A Failure of Early Behavior Therapy (circa 1966), Or, Why I Learned to Stop Worrying and to Embrace Psychotherapy Integration

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Reported here is the case of a man complaining of sexual diffidence who terminated a course of behavior therapy earlier than the therapist expected. Seen for four or five sessions by the author at the very beginning of his professional career in 1966, this patient may have been put off by one or more of the kinds of mistakes that, it is surmised, many early behavior therapists were subject to. Looking back on this therapeutic failure, the author understands better why he has taken a more integrative position over the past 20 years, and speculates on how a broadened perspective might have prevented the patient from leaving treatment prematurely.

KEY WORDS: psychotherapy failure; case studies; behavior therapy; psychotherapy integration.

During a postdoctoral clinical internship in 1966, a graduate student was referred to me by a former instructor for outpatient therapy in a private practice setting that I worked in on a part-time basis. As will be seen below in a short clinical vignette that I wrote for the sixth edition of the abnormal psychology textbook I have co-authored with John Neale (Davison & Neale, 1994), this young man saw me for no more than five sessions before he decided not to continue. While the early termination was amicable enough, this case remained unresolved for me for many years. From time to time I reflected on why occasional cases of my own in those earliest years and especially of graduate students I was supervising at Stony Brook left therapy early, usually to my own surprise and/or that of my supervisees. It seems safe to say that all therapists experience these failures—they are certainly not successes! —but we seldom if ever write or even talk about them, perhaps because we do not know what to say or to think about a patient who does not return for sessions that one had been planning. It is a truism that one is limited about the conclusions that can be properly drawn from successful therapies. It would seem that one can learn even less from failures. And yet, I believe it is instructive to consider possible reasons for a patient's premature termination. In the spirit of the present exchange with colleagues, I reproduce below with only minor editing the case as printed in Davison and Neale (1994, p. 364, by permission of John Wiley & Sons, Inc.).

Robert S. was a highly intelligent and accomplished twenty-five year old graduate student in physics at a leading west coast university who consulted a clinical psychologist for what he called "sexual diffidence." He was engaged to a young woman whom he said he loved very much and with whom he felt compatible in every conceivable way except in bed. There, try as he might, and with apparent understanding from his fiancee, he found himself interested very little either in initiating sexual contact or responding to it when initiated by his fiancee. Both parties believed for the two years of their friendship and later engagement that academic pressures on the man lay at the root of the problem, but an early discussion with the therapist revealed that the client had had little interest in sex—either with men or with women—for as far back as he could remember, and that his desire for sex did not increase when pressures from other obligations lessened. He asserted that he found his fiancee very attractive and appealing, but, as with other young women he had known, his feelings were not passionate.

He had masturbated very infrequently in adolescence and did not begin dating until late in college, though he had had many female acquaintances. His general approach to life, including sex, was quite analytical and intellectual, and he described his problems in a very dispassionate way with the therapist. In fact, he freely admitted that he would not have contacted a therapist at all were it not for the quietly stated wishes of his fiancee, who worried that his disinterest in sex would interfere with their future marital relationship.

After three or four individual sessions, the therapist asked the young man to invite his fiancee to a therapy session, which the client readily agreed to do. During a conjoint session, the couple appeared to be very much in love and looking forward to a life together, though the woman expressed concern about her fiance's lack of interest in her sexually. The following session was held just with the client, and the therapist outlined a tentative course of treatment, beginning with general discussions of sexual values and asking the client to masturbate once or twice before the next session, to get a clearer idea of what his sexual responsiveness might be to pictorial materials of his own choosing. The client said he would try to follow through, though he did not have a specific idea of what kinds of pictures he would find sexual arousing. Two days later he phoned the therapist to thank him for his efforts but to indicate that he did not want to continue therapy.

Among the many possible reasons the patient did not return, I offer the following:
1. He was put off by my early instruction for him to masturbate.

Though my patient did not express himself on this, I came to believe even then, but more so upon reflection, that his "sexual value system" (Masters & Johnson, 1970) did not accommodate as explicitly a sexual assignment as masturbation. I might also have introduced this "assessment-intervention" too early, perhaps in reaction to the stated urgency of the situation.

This possibility seems so obvious to me in retrospect that I am tempted to chalk up my (possible) error solely to inexperience and youthful enthusiasm. But I believe that more was at issue. When I saw this patient in spring 1966, the first Masters and Johnson book (1966) was just about to be published. Its straightforward approach to human sexuality, including filming volunteer subjects masturbating and having intercourse, was about to add considerable legitimacy to open discussions of sex, including the production and viewing of explicit sexual films in many health professional training programs as well as to patients seeking direct therapy of their sexual dysfunctions. I had also just had some clinical success with a technique dubbed "orgasmic reorientation" (and later, "Playboy therapy"), and had around the same time submitted a manuscript of a case of a student troubled by his reliance on sadistic fantasies for sexual arousal (accepted for publication just a few months later and appearing in 1968). I believe that the confluence of these factors conspired to my being overly focused (tunnel-visioned?) on how to help my sexually diffident patient become more sexual. One can never know, but I wish I had approached it more gingerly.

2. I did not probe enough on the possibility that he might be gay.

During the 1960s and into the mid-1970s, sexual reorientation for homosexuals was commonly a treatment target of behavior therapists (cf. Feldman & MacCulloch, 1971), even though the rhetoric in behavior therapy held that same-sex attraction was not abnormal, a conflictual position that I exposed as problematic in my 1974 Association for Advancement of Behavior Therapy presidential address and in subsequent publications (Davison, 1976, 1978, 1991). But I was a creature of the Zeitgeist, and I would aver that few therapists in the 1960s would have entertained the hypothesis that a young man engaged to a young woman and yet not sexual. I might also have introduced this "assessment-intervention" too early, perhaps in reaction to the stated urgency of the situation.

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3. I did not explore sufficiently some relationship problems between him and his fiancee.

A few years after seeing this patient, I began working with conventionally married couples and, in fact, was "converting" most of my individual therapy patients into candidates for conjoint therapy involving their partners (an example of the constructive nature of assessment that I have discussed elsewhere, Davison, 1991). I cannot know whether this construal would have been made with my sexually diffident patient, but I do believe that I did not consider carefully enough the nature and dynamics (if you will) of his relationship with his fiancee. As best I can recall, I was intending to do so after seeing him individually for a while but, of course, was denied the opportunity. Still, I would approach such a case more comprehensively today.

4. Related to 2 and 3, I took too readily at face value what he had told me to that point.

As I had the pleasure of recounting in my foreword to Paul Wachtel's classic book, *Psychoanalysis and Behavior Therapy* (1977), and believe even more strongly 20 years later, behavior therapists (at least of the 1960s-1970s genre) allowed themselves little in the way of inference when deciding what it was they should focus on in therapy. Perhaps this was the legacy of Eysenck's "Get rid of the symptom and you have eliminated the neurosis" rhetoric (Eysenck, 1959, p. 66, italics in original), but already by the late 1960s, behavior therapists were beginning to question the overly simplistic way we were carrying out assessment (e.g. Davison & Neale, 1974, p. 511; Goldfried & Davison, 1976, 1994, chaps. 2 and 3; Goldfried & Pomeranz, 1968; Lazarus, 1965, 1971). It did not take long for us to challenge whether "underlying cause" was necessarily a dirty expression. For example, Lazarus (1965) used the metaphor "neurotic roots" to caution behavior therapists against honing in too readily on what is immediately obvious in a patient's clinical picture. Bandura (1969), in his highly conceptual classic, spoke of the "strongest controlling variables" not necessarily being those that are most readily apparent in what patients bring to therapy. And Wolpe himself, who over the years has maintained a purer conception of behavior therapy than many of us (e.g., Wolpe, 1958), has always allowed himself considerable leeway in deciding how to construe a patient's problems. Contemporary behavior therapy in general is far more inferential than it used to he, especially
as the cognitively oriented among us forge links to cognitive psychology, a 
specialty that has, from its roots in philosophy and the earliest period of 
experimental psychology in the late 19th century, employed constructs like 
"set" (unbewusste Einstellung) and "schema," processes and structures of 
which subjects themselves may have no awareness.

But Wachtel would take us beyond this level of inference. His brief 
is against the normative biases that behavior therapists operate with, a 
stance that discourages them from considering underlying causes that are 
unpleasant or even taboo, and that leads them to take too much at face 
value what their patients tell them is the problem. For example, psycho-
analytic theory would have us entertain the hypothesis that children harbor 
strongly ambivalent feelings toward their parents, placing them in conflicts 
so painful and fearsome as to render it impossible to talk about openly or 
even to know about. True, psychoanalytically oriented therapists can go 
wide of the mark if they focus too readily on issues prescribed by psycho-
analytic theory (viz., Langer & Abelson, 1974). But at bottom, Wachtel 
and his analytic sisters and brothers have taught behavior therapists who 
are willing to listen that patients often do not know what they fear or want, 
or if they do, may be reluctant to tell the therapist. This may well have 
been operating with my diffident patient.

REFERENCES


