GOALS AND STRATEGIES IN BEHAVIORAL TREATMENT
OF HOMOSEXUAL PEDOPHILIA:
COMMENTS ON A CASE STUDY

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Offered here is a critical evaluation of a case report by Kohlenberg in which a homosexual adult pedophile male learned to respond sexually to other adult males and less so to male children. The therapeutic program combined aversive "conditioning" and a modified Masters-Johnson graduated in vivo exposure regimen. The present authors support Kohlenberg's ethical decision to work toward a homosexual adjustment for his client, pointing out that the theoretical bases of behavior therapy do not include a pathology view of homosexuality as can he found in most other orientations to human behavior. However, the strategies adopted in the case report reflect an inadequate behavioral analysis of the client's problem. In particular, question is raised concerning the initial decision to employ aversive procedures, given that the client's problems included anxiety in approaching male adults. It does not seem necessary to interrupt a prepotent pattern of sexual behavior before attempting more positively to instate another set of feelings and responses, and the apparently favorable outcome of the in vivo exposure regimen lends support to this view. Publication of this unconventional case study will hopefully contribute to open debate of the social values that underlie decisions by clinicians as to their goals in therapy.

We are grateful for the invitation to comment on the case report by Kohlenberg (1974) in which a male homosexual pedophile learned to respond sexually to adult males and less to male children via a modified Masters-Johnson (1970) graduated in vivo exposure regimen. We shall make some observations first on the choice of therapeutic goal, then on the strategies employed.

GOALS OF THERAPY

The selection of therapeutic goals is closely linked to theories of normal behavior development and with values about what appropriate behavior should he. Accordingly, adoption of increased sexual responsiveness to adult males as a therapeutic objective for a homosexual pedophile may be unacceptable to many readers of this Journal. The psychotherapy literature—including behavior therapy—shows little serious consideration given to improved homosexual functioning as a legitimate and meaningful goal of therapy for a homosexually oriented client. In most instances this reluctance to facilitate homosexual adjustment is part and parcel of attempts at therapeutic heterosexual conversion, deriving from the assumption that heterosexuality is a biological–psychological norm and that homosexual attachments are the result of some pathological deviation from the normal psychosexual developmental process (e.g., Bieber, 1962; Hatterer, 1970; Socarides, 1970).

In the case of behavior modification, however, there is no theoretical justification for this bias inasmuch as the social learning viewpoint is consistent with Kinsey's contention that man is inherently only sexual, the direction of that biologically based potential being a function of critical social learning experiences (Kinsey, Pomeroy, Martin, & Gebhard, 1953). As with other forms of unconventional sexual behaviors, homosexual responsiveness is assumed to be acquired, maintained, and modified in the same manner as heterosexual behavior (Simon & Gagnon, 1970). "Normal" and "abnormal" are seen as labels that reflect the prevailing value judgments of society's labelers, and it is worthwhile to recall that at different periods in Western culture, and presently in many non-Western societies, homosexual behavior is often expected and even encouraged (Churchill, 1967; West, 1967).

The recent proposal by the nomenclature committee of the American Psychiatric Association to remove the category of "homosexuality" from the next revision of the Diagnostic and Statistical Manual illustrates how the psychiatric

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nosology is more a product of socio-historical pressures than of scientifically justified generalizations (Szasz, 1961).

As Bandura, (1969) has tellingly indicated, "behavioral therapy is a system of principles and procedures and not a system of ethics [p. 87]."

The client has decision-making primacy in setting the goals of therapy, the therapist’s role in this process being to explore alternative courses of action and assess their likely consequences so that the client may make an informed choice (for a more extended discussion of these issues see Bandura, 1969, pp. 102-112).

It is of interest, however, that despite this value-free social learning model, and despite survey results which showed that the vast majority of behavior therapists would help clients improve homosexual functioning (cf. Davison & Wilson, 1973), there has been a dearth of published reports describing behavioral programs directed toward helping homosexuals adjust more satisfactorily to a permanent homosexual identity. To this end Kohlenberg’s case report represents an important contribution.

As practicing behavioral clinicians and researchers we have elsewhere urged the serious reevaluation of heterosexual orientation as the commonly preferred therapeutic goal (Wilson & Davison, 1974). We have been impressed by the failure of available research findings to demonstrate either that the psychological difficulties of homosexuals are due to factors other than the prejudices suffered by an oppressed minority group or that homosexuals of either sex are necessarily more disturbed than comparable heterosexual samples (e.g., Kinsey et al., 1953; Loney, 1972; Saghir, Robins, & Walbran, 1969; Thompson, McCandless, & Strickland, 1971).

Accumulating evidence suggests that homosexuality can be a rewarding and viable life style. This reconsideration of the proper focus for behavior therapy is important for, despite some successes in orienting homosexually inclined persons to heterosexuality, the data thus far indicate that not all homosexuals have responded to this type of treatment (Birk, Huddleston Miller, & Cohler, 1971; Feldman & MacCulloch, 1971). Moreover, as Wilson and Davison (1974) have proposed and as Kohlenberg’s case study suggests, behavior therapy might be useful in helping homosexuals live more happily and effectively as homosexuals.

THERAPEUTIC STRATEGIES

While we clearly wish to reinforce positively Kohlenberg’s innovative efforts, his report unfortunately illustrates some problems in the clinical application of behavior therapy, discussed elsewhere in greater detail (Wilson & Davison, 1974). Of major concern is the apparent lack of an adequate behavioral analysis of Mr. M’s presenting problem; that is, what were the key variables maintaining his child molesting actions, and how did these determine the behavior change techniques which were selected for use? Like most behavior therapists, Kohlenberg assumed at the outset that the prepotent but unwanted behavior pattern must be directly interrupted before an alternative heterosexual repertoire could emerge and that aversive stimulation was the method of choice. Yet there is still no definitive evidence to support such an assumption. If in fact the lack of arousal toward adult males and associated apprehension and tension were responsible for the absence of adult sexual activity, then we wonder why techniques designed to modify these variables were reserved for the second phase of treatment and not accorded priority. Barlow (1973) made the same point in summarizing a good deal of clinical evidence showing that techniques directed at increasing alternative sexual repertoires are frequently effective even in the absence of any attempt to reduce directly current patterns of prepotent, undesirable behavior. At the very least, efforts to develop an alternative mode of sexual fulfillment could be concurrently combined with therapy aimed at eliminating pedophilic tendencies.

The gratifying results obtained with the modified Masters and Johnson (1970) treatment (a clinical innovation for which Kohlenberg is to be commended) suggest that the factors which were maintaining Mr. M’s sexual inadequacy with adult males were such as to render aversion therapy both inappropriate and unnecessary. Curiously enough, however, Kohlenberg attributed the failure of the aversive procedure to highly debatable speculation about the particular parameters of the conditioning method used rather than to a mismatch of problem and technique. We have suggested that this is typical of the behavioral literature’s over concern with the technical details of the conditioning methods employed at the expense of an adequate behavioral analysis of presenting problems.

The case report also suffers from the failure to include important additional clinical outcome details. For example, what was the nature of Mr. M’s subsequent adjustment to the adult homosexual world? How did he cope with the problems of living—both those peculiar to an unconventional life style and those held in common by most adults in contemporary society (cf.
Davison & Neale, 1974)? Was he happy? his occupational adjustment improved?

CONCLUSION

It would be churlish, however, to overemphasize these objections to Kohlenberg’s most interesting approach to a difficult and increasingly controversial area of clinical practice. The thorny decisions concerning social values that therapists, be they behavioral or not, have to make on a daily basis can best be resolved by their open and public airing (Kanfer & Phillips, 1970). After all, abstract principles and technical maneuvers are used by human beings who themselves are children of their culture. This Journal’s publication of Kohlenberg’s article should provide a necessary and welcome opportunity to further the debate.

REFERENCES


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