Brit. J. Psychiat. (1969), **115**, 429–33

A Psychotherapist's Note on Behaviour Therapy

By DORIS Y. MAYER

To an analytically oriented psychiatrist a neurotic symptom is a meaningful expression or result of an unconscious conflict. To a behavioural therapist it is maladaptive, learned behaviour. The psychotherapist sees his task as a joint venture in which patient and therapist explore the patient's life history in order to determine how the trauma of the past manifests itself in the distortions of the present. Behavioural therapists contend that analytical theory, of whatever sort, is invalidated by their successes and by the fact that successful treatment of a symptom or set of symptoms has not, in their experience, led to substitution of some other symptom or to more serious pathological consequences. The claimed success rate for behaviour therapy is very high. Journals of recent years abound in reports of spectacular cures, especially of individual patients with traditionally refractory conditions (Clark, 1963; Cooper, A. J., 1963, 1965; Raymond and O'Keefe, 1965). The psychotherapist's aim is to help his patient to understand his problems and find his own solutions for them. Would he be better advised to use his authority to reward "acceptable" and punish "unacceptable" behaviour; or his imagination and inventive skill to figure out ever more ingenious procedures of deconditioning? Is the time-consuming process of intensive psychotherapy not only wasteful but inferior in results to techniques based on conditioning? It seems to me, to judge by recent reports, that some of the results of behaviour therapy are less impressive than a cursory reading would suggest.

For example, Meyer and Crisp (1966), reporting on a study of 54 patients treated by various forms of behaviour therapy, including desensitization, operant conditioning and aversive therapy, state in the summary that there was an overall improvement rate of 70 per cent., a rate which, if not remarkable, is certainly respectable. However, if we examine the full text we find that the improved group comprise patients who were "greatly improved" and patients who were "slightly improved"; and going back to the actual figures we note that 28 per cent. of the patients were greatly improved, an equal number, 28 per cent., were unimproved, and that the largest group, 44 per cent., were slightly improved. This is hardly an improvement rate of which any psychiatrist could feel particularly proud. Crisp (1966), in a very searching later article, discusses some of these patients in more detail. Here he points out that there was in fact some emergence of "new symptoms". If I understand him correctly, he considers both anxiety and depression as symptoms, but notes that such emergence did not occur " . . . so frequently or consistently as was predicted on the basis of psychodynamic theory". He refers to new symptoms rather than substituted symptoms, since the latter would imply acceptance of the idea that symptoms are meaningful.

In another recent study, by Gelder, Marks and Wolff (1967), three matched groups of phobic patients were treated respectively by desensitization, individual psychotherapy, and group psychotherapy. When treatment was terminated, patients in the first group were shown to have improved more than those in either of the psychotherapy groups. However, when they were re-evaluated only six months later there was no statistically significant difference among the three groups. A study by Hoenig and Reed (1966) is particularly instructive in its indication that improvement in the laboratory situation, as seen in four phobic patients treated by desensitization, had little correlation with improvement in the actual living situation.

Cooper, J. E., (1963) reports on 30 patients treated by various behavioural therapies

https://doi.org/10.1192/bjp.115.521.429 Published online by Cambridge University Press

including aversion and desensitization. They were assessed for improvement at the end of treatment, a month later, and a year after the end of treatment. Assessment was made on two levels, one in terms of specific symptoms and one general scale having to do with occupational, social and sexual adequacy. Immediately following treatment 17 of the patients had improved symptomatically, only 10 in a more general sense. At the end of the first year symptomatic improvement was seen in only 13 (less than half) and general improvement in 7 (less than a quarter). Matched controls (treated by various therapies)* were found for 16 of the patients. When their records were compared at the end of treatment it was found that those treated by behavioural therapy showed greater improvement, in terms of loss of symptoms, than the group treated by other methods. By the end of the year, however, the situation was so altered that the controls had a slightly better record on symptomatic improvement than the behavioural therapy patients. In so far as general improvement was concerned, there was no significant difference between the two groups.

Coates (1964) reviews the literature on behaviour therapy for sexual deviation, re-analysing a number of published cases in which either reciprocal inhibition or aversion therapy was used. He makes a convincing argument for such psychodynamic factors as identification and transference, rather than conditioning, as the probable curative process in a number of cases. He also compares a study by Freund of 67 homosexual patients treated by aversion therapy with a study of his own (the Portman series) of 45 homosexuals treated by psychotherapy. Even though Coates's criteria for improvement were more rigorous than Freund's, the percentage of patients improved in the Portman series (40 per cent.) was higher than in the Freund series (33 per cent.).

None the less, there appears to be good evidence that some patients are greatly helped by behaviour therapy; and so far there is little evidence that eradication of one symptom by such means leads to substitution of another symptom. It may instead lead to satisfaction and a general sense of well being, as would reasonably be expected from the loss of a symptom which was no longer ego-syntonic. Is it, then, an innocuous therapy in which there is little danger and only the uncertainty inherent in all therapy, i.e. no guarantee of success in any particular case? Or is it possible that since behaviour therapy is relatively new the long-term results are not yet known?

Perhaps we can look elsewhere for at least a partial answer to these questions. Although conditioning methods, whether of reward or punishment, or a judicious combination of the two, are relatively new as techniques of therapy, they are respectably old in child rearing. Many of us have read the poignant little interchange between four-year-old Ernest Pontifex and the Vicar of Battersby who tried to teach his son to say *come* instead of *tum* by beating him when he failed to do so. Samuel Butler transmits to the reader not only his own, probably autobiographical indignation, but also his sense of the connection between his parents' attitudes and the weak, sensitive, neurotic character which Ernest gradually develops. Yet the Vicar could surely have defended himself by pointing out that his was a time-honoured method of teaching, a method which need not be discredited because it failed to work on one particularly stubborn little boy. And, assuming that Ernest was physiologically ready to hear and pronounce *k*, the vicar may have been right. We know from our own and our patients' experience, as well as from literature, that conditioning methods can be successful in effecting changes of behaviour. Countless children have been dissuaded from thumb-sucking by having nasty ointments painted on their thumbs, and generations of schooboys in the past, if not so often now, have learned their lessons to escape a whipping.

It is not only to aversive therapy that one can find parallels in child rearing. A parent is not likely to make a formal "hierarchy" of anxiety-producing situations in order to "desensitize"

* Five phobic and one obsessional patient were treated by non-analytic, short-term psychotherapy: two phobic patients were treated by re-socialization, one by analytic psychotherapy, one by analytic group psychotherapy; one phobic patient was treated by acetylcholine injection; one obsessional patient was given electroshock treatment and one a leucotomy.

https://doi.org/10.1192/bjp.115.521.429 Published online by Cambridge University Press

his child to fear of the dark, but he is proceeding in a similar way when he allows first a relatively bright light, then a night light, then a light on the landing. And if, in addition, he provides some solace at bedtime, such as a story or a sweet, is this not very like reciprocal inhibition? Behaviour therapy and child rearing have much in common, not only in the methods used but also in the conditions necessary for success, conditions such as the positive motivation of the patient and the absence of secondary gain from the symptom. Such dicta as that it is important that reinforcement follow closely on the response to stimulus (Wolpe *et al.*, 1964), or that in aversive therapy it is " . . . most effective if the unconditioned stimulus is given immediately after the conditioned stimulus and if punishing consequences eliminate the positive reinforcement resulting from the act to be eliminated" (Meyer and Crisp, 1966) (i.e. that punishment should be prompt, sharp and unpleasant) are "old hat" to any experienced mother or schoolmaster. Again, I think that we know, from both life and literature, that conditioning methods unintelligently applied may have opposite effects to what is intended. We know how easy it is for certain mothers to teach their children to whine, to refuse food, to have tantrums, to continue infantile habits beyond the time when they would normally be relinquished, by paying selective attention to these matters. It is my belief that such teaching, or conditioning, can be just what it seems, the inept misapplication of proper teaching; or it can be, as in the case of the Vicar of Battersby, a visible sign of a much deeper trouble in the relationship between parent and child. Where the reason is the superficial one it is relatively easy to correct. This is exemplified by the oft-repeated story of the "spoiled" child who gets along splendidly at school. My guess is that it may be such children, grown to adulthood, who make excellent patients in behaviour therapy. But what about the others, those children whose behaviour is unchanged, or gets worse, when corrected in a way that is effective for most children?

A patient came to me for therapy because he feared that his masochistic "acting out" might land him in trouble. He had frequent sprees in which he paid girls to tie up and beat him. His deviant behaviour had started several years after he had left the well-known public school where he first experienced frequent beatings. He did not remember the punishment as having been unjust in terms of the particular culture in which it occurred. It followed certain offences quite automatically. The only difference he could recall in the treatment he received from that accorded his schoolmates was that he was beaten more frequently than others because in his case it was ineffectual. He did not consciously seek punishment, nor did it, until many years later, become involved in masochistic fantasy, the origin of which dated from a much earlier period than his schooldays. Why did a method which presumably worked for most of his schoolmates not work for him? The explanation, necessarily over-simplified here, was that at the time he entered school he had already been severely traumatized by various events, including the death of his father, events which he had attributed to his own infantile aggression. His unconscious guilt made him seek out punishment, so that the method which might be considered a schoolmaster's version of aversive therapy was not only ineffectual, but was used by him in the service of perpetuating his neurosis. The more subtle effects of the failed "behaviour therapy", or school discipline, were not grossly apparent for many years. He made a good adjustment in the army and in the early years of manhood; it was not until he himself became the head of his own household that his pathology, to which the beatings had been contributive rather than causative, became incapacitating.

A rather more striking example of early "aversive therapy" was described to me by a patient in his early forties who came for therapy because of a severe paranoid obsession and periodic crippling attacks of anxiety. When he first told me of his father's method of treating his early masturbation, I put it aside as one of those doubtful memories of the sort which had at one time made Freud think that all his hysterical patients had been sexually assaulted as children. Recently, however, having had confirmation of his story from an outside and unimpeachable source, I should like to present it

https://doi.org/10.1192/bjp.115.521.429 Published online by Cambridge University Press

as an example of a kind of "aversive therapy" which not only failed in its immediate objective but played a part in the development of the subject's pathological disorder.

The patient was the son of a New York doctor who had had some success with that "electrical treatment" fashionable in the early '20s for a wide variety of ailments. The father was very concerned, as was not unusual in those days, about his five-year-old son's nightly masturbation. He wheeled his electrical apparatus next to the boy's bed and placed electrodes around his thighs in such a way that a shock was received whenever the boy started to masturbate. Distasteful as this treatment may sound, it follows the principles generally accepted for successful aversive therapy. The boy, having been convinced by a father who was in many ways kindly and loving that masturbation was a dangerous habit, was himself well motivated to get over it. In fact, when he told me about it, more than thirty-five years later, he still agreed with his father's view on the matter and very greatly regretted that the treatment which like all good aversive therapy had been repeated several times over a period of months had not been successful. It was a punishment which followed closely on the conditioned response; and avoidance was rewarded by the cessation of punishment and by the approval of his father. There was some suppression of masturbation during and following treatment, and for the next few years a diminution in frequency which may have been due to treatment or to his entry into the period of latency. In early adolescence masturbation became increasingly compulsive and was never overcome, even after the patient had achieved an active heterosexual life.

It is difficult, perhaps impossible, to prove scientifically that any event or series of events are in fact causative of later pathology. The likelihood, however, of its having been so in this case has been evidenced by the patient's response to psychotherapy. In the course of uncovering details of this treatment and more especially re-awakening feelings toward his father in connection with it, there have been dramatic changes, first in intensifying his anxiety and later in mitigating both the anxiety and the obsessive paranoid ideation for which he had sought help.

If I am correct in my notion that behaviour therapy may in certain cases be a dangerous procedure, why have there not been more reports of catastrophic results? One reason may be that behaviour therapy, particularly the aversive variety, has not often been used on young children where it might adversely affect the actual process of personality development. Another possible reason is one that is often noted, but not given much attention; that is, the question of self-selection. Just as psychiatrists tend to choose among various available techniques those which are congenial to them, so patients, although they have less freedom of choice, since they are not in a position to evaluate the psychiatrist or clinic to which they may be sent, do have one important freedom. They can opt out. In the study by Gelder, Marks and Wolff (1967) in which patients were put into matched groups for three types of therapy, there is one very striking finding. Before the end of the third week, one-fourth of the patients in the behaviour therapy group had dropped out and had had to be replaced by others. There was no loss of patients in either of the other groups. It is pointed out in the article that this proportion of drop-outs is similar to that reported by Wolpe, whose claims of nearly 90 per cent. success are higher than those of any other worker in the field of behaviour therapy. The proportion of patients who refuse treatment initially, or after it has been started, would be of special interest in the case of aversion therapy. Patients often show very good sense about what they need and what they can tolerate. It may be of critical importance to study the personalities not only of those patients who are helped and of those who are not helped by behaviour therapy, but also of that group which refuses such therapy.

Summary

Examination of some recent reports on behaviour therapy raises questions as to its reported efficacy. Parallels are suggested between behavioural, and especially aversive, therapy and traditional methods of disciplining

https://doi.org/10.1192/bjp.115.521.429 Published online by Cambridge University Press

children. Retrospective evidence from two patients is given to show that child rearing techniques quite similar to those employed in aversive therapy may have adverse effects which do not become apparent until later life. Possible reasons for the low incidence of casualties among patients treated by behaviour therapy are: that these techniques have not been in use long enough for evaluation of long-term effects; that they are generally used on adults rather than children; and that patients who "need" their symptoms (in a psychodynamic sense) may refuse to accept behaviour therapy.

References

Clark, D. F. (1963). "Fetishism treated by negative conditioning." *Brit. J. Psychiat.*, **109**, 404–407.

Coates, S. (1964). "Clinical psychology in sexual deviation." In: *The Pathology and Treatment of Sexual Deviation* (ed. Rosen). London, 395–413.

Cooper, A. J. (1963). "A case of fetishism and impotence treated by behaviour therapy." *Brit. J. Psychiat.*, **109**, 649–652.

—— (1965). "Therapy in hysterical retention of urine." *Ibid.*, **111**, 575–577.

Cooper, J. E. (1963). "A study of behaviour therapy in 30 psychiatric patients." *Lancet*, *i*, 411–415.

Crisp, A. H. (1966). " 'Transference', 'symptom emergence', and 'social repercussion' in behaviour therapy." *Brit. J. med. Psychol.*, **39**, 179–195.

Gelder, M. G., Marks, I. M., and Wolff, H. H. (1967). "Desensitization and psychotherapy in the treatment of phobic states." *Brit. J. Psychiat.*, **113**, 53–73.

Hoenig, J., and Reed, G. F. (1966). "The objective assessment of desensitization." *Ibid.*, **112**, 1279–1283.

Meyer, V., and Crisp, A. H. (1966). "Some problems in behaviour therapy." *Ibid.*, **112**, 367–381.

Raymond, M., and O'Keefe, K. (1965). "A case of pin-up fetishism treated by aversion conditioning." *Ibid.*, **111**, 579–581.

Wolpe, J., Salter, A., and Reyna, L. J. (eds.) (1964). *The Conditioning Therapies*. New York.

Doris Y. Mayer, M.D. (U.S.A.), L.M.S.S.A., Dipl. Psychiatry, Amer. Board of Psychiatry and Neurology, *113 Grantchester Meadows, Cambridge*

(*Received 11 April, 1968*)

https://doi.org/10.1192/bjp.115.521.429 Published online by Cambridge University Press