch used homosexual practice after treatment as measures of success of failure. They note that 53 percent of subjects showed some homosexual behaviour after treatment, so it is hard to suggest a high level of success for "cure" of homosexual behaviour. However, the homosexual activity of many subjects lessened, and 32 percent showed heterosexual behaviour to some degree. When one considers, however, that of the sample 73 percent had had "significant previous heterosexual experience," the figures become less impressive Even when all homosexual behaviour had ceased, homosexual fantasies still occurred, demonstrating the gap between emotional and behavioural change in aversion therapy in this situation, in which both anticipatory and classical conditioning paradigms were used. Follow up, from eighteen months to two years, brought to notice two further patients who had "relapsed": one cannot help wondering how many more were not brought to notice.

The most favourable prognostic sign of Feldman and MacCulloch's 63 subjects was a pre-treatment history of pleasurable heterosexual behaviour: those showing such a history of more than twenty pleasurable heterosexual episodes of intercourse (39 percent) had the greatest chance of success. Since by this definition a large proportion of the sample were bisexual, rates of success are all the less startling. It

would seem quite reasonable to conclude that the therapy had no effect on predominant homosexuals, and merely facilitated the already present heterosexual side of behaviour in those who were bisexual. Success also depended on excluding all subjects with "poor personality" (defined as weak self control). If effectiveness could be described in terms of self control of the homosexual side of bisexual responsiveness, then the success rate is less surprising still. Considering all the factors acting for Feldman and MacCulloch's subjects: bisexuality, high motivation, "good" personality, the proportion of those "improved" at the end of the follow-up period is remarkably small. Any "success" could be as much due to factors inherent in the sample as to the treatment.

Lack of success probably occurs for three reasons. First, a response must be already established in a subject's repertoire before it can be facilitated. Second, the attempted removal of a homosexual response and replacement by a heterosexual one implies that such behaviours and their correlated emotional states are totally or to a large extent learned. While there is evidence to suggest that social learning may play a part in sexual response patterns, the etiology of sex orientation is still as vague as it was when von Krafft-Ebbing wrote on the subject nearly a hundred years ago. And third, there is some evidence (Ford and Beach, 1952) that sex per se is a primary reinforcer, which makes it doubtful whether attempts at change can either overcome its reinforcing effects or change its direction radically without a change in the correlated emotional internal states. Also, modification of homosexual fantasies has to date met with little success (Marshall, 1973). From the evidence to date, treatment of homosexual behaviour by aversive methods does not have any great effect on homosexual desire.

Possible Side Effects

While Feldman and MacCulloch's (1971) study raises questions concerning the various techniques of modification used, the half of the study who were judged as "improved", and the nature of the "improvement", an important question concerns the effects of aversion therapy on those who were not improved, the remaining 55 percent of those who agreed to treatment and the 94 percent of those who did not. It is clear that aversion therapy has some power to remove or repress homosexual behaviour. It is also clear that it is not able to replace it with heterosexual behaviour to any great extent, unless the latter is already present. It becomes obvious why there is no mention in the literature of those who are not classed as "successes" and who are quite possibly unable to express themselves physically to members of either sex. The Dutch Government Report of Homosexuality (Speiger Report, 1969, S 6, Para. 5, SubS 8) does refer to the problem:

> One wonders whether forms of treatment which negatively attack and humiliate the patient's existing love-object without putting something else positive in its place, are ethically responsible medicine.

The ideology of behaviour therapy, whether it be majority dictatorship,

laissez-faire neutrality or moral judgement, is at this stage of passing interest. The ethics of such a situation, however, cannot be ignored. Apart from the considerable possibility of patients being left unable to express themselves to others physically, or at least without some impairment of their expression, a generalization of guilt and a reinforcement of the attitude that homosexuality is "wrong" is a highly probable outcome.

Uncontrolled generalization is a particularly dangerous side-effect, in both "successful" and unsuccessful cases. In the London *Observer,* Foley (1973) reports:

> A homosexual in Los Angeles who underwent aversion therapy was happy to find himself attracted to women. There was, however, an unfortunate side-effect—men had become so completely repellant to him that even to shake one by the hand makes him physically ill.

Any treatment which produces such side-effects and has such a questionable rate of success, and in which even "success" can be dangerous since it is often defined as the lowering rate of occurrence of homosexual behaviour without the necessary replacement of alternate behaviours, is quite possibly bordering on the unethical when it is used as a treatment for an orientation considered neither a disease nor necessarily a maladaptation. Serber and Keith (1974) sum up the problem when they ask:

> Does anyone have the right to revise a person's entire value system in an area of behaviour which influences only himself and a consenting partner?

Indeed, does anyone have the right to attempt to do it in such a way, and with such a high possibility of dangerous side-effects coupled with a low rate of success?

Ethical Considerations

Some of the methods used are ethically questionable. Aversion therapy has been conducted using not faradic stimuli but drug injections as the unconditional stimulus. One drug commonly used in the United States is Succinylcholine (Anectine). It causes paralysis of all muscles, and patients are kept alive by mechanical devices. The Chief Psychiatrist at Vacaville State Hospital, California, is quoted as saying:

> The sensation is one of drowning. The patient feels as if he had a heavy weight on his chest and can't get any air into his lungs. The patient feels as if he is on the brink of death. (Richmond and Noguera, 1973).

The use of such methods for modifying behaviour such as homosexuality are ethically questionable. In response to lapses from the Hippocratic ideal in certain countries during the second world war, a modern restatement of that ideal was made in the Declaration of Geneva of 1947. Section 9 includes the statement:

> I will not use my medical knowledge contrary to the laws of humanity. (Medical Association of New Zealand, 1973.)

One cannot help wondering whether aversion therapy for homosexuals, especially with some of the techniques used and results produced, is "contrary to the laws of humanity".

When the behaviour it is attempting to change is so minimally, if at all, dangerous in our society, the issue becomes far more important. Bandura (1969) has this to say:

> Unconventional beliefs, styles of living and personal habits may be negatively sanctioned, even though these activities, apart from minor irritant value, rarely affect the welfare of others. Such pressures towards the standardization of life do constitute threats to personal freedom.

These pressures may well be forced on therapeutic agents. A report of Australian practice (Older, 1974) notes that two defendants were given the choice by a judge of undergoing psychosurgery or going to prison. While psychosurgery as a "treatment" for homosexuality is beyond the scope of this paper, the arguments against such measures are very similar. Pressures such as the above mentioned should not be used as excuses to attempt a change, and with a 6 percent success chance and side effects taken into account, such an attempt could well be regarded by some as approaching the unethical. Lebovici (1974) notes:

> Psychiatry has been no different in principle from any other branch of medicine . . . because any doctor can misuse his power, though such abuse is much easier in psychiatry where the ailment is intangible . . . Clearly, the practitioner has no right to cure people of their pecularities simply because they do not conform to ordinary social norms.

Responsible Alternatives

One is still left, however, with the situation of a person who is in some distress with regard to their homosexuality. The idea of change might not be entertained by a behaviour therapist familiar with the results and dangers of aversion therapy. What are the alternatives?

The most obvious alternative would be adaptation to the homosexual orientation, either through psychotherapy, or behaviour therapy. Serber and Keith (1974) have suggested that adaptation is the most effective and easy way of helping any patient who is not happy with his orientation, and give their own modification programme as an example. They observed that unhappiness with a homosexual orientation generally relates to an inability to express oneself adequately as a homosexual, or loneliness and isolation from the homosexual subculture. Attempts to change orientation are seen as failing to get at the root of the dissatisfaction and treating symptom rather than cause. At a more general level, Davison (1976) has suppored a similar programme:

> We might perhaps pay more attention to the *quality* of human relationships, to the way people deal with each other rather than to the particular gender of the adult partners.

Behaviour therapists, Brown (1973) suggested, should "Have the courage and integrity to forego waging battles on false fronts, finding solutions for substitute problems". In view of the implications and results to date of the substitute problems of attemping to change homosexuals to heterosexuals, change of the *dissatisfaction* with orientation using behavioural methods would seem to be an ethical, ideological and practical compromise for the therapist and promise a happier resolution of treatment of the patient.

Therapeutic Responsibilities in approaching Homosexuality

Aversion therapy appears to provide little benefit to those who are described as improved, and can be extremely deleterious to those in the majority who do not improve. It must be the responsibility of the behaviour therapist to be open about the dangers of attempting a total change in orientation. The therapist's responsibilities to a client have been summarised by Bandura (1969). Generally, it would seem (in terms of both method and outcome) that where the subjects themselves regard their homosexuality as a disorder, better to help them to fit happily into their social and emotional milieu by addition to, rather than subtraction from, their behavioural potential.

It is axiomatic that human rights and free choice should be available to all who seek help, whether of a behaviour therapist or any other agent. R. D. Laing (personal communication, 1973) has commented that "Aversion therapy . . . shouldn't be imposed on anyone who doesn't want it, who doesn't have a genuinely free choice. This is a benign, benevolent attack on a person 'for their own good!'." Addition of more alternatives in the client's repertoire, rather than lessening of alternatives, is therefore probably the most responsible course of action, unless one added behaviour pattern is mutually exclusive of another. If this permits people to enjoy their choice more, what Davison calls concern with the "Quality rather than the nature of the act", then this is probably responsible in the situation of the homosexual. But should homosexuality be treated in any way, if it is not considered a disorder? If "treatment", whether behavioural, analytic, chemical or psychotherapeutic, improves the quality rather than attempts to radically alter the nature of the mode of sexual expression and if such an improvement constitutes a step forward, rather than a retracing, of the path towards the individual's pursuit of happiness then in the case of homosexuality it could be regarded as a responsible application of psychological techniques.

Behavioural Ecology and Behaviour Modification

The argument for environmental control (Skinner, 1973) and through this, ultimately, control of the direction of human behaviour has emphasised the use of positive reinforcers as potentially the most effective. But one cannot help feeling with regard to Skinner's thesis, and the implications of behaviour therapy's uncontrolled additional

effects on a patient's behaviour and life-style due to generalization effects, that behavioural technology advocated by Skinner may produce a behavioural pollution through its attempts to sort out the best solution to a problem without regarding behavioural side effects. There is to date very little known about the relationships between various behaviours, and some disastrous results of unsuccessful attempts at change in sexual orientation are a prime example. Before major changes are attempted, far more must be known of the effects of such change in the total behaviour repertoire of the subject. Perhaps what is needed is a concept of behaviour ecology to combat the increasingly general and sometimes irresponsible use of behavioural modification without regard for more than the immediate consequences.

Rachel Carson (1962) wrote of the consequences of the indiscriminate use of biological pesticides. Reviewing the use of behaviour therapy on homosexuality, a similar sentiment could be expressed in terms of a behavioural ecology. The very nature of the forces used and their relative invisibility makes this imperative, if personal rights and ethical responsibility are to continue. This view is shared by Willems (1974), who sums up the problem in these terms:

> Within the larger context of behavioural ecology, self-defined successes may actually be failures, wherein unintended harm follows from short-term or narrowly circumscribed good.

This highlights the problems to date with modification of homosexual behaviour. What is being argued is simply this: male homosexuality cannot generally be regarded as a disorder, and thus modification of such a behaviour is not justifiable, except perhaps with the use of modification techniques to bring about adaptation to or acceptance of such behaviour. The methods (and ethics) used tend to compound the abuse of psychological techniques. These ethical and ideological arguments may well apply to other sexual variations still labelled "disorders".

We have looked at the ideologies behind behaviour modification, at current aversive practices with regard to attempts at change of homosexual orientation, at the ethics and responsibilities facing a therapist in this situation, and at some alternatives that are morally, ideologically and ethically a responsible compromise for the therapist as well as beneficial to the patient. We have looked at some of the more general implications of indiscriminate behaviour modification with regard to the total environment. And we can only conclude that, while Skinner feels that we can advance beyond freedom and dignity, our immediate battle is to keep freedom and dignity as concepts to go beyond, whether as therapist or patient.

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