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Practice of Behavior Therapy (Chapter 6 from The Human Reflex)

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The definition of behavior modification is so broad—changing behaviors which are labelled as socially deviant in some social context—that the range of topics and behaviors that could be included in behavior modification is large. Possible topics include development of minimal social behavior in severely retarded individuals, developing academic skills in more mildly retarded and learning disabled persons, establishing speech and minimal social behaviors in psychoticly disturbed persons, modification of drug and alcohol abuse, elimination of smoking, weight reduction, development of more effective social skills, elimination of disabling fears and anxieties, and management of sexual behaviors. This chapter, however, is limited to the discussion of four of the more common problem areas encountered in an outpatient context: (1) fear responses; (2) depression; (3) assertive behavior; and (4) sexual behavior.

Fear Responses

While the definition of emotional behavior as respondent in nature is adequate from a technical standpoint, much of what the average person understands as fearful behavior is actually operant. In order to understand behavior therapy approaches to the treatment of disabling fears, it will be helpful to understand some of these complexities.

Most fearful or phobic behavior involves a complex interaction between operant and respondent behavioral processes. In the presence of a fear stimulus (e.g., a snake), emotional respondents are automatically elicited. Since the emotional responses produced in the presence of the snake are unpleasant, any performance that terminates those respondents will be negatively reinforced. Performances such as closing the eyes, turning the head, running away, or screaming until someone else comes and removes the...
snake, may thus be strengthened by the removal of the snake stimulus. 1

When the fear response is strong, as fear of snakes is for some people, any other stimulus that is associated with the presence of the snake may acquire the capacity to elicit the same emotional response, by the process of classical conditioning. Once this occurs, escape and avoidance responses will be reinforced not only in the presence of snakes, but also in the presence of any other stimuli associated with the presence of snakes. Thus people who have seen snakes in the park may avoid parks; if snakes have also been encountered in the back yard, they will stop going into the yard; and so on. In extreme cases, if such people are told that there is a snake in a cage in a room down a particular hall in a large building, they will refuse even to enter the hall. When avoidance responses like these are effective, such people may not experience much subjective fear, but may find their lives completely disrupted by the inability to go places or do things in a normal fashion. At an extreme, the person may become continuously fearful.

In approaching treatment to such fearful or phobic responses, several factors must be kept in mind. First, treatment must deal with both respondent and operant elements in order to be optimally effective. Second, it must be remembered that many fears are realistic, at least within limits (e.g., snakes are dangerous, and must be approached with due caution). But precautions such as those described above are generally recognized as excessive. Third, the conditions under which a particular response develops are not necessarily the same as those that subsequently maintain it. For example, a college student who experiences considerable anxiety about taking tests may initially miss a test because she had contracted the flu. Having once learned that exams may be deferred if she is ill, however, she may gradually come to voice complaints of physical illness whenever faced with a difficult test. Once reinforced for pleading illness, she may exhibit this response more and more frequently.

With a problem like snake phobia, several different approaches may be taken: systematic desensitization, modeling and imitation, and in vivo desensitization. Many common features may be found in these approaches. Each begins with activities or events in which the person experiences just enough anxiety to detect it, and pro-
gresses gradually to more difficult situations. Each involves the person making some other overt response to the feared stimulus in place of escaping from it: relaxation, observing another person interacting without fear or harm, or actually approaching the feared stimulus. Based on the principles of respondent conditioning, we would expect any elicited fear response to gradually abate if the person is exposed to the conditioned fear stimulus without experiencing any actual unpleasant effects. To the extent that operant performances are a part of the fear response, developing a new performance in the presence of the fear stimulus that is incompatible with the escape/avoidance performance should eliminate it.

The specific goal of treatment may depend on the needs of the particular individual. For example, a Forest Service employee who fears snakes might need to learn to recognize different types of snakes and become able to kill poisonous snakes when located in camping areas. For most individuals, however, a more likely goal is to develop the capacity to enjoy outdoor activities, with a moderate degree of caution, in areas with high risk of exposure to harmful snakes.

Another example of a fearful behavior pattern is that of Madge, a young woman who became anxious whenever she went out of the house. When her husband was along to comfort and reassure her, she was able to go many places, but when alone it was a major ordeal even to go out and pick up the mail. The mere thought of leaving the house by herself was enough to produce an anxiety attack: sweaty palms, heart palpitations, tightening in the stomach, chest pains, dry mouth, and so on.

Examination of the history of Madge's fear did not reveal any specific point at which the problem began; but it had been getting progressively worse over the last two or three years. When first married five years ago, Madge and her husband were very close, but after he graduated from college and began his present job as an engineering consultant, his work entailed frequent late nights at the office and periodic travel to distant cities. Madge felt neglected and unloved. As Madge's problems became more severe, her husband found it necessary to curtail his travel and to spend more time at home; he was also unable to work evenings, because he had to accompany Madge on shopping trips and help with picking up the
children. As a result, Bill began to spend more time with Madge. He was sympathetic about Madge’s fears, but resentful of the need to do so much for her.

Madge’s treatment focused less on any possible fear responses than on the overt performances that pose problems: doing things outside the house. Since interaction with Bill was suspected to be the major reinforcement, treatment focused on making such interactions contingent on more adaptive responses. Since it was summer, and Bill liked to be able to spend time outdoors, it was agreed as a first step that Bill would try reading the paper in the back yard after dinner. If Madge decided to come out and join him, he would put down the paper so that they could talk together for a while. To make this time as pleasant as possible, it was agreed that Madge was not to mention her fears, and they were not to discuss any other unpleasant issues at this time. After a couple of weeks of intermittent success, this became a pleasant evening ritual.

The second step agreed upon was for Bill to meet Madge for lunch. A restaurant was chosen that was only a couple of blocks from home. The first time, Bill picked Madge up at the curb in front of the house. The next time, he arranged to meet her at the end of the block and the two walked together to the restaurant. After a few more “dates,” it was agreed that Bill was to arrive at the restaurant at a given time; Madge was to meet him there a few minutes later (to ensure that he got there first). In each of these steps, seeing Bill was the reinforcing consequence for Madge leaving the house.

After similar procedures for going to the shopping plaza, Madge began to find that she was able to go out fairly readily without experiencing anxiety attacks. She and Bill also found that their relationship had improved significantly. Bill found that he was spending more time with Madge than he had done for a couple of years, but was enjoying it much more than when she was having her anxiety attacks.

**Depression**

One of the difficulties in dealing with depression is that it may arise for a wide range of reasons. Failure in the academic or work
setting, death of a loved one, physical fatigue, illness, and major changes in personal circumstances may all be contributing factors in a given instance of depression.

In terms of the conceptual framework that was presented in Chapter 1, depression may occur because of the onset of large amounts of punishment, the cessation of reinforcement for a wide range of behaviors, or because of major changes in setting events (e.g., loss of sleep, major illness, loss of a loved one, and so on).

We generally view depression essentially as an emotional condition. It is important to remember that ongoing reinforcement and punishment experiences continuously affect a person’s emotional state, which in turn has setting events effects. Thus reductions in reinforcement or increases in punishment have setting event effects. These setting events generally reduce the probability of engaging in various responses, and thus further reduce reinforcement and/or increase the frequency of punishment, contributing to a downward spiral of increasing depression.

Jim’s experiences are a good example of the process described. He had studied long and hard for the bar exam, and looked forward to the day when he would be able to enter law practice with his father. Then he received the disappointing news: he had failed. Jim was crestfallen and embarrassed. The fact that several of his close friends had passed made things worse. Because he was too embarrassed to see them, he began to refuse social activities and quit playing tennis.

As time passed, Jim began to lie around the house all day, watching the soap operas. He began to have trouble sleeping. His appetite decreased and he drank more and more. As a result of all these factors, Jim’s health began to deteriorate. He became more and more depressed throughout this period, gradually coming to consider suicide as the only solution.

Several setting events contributed simultaneously to Jim’s depression. First, there was the absence of reinforcement for his study for the bar exam. Second, fatigue was likely to have been a contributing factor. Third, there was the social embarrassment of not doing as well as his peers. Quitting tennis and social activities cut off further access to reinforcement. Changes in diet, increased alcohol consumption, and loss of sleep added physical complications to the problems he already faced. All of these factors contrib-
uted to the apathy, inactivity, negative self-statements, and expression of desire to end his life that characterized Jim's depressive condition.

Because of the complexity of factors entering into Jim's present condition, no single approach was likely to be completely effective, and immediate and dramatic changes were not expected. The basic goal was to reestablish a normal level of social and work behaviors over a period of time, while ensuring that initial efforts met with sufficient reinforcement to sustain the effort that Jim needed to make.

The first step involved identifying existing reinforcing interactions, and using these to reinforce successive approximations to normal (nondepressed) activities. Watching TV and drinking bourbon were observed to be two major reinforcers; since the therapist had reservations about encouraging alcohol consumption, TV was chosen. The first step, then, was to complete an agreed-upon activity before the TV could be turned on. Jim agreed to eat a good breakfast before watching TV.

After a few days, Jim began to report enjoying his breakfast, and indicated some satisfaction with his progress. The breakfast-TV contingency was left intact for the time, and it was agreed that Jim would engage in one of two activities before drinking: efforts to find a job, or social activities. Each of these activities was carefully defined. Seeking a job included (1) contacting a prospect and arranging an interview; and (2) participating in an interview, whether arranged for by Jim or by an agency with which he was willing to work. Social activities were defined to include playing at least nine holes of golf or one set of tennis; Jim was free to do more if he desired, but must complete the minimum amount before taking a drink. If he did none of these activities on a given day, he agreed he would abstain.

After a few days of intermittent success and failure, Jim was fairly regularly engaging in social activities, mostly tennis. Job interviews were slower to develop. Since Jim had begun to enjoy his tennis games again, it was agreed that he would play tennis on Tuesday and Thursday only if he had completed one job-related activity in the preceding two days. Within two weeks after this change in procedure, Jim had located a job and agreed to begin work on the following Monday.
Although the most difficult part of the work had now been accomplished, it took several additional weeks for Jim to complete dealing with his periodic episodes of depression. A major factor was working out a plan for reviewing the areas in which he was weakest, and planning to retake the bar exam about a year later.

Assertive Behavior

Perhaps the simplest way to conceptualize assertive behavior is to suggest that assertiveness is the midpoint on a continuum from passivity to aggressiveness. The passive person does not express opinions, wants, hurts, requests and so on. Through failure to take action, such a person fails to gain satisfaction from the social environment. The aggressive person tends to respond too hastily, to pursue courses of action without regard for the rights and privileges of others, or to actively seek to harm or exploit others.

Assertiveness may be defined as: (1) giving value to oneself and one's own desires and opinions; (2) freely initiating interactions with others; or (3) expressing an opinion, defending a position or action, or pursuing a goal in spite of obstacles or the opposition of others, so long as the rights of others are respected. Assertiveness implies a positive attitude both toward the self and toward others. By contrast, passivity suggests a negative attitude toward self, while aggression suggests a negative attitude toward others.

Historically, assertion and aggression have been viewed as overlapping or even synonymous domains of behavior. Psychologist Joseph Wolpe originally defined assertion to include "not only more or less aggressive behavior, but also the outward expression of friendly, affectionate and other nonanxious feelings." The first item on the Rathus Assertiveness Scale, one of the more widely used scales, reads: "Most people seem to be more aggressive and assertive than I am." And in his 1973 American Psychological Association presidential address, Albert Ellis suggested that assertion is one form of aggression, perhaps the healthiest form.

More recently, a number of critics have pointed out some of the difficulties posed by this view that assertion is a form of aggression. Echoing these criticisms, Psychologist Paul A. Mauger and his colleagues have recently developed the Interpersonal Behavior Survey (IBS), with the explicit purpose of assessing assertive and aggressive behaviors in a single inventory. Results of research and scale
construction suggest that assertion and aggression, as measured by the IBS, are independent behavioral dimensions. This implies that assertion and aggression may be viewed as distinct forms of behaviors.5

The IBS has high reliability, and has been shown to be sensitive to the effects of assertion training. One limitation is that it does not assess the roles of situations and persons in assertive performances. Thus, in assessing assertive performances, it is necessary to use self-report data and records of behavioral episodes to supplement data from the IBS. Such data may reveal that the person is generally assertive, but is passive in relationship to one or two key individuals, often his or her spouse or boss.

To put the assessment question differently, it is important to distinguish between deficits in the person’s skill repertory and deficits in the occurrence of available performances due to problems in stimulus control or to suppression of available responses by real or anticipated punishment.

Several steps are involved in training assertive behavior. The first step is assessment of the person’s current repertory of assertive performances. The IBS may be used in this process. Additional data may be gathered by means of behavioral interviews, which focus on collecting specific details of the person’s interactions with others, and through direct observation. For example, a woman who has difficulty refusing requests for personal favors from coworkers may be asked to keep a written record of these requests and her responses.

Once the preliminary assessment is completed, training progresses along several fronts. First, it is helpful to explore people’s expectations and fears about the reactions of others to assertive responses on their part, and any unpleasant experiences that they may have had in the past when attempting to be assertive. People who have been punished in the past for efforts to be assertive may need a great deal of encouragement to begin to explore the possibility that such punishment is presented only by one or two key individuals.

A second avenue of approach involves presenting a rationale for assertiveness. People often believe that expressing their own opinions, requesting things they want from others, and so on, are “wrong.” Here again, values enter; it is helpful for people with a biblical orientation to show examples of assertiveness in the Bible
and explicit biblical teachings that encourage assertive performances.

A third approach is to encourage people to observe how others handle similar situations and the resulting consequences. This serves to expose them to constructive models, and also may help to alter expectations about the consequences of assertive responses.

Fourth, they are encouraged to participate in behavioral rehearsal or role-playing of new responses to others. For example, the therapist may first play the client, while the client plays a coworker. The therapist models appropriate assertive performances. Roles are then reversed, and the client is asked to practice the same responses in the session. This stage often proves to be very difficult, but also to be highly productive.

Finally, the client is encouraged to practice with individuals in their living environments. Frequently, this is first initiated with people who are not very significant in the client’s life; then, as skill and confidence develop, the client is encouraged to try the new performances with key persons.

For example, Mamie, an attractive wife and mother, was employed in a large business office. Her boss and coworkers frequently asked personal favors of her; she almost always said yes, but frequently resented the requests and found them to be an imposition on her time. She viewed herself as a helpful, loving person, who did things for others as her “Christian” duty. At the same time she resented it, and struggled with her feelings of resentment, which she viewed as sinful.

In therapy, Mamie was helped to see that she was already failing others frequently. Because of the overwhelming burden of requests at work, the needs of her family were often neglected. Once it was clear that the task she had set was impossible, she was helped to evaluate where her most important responsibilities to others lay; she concluded that her family had to be placed first. Next, she was confronted with the possibility that she did things for people in an effort to get them to like her. This was interpreted to her as selfish. Mamie was reminded that God called upon her to deal with others in love, and that they would like her more if she dealt with them in such a fashion.

Once Mamie had come to agree that she needed to learn when and how to say no to others, she was encouraged to observe others around her to see how they handled refusing requests, and to
evaluate the effectiveness and desirability of the approaches she observed. Role-played interactions with key persons were begun; in these Mamie refused realistically presented requests. Initially, Mamie had a great deal of difficulty with these; her “no” sounded more like “yes.” She was praised for her effort and encouraged for progress. Many specific suggestions were given in helping her to improve her presentation of her “no” responses.

Once Mamie had begun expressing a convincing refusal statement in treatment sessions, she was encouraged to practice saying “no” at work. Again, her initial efforts were not well presented, and consequently not very effective. By now, however, she was able to evaluate her own performance and to see ways in which she needed to change to become more effective.

Once Mamie had begun to refuse requests effectively, treatment turned to being assertive in other contexts. Mamie continued to improve in saying “no” over the next several months, as other areas of assertiveness were developed. The therapist provided additional encouragement, but the freedom from unwanted responsibilities was the main reinforcement for refusing requests.

Before leaving our discussion of assertive behavior, some comments must be addressed to the ethical issues surrounding assertiveness. The danger exists that assertion may become blatantly self-serving. Joseph Wolpe, for example, suggests that the goal of assertion is for the individual to place the self first, but to take others into account. The biblical teachings in this area suggest that Wolpe, and apparently many others, have gotten the emphasis backward. Biblical teachings emphasize giving preeminence to others rather than to the self. Similarly, it is common for personal rights to be emphasized in presentations of assertiveness, most notably in the popular book, *Your Perfect Right.* In contrast, the Bible seems to say little, if anything, in support of personal rights, but a great deal in support of the right, with focus on righteousness, justice, and mercy in dealing with others. Assertiveness serving these values can be shown to be consistent with biblical teachings; self-serving assertiveness is contrary to them.

**Sexual Behavior**

Concerns with sexual problems have become sufficiently common in recent years that a new specialty area, sex therapy, has
developed. Because entire books have been written on various approaches to sex therapy, it will not be possible to present here anything approaching a comprehensive overview of behavioral approaches to treatment of sexual behavior. However, we will introduce some of the issues and basic strategies employed in approaching sex therapy from a behavioral perspective.

The first point to be emphasized is that both sexual attitudes and sexual performances are learned. As sex researcher Alfred Kinsey and his colleagues note, "An individual learns how to utilize particular techniques in petting, in coitus, or in homosexual or other relations...." Thus, from a behavioral perspective, sexual performances—whatever their form—are viewed as learned performances. One of the problems in the area of sexual behavior is that, while sexual performances are learned, they are rarely taught in any systematic way. Parents and teachers are involved in teaching reading, grammar, table manners, athletic skills, and so on. But, too frequently, little explicit sexual teaching goes on except at the level of communicating attitudes toward sexual performances of various types.

A second factor that must be recognized is that sexual behavior is quite complex, involving an intricate interplay of operant and respondent behaviors. Much of the physiological pattern involved in sexual arousal is respondent in nature; however, the particular stimuli that come to elicit the pattern of sexual arousal are learned in social contexts. In addition, the actual overt sexual performance is largely operant in nature. The particular sexual partners, forms of sexual interaction, and so on, are learned operant performances. Thus approaches to treatment of sexual behaviors must consider both respondent and operant components of sexual behavior.

A third factor to keep in view is that, while sexual responding is in many ways a natural physiological process similar to respiration, elimination and circulation, it is unique in one respect. As William H. Masters and Virginia E. Johnson, a noted sex research and therapy team, observe, "Sexual responsivity can be delayed indefinitely or functionally denied for a lifetime." This implies that there is no biological necessity for sexual expression; a person who has no sexual "outlet" will not experience any physical harm as a result. Because of this factor, it is possible to defer sexual activity until an appropriate social and physical context is
available, or indeed to forego sexual activity entirely, as is the practice in some religious communities.

Another factor to be emphasized is that concerns about sexual functioning and expression cannot be divorced from social contexts. A central concern of the Masters and Johnson approach to sex therapy is a focus on dealing with the relationship between couples who are experiencing sexual difficulties. “The basic means of treating the sexually distraught marital relationship is, of course, to reestablish communication... Obviously, the more stable the marriage the better the climate for effective sexual function... the marital relationship per se is under treatment.”

Basically, a good interpersonal relationship is central to a satisfying sexual relationship. This reemphasizes the social characteristics of sexual behavior.

The varieties of sexual disorders are numerous, including such forms as homosexuality, sadism, masochism, fetishism, impotence, orgasmic dysfunction, vaginismus, dyspareunia, exhibitionism, voyeurism, and many others. Here we will limit our discussion to two forms of sexual disorders, impotence and homosexuality.*

**IMPOTENCE**

Impotence in males involves inability to attain intercourse through one of two difficulties: (1) premature ejaculation, which occurs either before or immediately upon penetration; or (2) failure to attain an erection. The behavioral approach to impotence proceeds along lines that largely parallel the procedures of systematic desensitization. Systematic desensitization for a hierarchy of visualized sexual acts may be used as an accompanying strategy. First, the man is encouraged to avoid further failure experiences. Second, the couple is encouraged to engage in progressively more intimate sexual activities when there is a strong desire to do so, but to stop at the first signal of anxiety or tension.

Psychologist Barry McCarthy describes a behavioral adaptation of the Masters and Johnson procedures for outpatient therapy treatment of couples with male impotence. In the treatment process, “[Sex] was defined as an area of their lives that they had to

*A number of good sources may be consulted for more detailed discussions of behavioral approaches to these and other forms of sexual disorders."
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learn about and then learn as a couple to respond to each other. The pleasuring or sensate focus procedures were introduced as a primary means of beginning this process." The "sensate focus" procedures developed by Masters and Johnson involve a systematic exploration between the partners of the role of physical touching in providing pleasure.

Aided by specific direction from the recipient partner as to interest in specific body area and intensity of touch desired, the "giving" partner is to trace, massage, or fondle the "getting" partner with the intention of giving sensate pleasure and discovering the receiving partner's individual levels of sensate focus. If neither partner has any idea of physical preference, a gentle trial-and-error approach is suggested.

In the McCarthy variation, the couple is instructed to practice three days, rest one, then practice the remaining three days before the subsequent weekly session. They are told to practice explicitly and in sequence: (1) sensate focus, eyes closed, no genital touch; (2) sensate focus, eyes closed, no genital touch, spouses guiding each other; (3) eyes open, no genital touch, guiding each other; (4) off day; (5) sensate focus with lotion, no genital touch; (6) genital touch with eyes closed; (7) guided sensate focus with genital touch, eyes open. "However, the couple is told they need not view this as a rigid program, but rather as a guideline. The first few exercises are carefully and fully programmed, but . . . the structure of programming gradually decreases and the couple are encouraged to be spontaneous and experiment." Through gradual engagement in more explicit forms of sexual activities such as sensate focus exercises (which involve systematic exploration of ways to experience physical pleasure short of coitus, while insuring avoidance of unpleasant experiences), the natural reinforcement for those behaviors will gradually strengthen them. At the same time, the stimuli that elicit anxiety will gradually lose their effectiveness as unpleasant outcomes are avoided.

A supportive relationship with the sexual partner is vital to the process of treatment described here. The partner must be willing to cooperate in engaging in a variety of sensate focus exercises with the person experiencing difficulty, and to cooperate in not forcing efforts to engage prematurely in coitus, thus again risking failure.

Emerging data on the effectiveness of behavioral sex therapy ap-
proaches suggest that impotence can be effectively treated when the marriage relationship is adequate, but severe marital conflict prevents effective treatment. For this reason, marital therapy is recommended as a standard preliminary procedure for couples who present significant levels of marital conflict.

HOMOSEXUALITY

Homosexuality, per se, is no longer recognized as a mental disorder by the American Psychiatric Association, though the decision to delete it involved considerable controversy. However, provision is made for classifying those persons who present themselves as homosexual, and who experience discomfort or dissatisfaction in their homosexual relationships. Although more controversial than treatment of impotence, and thus less carefully investigated, behavioral approaches to altering sexual orientation in practicing homosexuals who wish to change their sexual orientation have shown some promise.

Even more so than with impotence, homosexuality involves a diverse range of behaviors both in kind and in frequency. Further, the degree of homosexual involvement relative to heterosexual involvement is quite varied. Kinsey and his colleagues used a seven-point scale to rate the relative degree of homosexual experience in their study. Because of these complexities, it is necessary to assess the specific sexual practices of the person and relate these to decisions about treatment approaches and investigations of treatment outcomes in altering sexual preference.

Behavioral approaches to changing sexual preference are varied, and combinations of the various discrete techniques are often used in dealing with a particular person. In general, the basic goal of treatment has been to increase heterosexual activities and decrease homosexual activities. Techniques include (1) desensitization of aversion to members of the opposite sex; (2) training in social interaction and assertion especially with members of the opposite sex; (3) aversive conditioning for sexual stimuli associated with the same sex; (4) use of sexual imagery with members of the opposite sex; and (5) use of explicit heterosexual stimuli. In addition, work on development of better self-esteem to facilitate approaches to members of the opposite sex has also been employed.

Let us use Bill as an example of a client who sought treatment
with the indication that he was concerned about his homosexuality, and wished to become heterosexual. Bill was a dorm resident at a small college. He had been raised as the child of a missionary/minister, and most of his high school period was spent in Africa, where his peer contacts were limited largely to one girl, about five years older than himself, who was much like a sister to him. Bill’s sexual experience was limited to a couple of episodes of explicit homosexual interactions initiated by an older brother, and to masturbation accompanied by fantasies of sexual activities with members of the same sex.

The major elements of the presenting problem for Bill seemed to include (1) strong heterosexual taboos, affirmed when a brother impregnated a girlfriend; (2) an explicit homosexual experience; (3) the eliciting function of male stimuli for sexual arousal established by masturbation associated with same-sex imagery; and (4) general passivity in social relationships, especially with young women.

At the time therapy was initiated, Bill reported having a relationship with a young woman, but he was troubled by it in two ways. First, there were his fears about his sexual orientation. Second, he felt “trapped” in the relationship because it had developed with the daughter of a family with whom he had lived during the previous summer.

In working with Bill, treatment began with a behavioral rationale for his present attraction to males. The pairing of sexual gratification with male stimuli was pointed out, and the attraction to males was described as a natural result of this experience combined with the strong taboos Bill had experienced associated with heterosexual behavior. Treatment was then described in learning terms to involve learning to associate sexual arousal with members of the opposite sex and detach it from members of the same sex.

Treatment progressed along several lines, more or less simultaneously. Bill was encouraged to discuss his relationship with his current girlfriend, and ask that they each be open to dating others for the present time. A second task was to begin to identify those features about males that he found sexually attractive, and to look for similar features in females. Fortunately, Bill found that the qualities in males that appealed to him were largely “feminine” qualities; thus it was easy to locate pictures of women whom he
found attractive in various popular news magazines. Bill agreed to refrain from masturbating with male images. He reported that he saw nothing wrong with masturbation per se; thus it was agreed that, if he masturbated, he would use female or autoerotic images.

Although Bill did not become very actively involved in dating other women, he did develop some closer relationships with both female and male peers. As Bill’s relationships with peers improved and his concept of himself as a normal male began to develop, he experienced renewed interest in the relationship with the young woman he had come to know the previous summer; he no longer felt “trapped.”

Treatment was terminated at the end of the school year when Bill left town for the summer. At that time, he reported a growing interest in relationships with women, especially in a sexual sense (although he seemed committed to reserve expression of this interest for a marriage relationship) and no further concern with homosexual tendencies.

**BIBLICAL PERSPECTIVE ON SEXUALITY**

During the mid-60s, the prevailing opinion among the clinical faculty I knew was that the treatment approach of choice with homosexuals was to convert them into practicing heterosexuals. One professor expressed the wish that a “stable” of cooperative females could be made available to provide the opportunity for explicit sexual experiences as a part of the treatment process for homosexual males. In the interim, professional opinion has shifted toward the view that the desired treatment goal is to help the homosexual become comfortable with his or her orientation.

The prevailing attitudes among therapists toward sexual behavior reflect a cultural-relativistic position on what behaviors are acceptable. Upon examining them, one soon comes to the conclusion that, from a biblical perspective, there is not much to choose between these two alternatives. The biblical standard for sexual relationships emphasizes that the place for sex is within marriage. Homosexual and heterosexual activities apart from marriage are equally denounced. Although there is room for controversy, the Bible seems to be largely silent about the question of masturbation, thus leaving it as a matter of conscience. Thus individual judgment is required in determining how to handle masturbation.
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The biblical teachings about the context for appropriate sexual conduct focus largely on the area of goals. However, it seems reasonable to conclude that any treatment procedure that involves the use of explicitly forbidden sexual activities would be an unacceptable means of sex therapy. In this context, the approach to dealing with male impotence described above would be acceptable, since the goal of functional sexual relationships in marriage is biblically supported, and since the methods used seem to be consistent with biblical teachings as well. The treatment approach taken with Bill's homosexuality is a bit more controversial, chiefly in the sense that masturbation was not actively discouraged. Otherwise, the goals of developing positive social relationships and a sexual orientation toward females that is reserved for a future marriage relationship seems to be consistent with biblical teachings.

There is a growing awareness that good sexual adjustment is most likely to occur in the context of a constructive social relationship. Such a view is generally consistent with biblical teachings. One way of putting together biblical teachings with such findings is to conclude that the marriage relationship is the only relationship in which this is possible. Although the values of many behavior therapists are not consistent with the biblical position on sexual expression, evidence about the practical outcomes of therapy, nonetheless points toward a view of effective sexual functioning that is surprisingly close to the biblical standard.

NOTES

7. See Phil. 2:3–4.
8. Alberti and Emmons, Your Perfect Right.
18. Ibid.