DESENSITIZATION, RE-SENSITIZATION AND DESENSITIZATION AGAIN: A PRELIMINARY STUDY

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Summary—When desensitization was applied to a patient’s anxiety reactions to images of the theme of “infidelity” by his wife, his obsessive compulsive behavior progressively diminished. Then high anxiety stimuli were prematurely introduced into the treatment and the obsessive compulsive behavior recurred. It was finally overcome by resuming the standard progression of scene presentations.

This paper describes the apparently successful desensitization, re-sensitization and repeat desensitization of a case of obsessive-compulsive sexual behavior. The typical procedure for isolating effective treatment variables is the group comparison. An alternative approach is to attempt an intra-subject replication. The intra-subject replication can provide a demonstration of the functional relationship between antecedent and consequent variables. Comparing the procedures Sidman (1960, p. 85) notes, “Intra-subject and to a lesser extent intra-group replication provides a unique demonstration of a technique’s reliability”.

BACKGROUND INFORMATION

The patient, Mr. C., a 41-year-old, white, married male, was referred to our clinic by his family doctor for the treatment of “obsessive thoughts of a sexual nature which are disturbing his marriage and which threaten his employment.” The subject (S) had been married for 17 years and employed on the present job for 12 years.

S attributed the onset of his symptoms to the discovery (in the form of love letters) of his wife’s infidelity, 6 months prior to his first contact with the present therapist. His symptoms had apparently not responded to various medications prescribed by physicians. The primary presenting symptoms were restlessness, insomnia, sporadic crying and extended outbursts of verbal abuse (bitch, whore, etc.) focused on his wife. In addition, he had lost weight (approximately 30 lb), was demanding and attempting sexual intercourse with his wife several times a day (range 1–7) and was extremely suspicious of her. He appeared to have an “uncontrollable urge” to drop whatever he was doing several times a day and rush home to “check” on her, remind her of her infidelity, and have intercourse. The frequency of these unscheduled visits home was such that his employer was threatening to discharge him.

The patient’s wife admitted that she had been “unfaithful” (several sexual contacts with the same man in motels and in her own home) for a period of approximately 4 months, but insisted that after her husband had discovered her infidelity and “exploded”, all contacts (verbal and non-verbal) with her lover had ceased. She claimed that her marriage had been in a “rut” and that she did not “really love” the man she had been involved with. She said that she was sorry for the pain she had cost her husband and had attempted unsuccessfully to make it up to him in the last 6 months. But she claimed that his sexual preoccupations, abuse of her, loss of weight, and unauthorized absences from work had only increased. She stated that she believed he wanted to continue to punish her.

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The patient stated that since the onset of his symptoms his wife had improved her housekeeping, quit work, and was more attentive to him as a wife. S stated that he wanted to be hypnotized so that he could “forget” his wife’s infidelity and no longer be “possessed” by it. He stated that thoughts of his wife in different “positions” and “places” with her lover were what was “driving him crazy”.

METHOD
Formulation of treatment plan

“Psycho-dynamically” a sado-masochistic interaction between husband and wife seemed the central problem. The patient’s compulsive sexuality and his wife’s need to atone seemed to be reinforcing their complementary role enactments (Kelly, 1955).

The treatment plan was to desensitize the respondent consequences of the patient’s obsessive thoughts (operants) and to guide his thoughts toward a rationale or “insight” for giving up his symptoms, no longer to leave him vulnerable to future recurrences of infidelity. An attempt was also made to help the patient find some “meaning” in his present suffering. Specifically, he was encouraged to see his present symptoms as having contributed to some degree to the revitalizing of his marriage.

Preliminary procedures

The background information having been gathered in an intensive (2 hr) interview with S and his wife, separately and together, S was told that it would be 3 weeks before his next appointment. He was instructed to start keeping a careful record each Friday evening of his weight till treatment was terminated, and arrangements were made to weigh him on each visit to the clinic. In the course of a private interview with S’s wife, she was instructed immediately to start observing and recording 2 types of information about her husband’s behavior: (1) The frequency of all his visits home on working days between 8 a.m. and 5 p.m. (excluding the regular return home from work at the end of the working day). This class of observations would be an index of paranoid behaviors. (2) The frequency of his attempts at sexual intercourse (partial or total removal of his pants with statement of sexual

![Fig. 1. Frequency of paranoid and sexual behaviors per week in treatment.](image-url)
interest) with her each week. These observations would be an index of sexual behaviors. Careful observing and accurate recording were stressed and she was told to make every attempt to ensure that her husband did not know she was collecting these data. The decision was made to monitor these 2 areas (paranoid and sexual) of behavior in addition to his weight, because they seemed more amenable to objective specification than other symptoms and because they were very disruptive to his life.

In terms of Figs. 1 and 2, the initial intensive interview occurred at “0 weeks in treatment”. After the 3 weeks baseline period, the Stanford Hypnotic Susceptibility Scale (SHSS) Form A, was administered to measure the S’s current hypnotic susceptibility, since he had requested hypnotic treatment in the initial interview. His score on the SHSS was low (2) and the clinical impression was that he was resisting “induction”. After the administration of the SHSS, the S was told that the present therapist suspected that his “resistance” to hypnosis was based on the fear that through hypnosis the memory of his wife’s infidelity would be erased and that would leave him vulnerable to similar infidelities in the future. He was told that there was an “unpleasant” procedure involving sensory restriction (Wickramasekera, 1969, 1970) which might reduce his “resistance to hypnosis”, but an alternative “pleasant” method called “desensitization” which did not involve hypnosis was also available for treating him. He was told that desensitization would “drain the pain out of his memories but leave them fresh and clear”. The desensitization procedure was described briefly and presented as being “non-hypnotic”. He was told to think about these alternatives (sensory restriction and hypnosis, or desensitization) and make a decision before the next session.

First desensitization

In the next session (“4 weeks in treatment”) according to Figs. 1 and 2) the patient requested the desensitization treatment and hierarchy construction and desensitization was begun. The total hierarchy consisted of 48 scenes. The least aversive scene (1) was seeing himself at home lying on the couch listening to his wife cooking in the kitchen. The most aversive was (48) seeing Mrs. C. indulging in an “unnatural act” of sex with her lover on S’s own bed.
Each scene was put on a separate note card (total 48 cards) and very infrequently changed in order or content during treatment. Relaxation training was given both in the office and by means of a taped set of relaxation instructions recorded on a cassette tape. The portable recorder and tape were rented to S for a sum of $10.00 per week (not included in regular fee per treatment session). The major purposes of the recorder rental procedure were to motivate speedy acquisition of the relaxation skill and to increase the probability of the practice of relaxation in the patient's natural habitat.

Sessions were one week apart. Each session was 55 to 60 minutes. The only departure from the standard desensitization procedure (Wolpe, 1969) was that during the entire treatment (desensitization and re-sensitization) the patient was told to keep his eyes open and concentrate on the empty white wall in front of him.

Re-sensitization

An attempt was made to re-sensitize the patient in the 13th and 14th session of treatment. Wolpe (1958) observed and Wolpe (1969, p. 127) specifically states that “exposure and prolonged exposure in particular to a very disturbing scene can seriously increase phobic sensitivity.” Though an “obsession” may be different in many respects from a phobia, the present treatment procedure was based on the assumption that they had similar “respondent” (excessive autonomic arousal) consequences. From an ethical point of view there appeared to be no problem, since there was no solid evidence that “re-sensitization” was even possible with the procedure to be described below.

Re-sensitization consisted of telling the patient that “a slightly different but improved method will be used today. Please signal any discomfort or anxiety you feel in the usual way but continue to imagine the scene until I tell you to stop imagining it.” When the desensitization procedure was terminated, there remained 30 scenes which had not been presented. All 30 of these scenes were presented in rapid succession during the attempted re-sensitization procedure (sessions 13 and 14). During re-sensitization whenever the patient signalled anxiety (with left forefinger) the presentation was continued for 1½ minutes from the time the signal was observed. The re-sensitization sessions were approximately equal in length (55–60 minutes) to the regular desensitization sessions.

Second desensitization

Standard desensitization was resumed at the 15th session and continued until the 28th. Sessions were again one week apart, except that the 19th and 20th were 5 weeks apart.

RESULTS

The “baseline” was presented to the patient as a waiting period. During the baseline there was no verbal or other contact between the subject and the therapist. Both S and his wife called in their reports to a secretary, who recorded and plotted the data they reported. Fig. 1 shows that paranoid and sexual behavior increased somewhat during this period. Fig. 2 indicates that the patient’s weight remained fairly stable. During the first desensitization period (scenes 1–18) the paranoid and sexual behaviors declined steadily over time while the patient’s weight increased. Associated impressionistic clinical features included good rapport and lack of resistance in the treatment situation. S’s symptoms seemed to respond so rapidly that the therapist was genuinely sceptical about the existence of a functional relationship between the desensitization procedure and the symptomatic changes. The hypotheses of “spontaneous recovery” and/or a “placebo” effect seemed more likely.

During the re-sensitization period (scenes 19–48) the paranoid and sexual behaviors increased in frequency and the patient’s weight declined. Clinically, the patient seemed more agitated and depressed during the 14th and particularly the 15th session of treatment. The therapist continued to try to maintain rapport by being sympathetic and attentive. Before the 15th session, the patient’s wife called the clinic
and insisted on speaking to the therapist. She seemed extremely agitated and insisted that he was getting worse. She stated he had come home intoxicated twice, was eating less and not sleeping (lying in bed awake and sporadically abusing her and demanding intercourse). The therapist tried to be sympathetic and stated that all he could do was to continue to try to “find out what was wrong with the patient”. When the patient came in for the 15th session he seemed more agitated than ever before and was even “hostile”. He spontaneously stated, “Doc, last time you threw too much at me, you hit me with a sledge-hammer.” The therapist’s response was to accept the patient’s “insight” and to suggest that we “slow down and back up” to the previous procedure.

In the 15th session systematic desensitization was restarted 10 scenes down from where it had been stopped in the first desensitization phase. It was subsequently continued to scene 48. During this phase of desensitization the patient’s paranoid and sexual behaviors again declined in frequency and his weight began to increase steadily till termination. Clinically the patient also appeared to improve in terms of rapport and seemed more calm and optimistic about his future. Desensitization was completed in the 24th week in treatment.

Three additional sessions were spent mainly guiding the patient’s thinking towards a rationale for his previous “suffering” and reinforcing the view that through his symptoms his marriage had been “enriched” and salvaged from the “rut it was in”. An intensive follow up with a structured interview with the wife and husband 6 months after termination indicated that there had been no reactivation of the previous symptoms nor had new symptoms developed.

**DISCUSSION**

Since the patient’s obsessive thoughts were not directly observable (a covert symptom), three apparently correlated aspects of his problem were monitored. In the final analysis the relationship between the obsessive thoughts and his overt symptoms is only inferential. The two behavioral measures (paranoid and sexual) could be specified relatively objectively but the accuracy with which the patient’s wife observed and recorded these behaviors is unknown. Diagnostically it appears that the patient’s problem was of the “acute” type that is known often to “remit spontaneously”. But the observation that the symptoms could be manipulated up and down suggests the attainment of a measure of stimulus control over these symptomatic responses. How many reversals are necessary with clinical problems of this type is a question which has both statistical and ethical implications. It seems that the results of “implosive therapy” (Stampfl and Levis, 1968), and practical considerations have discouraged previous attempts to determine if the “re-sensitization” could be produced in the manner implied by Wolpe (1969).

One may doubt the generality of the phenomena demonstrated in this case study. But as Sidman (1960) notes, “Once we find that repeated manipulation of a variable produces consistent behavioral changes in a single organism, a failure to get consistent inter-subject replication simply points the way to a more intensive functional investigation.” Parametric studies of the variable in question should then be undertaken.

The re-sensitization procedure described in this paper seems relevant to what Eysenck (1968) has called the “Napalkov phenomenon” which he describes as “an increment in the CR over a period of time when the CS is applied once or a number of times, but without reinforcement.” Normally this procedure would give rise to extinction. Eysenck suggests that his concept of incubation, “increments in the CR after several evocations of the unreinforced CS”, is necessary to account for certain phenomena in the formation of neuroses and for the effects of “aversion therapy”. From his formulation of “incubation”, Eysenck derives two parameters. These are strength of the UCR and score elevation on
"neuroticism–anxiety–emotionality inventories". It would be interesting to see the results of further studies of "re-sensitization" with better controls and outcome measures along the parametric dimensions suggested by Eysenck.

Clinicians have anecdotally reported that "in vivo" re-sensitization occurs, but there does not appear to be any previous empirical demonstration in the literature of specific re-sensitization with a non-"in vivo" or imagination-relaxation procedure. The use of a desensitization-re-sensitization-desensitization design appears to be a promising approach to the validation and more intensive study of "active process variables" in systematic desensitization.

REFERENCES


(Received 24 August 1970)