

A History of the Behavioral Therapies: Founders' Personal Histories

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on

ring memory of Janet Bijou,
and whose intelligence and
spirit guiding us all.

Chapter 18

Values and Constructionism in Clinical Assessment: Some Historical and Personal Perspectives on Behavior Therapy¹

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It's been said that key decisions in life are determined or at least strongly influenced by unforeseen chance events. A social gathering we decide only at the last minute to attend turns out to be the place we meet our future spouse. A careless moment while driving leads to a terrible accident that affects our health and our family's well-being for the rest of our lives. Though the idea that chance events play a major role in shaping our existence may not fully satisfy our existential needs, I've been struck many times by how germane this perspective is in reflecting upon the careers of many of my friends and colleagues. It certainly applies to mine.

The task set for participants in the Reno Conference on the History of Behavior Therapy was to present what we see as the formative influences in our professional lives, discuss a publication that we believe has had some importance in behavior therapy, and reflect on the nature of that influence on the field. This paper is an effort to fulfill this unusual and intriguing assignment.

My High School and College Years

I spent grades 7 through 12 at Boston Latin School, at the time not a particularly reinforcing or supportive secondary school and known for a number of notable graduates like several signers of the Declaration of Independence, among them Samuel Adams and John Hancock. Another signer was Benjamin Franklin, who enrolled in the school in 1714 and was doing very well when his father withdrew him after just one year. It seemed that Josiah Franklin did not consider his son pious enough for the ministry, which was the profession that most of the boys were oriented towards after they graduated and went on to Harvard. Other well-known graduates were Cotton Mather, George Santyana, Ralph Waldo Emerson, Arthur Fiedler, and Leonard Bernstein. Not too much pressure on contemporary students! For generations this school has been the way out of several of the Boston ghettos for the children of parents and grandparents who immigrated from Europe and who saw a rigorous education as the most reliable way for the kids to make it into the mainstream of American society.

Nearly all of my 240 classmates of the class of 1957 went to college, and about a fifth of these entered Harvard as I did. Like many other Jewish boys, I was supposed

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to become either a physician or a lawyer. I spent the first year studying German, Russian, political science, biology, western civilization, and other general education topics that were supposed to enable me to declare a major (or "concentration," the term favored by Harvardians). By the beginning of my sophomore year, however, I had managed only to reject political science as a major and to locate myself in the German department, where I found myself intrigued more by the characters in the novels I was reading than by the language or whatever else it was that a literature major was supposed to find interesting.

Then something unexpected happened during the first day of classes of my sophomore year. Having read during the previous summer Freud's Clark University lectures and being both drawn to and annoyed by Freud's ingenious speculations about people's putative unconscious motivations, I found myself deciding at the last minute to drop into a class that was sandwiched between my 9:00 and 11:00 AM lectures. It was called Social Relations 10, the first of two semesters of a massive introductory course in a department that had been created after the second world war as a combination of anthropology, sociology, and psychology. There was also a department called Psychology, where Skinner was situated, but there was little more than animosity and mutual suspicion between the pigeon and rat-runners of Psychology and those more interested in complex human interactions in Social Relations.

So, with a long-standing curiosity about why people – especially myself – behaved as they did, and with the summer's reading of Freud still knocking around in my head, I veered off my intended path and entered Emerson Hall to listen to the first lecture of the introductory Soc. Rel. course. And my life changed.

The lecture was by Robert White, a courtly New Englander and, in what would be an irony for me fifteen years later, author of what was at the time one of the leading abnormal psychology textbooks. What White did in this opening lecture was place psychology in context, as an approach to understanding the human condition that straddled biology, sociology, anthropology, political science and other social sciences, and even philosophy and theology. While my reaction may have fallen short of being an epiphany, I nonetheless made the decision to alter my fall schedule so that I could enroll in the course – while continuing as a German major for the nonce.

Throughout the two semesters that year, I had as lecturers in addition to White the following senior professors: Clyde Kluckhohn, Talcott Parsons, and Jerome Bruner. Not too shabby for a poor Jewish kid from Dorchester. We read widely in the several domains of what was called Social Relations, but there was one set of readings and experiences that were pivotal for me. In discussion section, we were examining a clinical case history of Benjamin Feingold, a young man with lots of insecurities and anxieties. One day the topic of discussion was a dream he had of sitting at the wheel of a car and then seeing to his right his brother-in-law coming to a stop next to him so close to his car that the two cars scraped together. What did the dream mean, the teaching fellow asked us. A lively conversation ensued during which everyone in the section except myself saw very clearly that the dream was a

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disguised expression of Benjamin's homosexuality: the two cars scraping together obviously signified a wish on his part to rub up against the body of his brother-in-law. The Radcliffe students in the class – "Cliffies," we called them with a mixture of envy and resentment since most of them were smarter and more verbal than the Harvard students – were especially vocal in this rendition of the dream.

Now it turns out – as I have learned at the several reunions I've attended over the past thirty years – that most of us were somewhat intimidated by our peers, all of whom appeared brighter and better read than we. I was certainly no exception. I recall looking around the room and deciding that even if I were not downright stupid, I was certainly poorly suited to any specialization of psychology that had to do with trying to understand and help people in emotional distress. No matter. There were other areas of psychology that intrigued me, and I spent the next three years working with two faculty, Richard Alpert (aka Baba Ram Dass) and Jerome Bruner on topics relating to motivation and cognition. I ended up doing an honors thesis with Bruner on perceptual problem-solving under conditions of degraded but improving stimulus input. This early interest in cognition diminished drastically at Stanford, as seen below, but returned soon thereafter with my involvement in cognitive behavior therapy. Towards the end of my senior year – after a dalliance with applying to law schools – I found myself with an acceptance to Stanford, to study cognitive dissonance with Leon Festinger.

But the uncertainty earlier in my senior year – whether to go to law school or to graduate school in psychology – had led me to seek ways to postpone a firm decision. I applied for several foreign study fellowships and was awarded a Fulbright Scholarship to study for a year in Germany following graduation in June 1961.

My Graduate School Years

The year abroad was, well, broadening. I immersed myself in the culture, language, and wine of the southwestern part of Germany, took courses at the University of Freiburg in dream analysis, handwriting analysis, the Colored Pyramids Test, and psychoanalysis, and sang in Freiburg's Russian Chorus. By the time June came around, I was ready to trek out to Stanford and begin a new life.

Eager to become a Festinger-type social psychologist at Stanford beginning in Fall 1962, I was dismayed to learn that he had switched into eye movement research, both forcing and freeing me to explore a bit that first year. Having an NSF fellowship, I was able to move pretty much as I wanted and decided to do some research in something I had never had contact with or even given any thought to, physiological psychology. This found me learning about brain stimulation of the rat brain from J.A. Deutsch, who had recently published an unusual book on what he called "a structural theory of behavior." Deutsch had studied at Oxford, where much of the teaching is done via individual tutorials, so we had innumerable seemingly discursive conversations in his lab, with me watching him run rats while he peppered me with questions on what I had been reading. I found it very intellectually stimulating but somehow constraining, because as complex and challenging as rat's

appetitive behavior was as understood by Deutsch's ingenious theorizing, I continued to feel unfulfilled.

And now another unexpected event. Because my mother was worried that I would not eat well in California, she'd prevailed on me to join a meal plan for at least my first quarter at Stanford. This found me eating dinner each evening in the graduate dining hall with other first year students in psychology. Some of these were clinical students (Stanford had an APA-approved clinical program at the time), and they often talked about a professor named Bandura and something called "behavior therapy." The basic notion was that all the stuff I'd been learning as an experimental psychologist had relevance for understanding and treating abnormal behavior. This was a new notion for me. None of my professors at Harvard had ever mentioned this viewpoint – and recall that Wolpe's classic book had been published in 1958, while I was a sophomore. Recall also that Skinner was at Harvard and had published a couple of papers with Ogden Lindsley on operant conditioning of regressed schizophrenics. But these new-fangled notions had not found their way into the ego-analytic, psychodynamic stronghold of Emerson Hall.

These dinner conversations bounced around in my mind during the fall and winter quarters of my first year, and then another unexpected thing happened. Visiting that year from the University of Illinois was a young associate professor named Perry London, whose courses I had of course been avoiding because they had to do with clinical. Somehow we found ourselves playing tennis, and during a break, he asked me what I wanted to do when I grew up. When I confessed that I had little idea except that I thought I'd like to be an academic like him, he took me back to his office and showed me a few vitas of colleagues of his. He asked me whether anything struck me about the publications. They were all very different from each other, and each vita was, within itself, very heterogeneous. Precisely, he said, but one thing they had in common was that all the people were clinical psychologists. Clinical psychology, he said with obvious relish, is a bastard discipline. And that's what makes it exciting and promising. That conversation with London was pivotal.

Soon I found myself in Bandura's office, doing a song and dance about why he should let me switch into clinical. I interpreted his mm-hmms and nods as signs that I should continue my persuasion attempts, but after a while he interrupted me and said "OK." "OK, what?" I asked. "OK, you can switch into clinical," he said with some bemusement. And that was it. Stanford was a remarkably flexible place, and I am forever grateful for that. For I knew then and there that I would not have found myself now in a clinical program had I gone to either of the other two places that had been options for me, Berkeley and Michigan. I had finally found a true intellectual and professional home in a department whose earlier appeal had had nothing to do with clinical psychology. Indeed, I hadn't known what area of psychology I would specialize in, only that it would not be clinical.

Dumb luck continued. I took Bandura's course that spring, worked with some autistic children at a nearby daycare center, read virtually everything that had ever been published in behavior therapy, and then found myself in my second year taking

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an assessment course with Walter Mischel and a behavior therapy course with a visitor from South Africa named Arnold Lazarus.

This triumvirate – unbeknownst to them, I think – presented me with a marvelous apprenticeship in theory, research, and practice in what we then called social learning approaches to psychotherapy, or sometimes just behavior therapy. Lazarus began to see private patients at a greatly reduced fee and permitted a few of the clinical students to sit in with him. I must have spent at least 10 hours a week during my second year, from September 1963 to June 1964, watching Lazarus work with patients. Somewhere along the line the conceptual introduction I had received from Bandura and Mischel came to life in my sessions with Lazarus, such that behavior therapy had a completely different meaning for me at the end of that incredible year than it had had in the beginning.²

Lazarus returned to South Africa in the summer of 1964 and I globbed onto a dissertation project on systematic desensitization (which I would have been very reluctant to undertake had I not learned the procedure and related things from Lazarus) that went well and enabled me to complete my degree by July of the following year. In those days one could do an internship postdoctorally, and that is what happened. I spent a good internship year at the Veterans Administration (VA) Hospital in Palo Alto.

One last tidbit from my formative Stanford years is in the form of another chance event. I began my internship in July 1965 and was assigned to a ward on which Gordon Paul had been working as an intern the previous several months. It turned out that he was not leaving till August, so we had one month's overlap. During that time I did pretty much what I'd done with Lazarus – I followed him around and sat in on practically every meeting and session he had. (My advice to graduate students has for some years been: Find someone good and follow that person around.) I hate to think what my internship year would have been like had it not been for Paul's calm and skillful introduction into the sometimes surreal world of the VA mental hospital.

My Stony Brook Years

After completing my internship in August 1966, I migrated to SUNY-Stony Brook to join a dedicated, sometimes hypomanic group of behavior therapy enthusiasts in an avowedly behavioral Ph.D. program set up by Len Krasner (director of clinical training) and Harry Kalish (department chair). I arrived there along with the first cohort of graduate students as well as the first group of postdoctoral fellows in what was the very first postdoctoral training program in behavior therapy.

It was a heady time. Here was a program that, well before the empirically supported treatments movement, elected to focus on assessment and intervention that enjoyed some measure of empirical support, eschewing unvalidated approaches and procedures without a concern that our students would be unable later on to obtain clinical internships. True, we were narrow, but the Krasner-Kalish vision was to specialize in something that we all believed had more promise than the traditional clinical fare.

I worked most closely with three colleagues during my Stony Brook years, and these collaborations enriched my professional life immeasurably. First there was my attribution research in the late 1960s with Stu Valins, a Schachter-trained social psychologist. Together we published the first experiment showing that attribution of behavior changes to oneself rather than to a drug leads to greater maintenance of therapeutic change (Davison & Valins, 1969). Second was getting together with John Neale to write our abnormal psychology textbook, the first edition being published in 1974. It was an instant success, and we recently completed our 8th edition (Davison & Neale, 2001). And finally there was *Clinical Behavior Therapy* with Marvin Goldfried, published in 1976 and reissued in 1994 in an expanded form (Goldfried & Davison, 1976, 1994). This book helped bring research and theoretical abstractions to life, contributed to the cognitive trend in behavior therapy, and made a case for trying to integrate ideas and procedures from the non-behavioral psychotherapies. I was very fortunate to have had such talented colleagues as these as well as other Stony Brook faculty.

During the 1970s a number of Stony Brook faculty were doing sex research. I was spending a lot of time with two colleagues in particular, Jim Geer in Psychology and John Gagnon in Sociology. We planned and we plotted, and at one point Gagnon and I co-taught a graduate seminar in human sexuality that attracted a lot of interesting and occasionally unconventional students and colleagues.

Around 1971, I began doing a good deal of reading in what was then known as the radical gay literature, books like *Lesbian/Woman* by Martin and Lyon (1972) and *Homosexual Behavior Among Males* by Churchill (1967). Between 1971 and 1973 I taught two advanced graduate seminars on homosexuality, which were well attended by students in Stony Brook's clinical program, postdoctoral fellows in the behavior therapy program I was directing, and a few selected undergraduates and graduate students from other departments. It was my impression that some of the students had a very personal interest in the subject matter, but most of the seminar members were involved in the subject more from an intellectual than from a personal or political point of view. A couple of colleagues mentioned to me a few years afterwards that they wondered if these might have been the first courses taught in a psychology department with the focus primarily on homosexuality.

Much of what we read and discussed in seminar was new to us, and some of it was disturbing. The disturbing part came from the anger expressed in many of the books and articles towards scientists who were investigating the causes of homosexuality and towards practitioners who were engaged in sexual reorientation programs. It took me a while to understand the source of that anger.

Why focus on the etiology of homosexuality, this literature asked, rather than on the etiology of heterosexuality? The reason, it was asserted, was that the latter was viewed as the universal norm and that the only thing worth looking into were aberrations from that norm, i.e., homosexuality. A not-always-articulated agenda was at work, therefore: By focusing on the causes of homosexuality more than on the causes of heterosexuality, the message was being conveyed that the former was intrinsically abnormal and needed special scrutiny. Psychoanalytic theorizing of

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course viewed homosexuality as deviant, and while the rhetoric of behavior therapy disclaimed intrinsic abnormality in favor of a socially relative view – it depends on the culture one is in – the reality was that some of the earliest work in behavior therapy entailed efforts to eliminate homosexuality in favor of heterosexuality.

Of more interest to me, though, was the brief against sexual reorientation treatment. Simply stated, why spend so much time and effort developing, evaluating, and providing change-of-orientation therapies when they are aimed at a “problem” that is socially defined?

This was a toughie for me. I had already written on sexual reorientation in a paper with my student Terry Wilson (Wilson & Davison, 1974) and had even made a training film with Bob Liebert, *Behavior Therapy for Homosexuality* (Davison & Liebert, 1971) that demonstrated the “orgasmic reorientation” technique I had published on several years earlier (Davison, 1968). The basic theme of the article with Wilson was that there were more sophisticated ways to analyze and change homosexuality than were prevalent in the behavior therapy literature, and we offered an analysis that we believed would eventuate in more effective and more humane – little or no aversion therapy – ways to alter sexual orientation from the homosexual to the heterosexual. In fact, it was the material in this paper that formed the basis for the workshop I gave at the AABT convention in October 1972, a pivotal event for the contribution that I’ve selected to focus on as important in my professional development and of some significance as well for the field.

The 1972 AABT Convention

Chance rears its head once again, but in this case the foundations had already been laid.

One of the people attending my 1972 AABT workshop on better ways to change homosexuals into heterosexuals was Charles Silverstein, a recent Ph.D. from the Rutgers clinical program. I recall Chuck sitting in the meeting room with an interested and fairly friendly expression on his face, occasionally asking questions about why I was involved in this sort of scholarship and application. My answer, which was the standard response of behavior therapists at the time, was that I would never impose such conversion treatment on an unwilling homosexual patient, but that I saw it as appropriate and, indeed, inherent to my professional role to make such reorientation interventions available to gay and lesbian patients who asked for sexual reorientation. He never seemed quite satisfied with my answer but he didn’t push the issue. Not during the workshop.

During a break, he came up to me and asked if he could circulate some flyers for a symposium he had organized for the last day of the convention. He showed me the flyer, and it looked like one of those radical political diatribes that were prevalent in the early 1970s on a variety of social issues. I thought to myself that I would certainly not attend the symposium but felt it would be imprudent and uncollegial not to permit him to distribute it to the members of my workshop (assuming that I actually had a choice in the matter, since he could easily have handed them to people as they left the workshop).

Now here's where chance enters the picture again. I had intended to leave the New York Hilton at a time on Sunday that would enable me to catch a late-morning train from Penn Station out to Port Jefferson, a town I lived in just east of Stony Brook. But I fell into unplanned conversations with some friends as I was trying to leave the hotel and then realized that I would never make my intended train. I found myself with a couple of extra hours, and then Silverstein's symposium came to mind. With no one in particular to talk to and deciding it would be more interesting to spend the extra time at the convention as it was ending rather than cooling my heels elsewhere, I found the room where the radicals were to hold forth.

It was a boisterous affair. Silverstein enraged me. He accused people like me of strengthening the unjustifiable bias against and discrimination towards homosexuals by virtue of even making conversion programs available. Others spoke in a similar vein, but what I remember most was that Silverstein was not radical enough for some members of the audience (some of whom may not have been actual convention registrants – but that's how it was in those days). So this man, whose views I reacted to with a mixture of outrage, curiosity, and a nascent respect, was accused in angry tones of selling out to the oppressing establishment, to the behavior therapy fascists, by the very fact of his participating in the convention.

I returned to Stony Brook and over the next several weeks began discussing these events and my reactions to them with several friends and colleagues, and with my homosexuality seminar. I wish I could remember how my ideas evolved after that, but it could not have been more than a few weeks before I concluded that Silverstein and the radical therapists were right.

Being President of AABT in 1973-1974

During my presidential year, I initiated a motion in the AABT Board of Directors, which passed the following resolution at its meeting of May 11-12, 1974. It was supported by an overwhelming vote of the membership later that spring:

The AABT believes that homosexuality is not in itself a sign of behavioral pathology. The Association urges all mental health professionals to take the lead in removing the stigma of mental illness that has long been attributed to these patterns of emotion and behavior. While we recognize that this long-standing prejudice will not be easily changed, there is no justification for a delay in formally according these people the basic civil and human rights that other citizens enjoy.

But this position statement, as forward-looking as it was, went only just so far. The implications (as I saw them) had yet to be drawn out. This would be the theme of my 1974 presidential address, which I entitled "Homosexuality: The Ethical Challenge."

The Context of My AABT Address

The AABT convention in Chicago in November 1974 was a tense affair. Behavior therapy had been lambasted in the media the preceding year by several

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groups – by the ACLU and by Senator Sam Ervin's committee that was looking into behavior modification for denying people their civil liberties (especially prisoners in the federal penitentiary in Springfield, Missouri)³. Also critical of behavior therapy was an unruly and violence-threatening group of self-appointed guardians of The American Dream who saw fit to engage in such activities as circulating the home addresses of fascists like myself, Israel Goldiamond, and other putative enemies of the people. Since Goldiamond was a featured presenter at the 1974 convention, we had to arrange for plainclothes as well as uniformed police to ensure the orderliness and safety of the proceedings.

It was in this context that I presented the arguments summarized below. For reasons that I believe will be evident, I was fairly nervous. But with the support of a number of friends who sat down front in the large ballroom and gave me encouraging nonverbals – even though most of them disagreed with the substance of my remarks – I got through the address.

Homosexuality: The Ethical Challenge

Below is a brief rendition of my AABT address (Davison, 1974/1976), expanded in recent years to encompass more general issues of the constructive nature of clinical assessment (Davison, 1991).

We Only Want to Help

API (Apocryphal Press International). The governor recently signed into law a bill prohibiting discrimination in housing and job opportunities on the basis of membership in a Protestant Church. This new law is the result of efforts by militant Protestants, who have lobbied extensively during the past ten years for relief from institutionalized discrimination. In an unusual statement accompanying the signing of the bill, the governor expressed the hope that this legislation would contribute to greater social acceptance of Protestantism as a legitimate, albeit unconventional, religion.

At the same time, the governor authorized funding in the amount of twenty million dollars for the upcoming fiscal year to be used to set up within existing mental health centers special units devoted to research into the causes of people's adoption of Protestantism as their religion and into the most humane and effective procedures for helping Protestants convert to Catholicism or Judaism. The governor was quick to point out, however, that these efforts, and the therapy services that will derive from and accompany them, are not to be imposed on Protestants, rather are only to be made available to those who express the voluntary wish to change. "We are not in the business of forcing anything on these people. We only want to help," he said.

The Myth of Therapeutic Neutrality

Therapists never make ethically or politically neutral decisions. "Any type of psychiatric [psychological] intervention, even when treating a voluntary patient, will have an impact upon the distribution of power within the various social systems

in which the patient moves. The radical therapists are absolutely right when they insist that psychiatric neutrality is a myth" (Halleck, 1971).

This is the thesis of Seymour Halleck's noted – and too little read – book, *The Politics of Therapy*, and it plays a major role in my argument about sexual conversion therapy. Most of the time the very naturalness of and familiarity with our therapeutic practices blind us to the nonempirical biases that affect how we construe the patient's problems and the goals we regard as acceptable to work towards. Better to be aware of and own up to our biases than to pretend that we have none.

Differences Do Not Imply Pathogens

Sometimes those who have argued in favor of sexual conversion therapies for gays and lesbians seek to justify their position by asserting that homosexuality is pathological and that, as doctors of the mind, it is our duty and right to set things straight (pun intended). One form that the argument takes is that homosexuals differ from heterosexuals in how they were raised, and that this difference indicates something pathogenic. The classic study in this vein is by Bieber, Dain, Dince, Drellich, Grand, Gunlach, Kremer, Rifkin, Wilbur, & Bieber (1962), a survey so flawed both conceptually and methodologically that it is hard to believe that it has been taken seriously by anyone. The logic of the findings takes the following form: the parents of male homosexuals more often reflect a pattern of a "close-binding intimate mother" and a cold and detached father. Ergo, homosexuality is a mental illness.

A moment's reflection reveals the absurdity of the argument. Simply put, what is wrong with such child-rearing unless one has decided before the fact that homosexuality is an illness? Post hoc ergo propter hoc. Weak reasoning indeed.

No Cure Without a Disease

Clinicians devote effort to developing and analyzing therapeutic procedures only if they are concerned about a problem. Until the 1980s behavior therapists spent a good deal of time and effort reducing homosexual attraction and increasing heterosexual attraction in homosexuals (and for the most part, the target population was men only). Again, until recently little if any time – and none at all when I first made my remarks – was spent by mainstream therapists encouraging health professionals to change their biases against homosexuality and foster gay-affirmative attitudes and behavior in patients who happened to be homosexual. The question for me was and still is the following: How can therapists honestly speak of nonprejudice when they participate in or tacitly support therapy regimens that by their very existence and regardless of their effectiveness condone the societal prejudice and perhaps also impede social change? As Begelman pointed out many years ago (1975), sexual reorientation therapies

...by their very existence constitute a significant causal element in reinforcing the social doctrine that homosexuality is bad. Indeed, the point of the activist protest is that behavior therapists [and other therapists] contribute significantly to preventing the exercise of any real option in decision making about sexual

identity by further "problem behavior" tend to seek treatment behavioral therapy very act of providing indicates otherwise.

I would add that the Wolpe's (1958) system therapists looked vigorous hierarchy and be pair like social isolation and anxiety that could be the therapist's assessment therapeutic technique it does skew what the to next.

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identity by further strengthening the prejudice that homosexuality is a "problem behavior" since treatment may be offered for it. . . . homosexuals tend to seek treatment *for being homosexuals*. . . . contrary to the disclaimer that behavioral therapy is "not a system of ethics" (Bandura, 1969, p. 87), the very act of providing therapeutic services for homosexual "problems" indicates otherwise (p. 180, emphasis in original).

I would add that the availability of a technique encourages its use. For example, Wolpe's (1958) systematic desensitization ushered in a period in which behavior therapists looked vigorously for antecedent cues that could be arranged on an anxiety hierarchy and be paired in imagery with deep muscle relaxation. Thus, a problem like social isolation might be viewed at least in part as a consequence of unnecessary anxiety that could be translated into an anxiety hierarchy and then desensitized. The therapist's assessment and problem-solving efforts are shaped by the availability of therapeutic techniques that are believed to be effective. This is not a bad thing! But it does skew what the therapist sees and finds out about a patient, a topic we turn to next.

Clinical Problems as Clinicians' Constructions

As I have argued elsewhere (e.g., Davison & Neale, 2001; Davison & Lazarus, 1995; Goldfried & Davison, 1994), clients seldom come to mental health clinicians with problems as clearly delineated and independently verifiable as what patients often bring to a physician. A client usually goes to a psychologist or psychiatrist in the way described by Halleck (1971). That is, the person is unhappy; life is going badly; nothing is meaningful; sadness and despair are out of proportion to life circumstances; the mind wanders and unwanted thoughts intrude, etc. The clinician *transforms* these often vague and complex complaints into a diagnosis or functional analysis, a set of ideas of what is wrong, what the controlling variables are, and what might be done to alleviate the suffering and maladaptation. My argument, then, is that psychological problems are for the most part *constructions* of the clinician. Clients come to us in pain, and they leave with a more clearly defined problem or set of problems that we *assign* to them.

In the case of homosexuality, I argue that when a person with such attractions/behavior goes to a therapist, whatever psychological woes they have are generally construed as caused entirely or primarily by their sexual orientation. This happens because (a) their sexual orientation is usually the most salient part of their personhood, to the clinician and usually to the clients themselves because of the negative salience homosexuality has been accorded by society; and (b) it is regarded as abnormal, regardless of the liberal stance the clinician may take overtly. Even with the changes in the DSM over the past 25 years, but especially when I first articulated this position in 1974, the clinician's perceptions and problem-solving are skewed in a direction that implicates homosexuality – no matter what the actual presenting problems are (cf. Davison & Friedman, 1981) – and, most importantly, imply the desirability of a change in sexual orientation.

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None of this is to gainsay that being homosexual in our society is difficult psychologically and that it can occasion people considerable distress – particularly a generation ago but even now, given the disproportionate exposure to hate crimes and simple everyday prejudice that homosexuals are subject to (discussed in next section). The moral point I tried to make in 1974 and, despite incredulousness on the part of some of my friends and colleagues I still hold to, is that mental health professionals have a responsibility not to be co-opted by the societal pressures that, sometimes subtly, channel our clinical problem-solving and decision-making into narrowly defined domains that result in a maintenance of a status quo that, in official pronouncements, we say we do not support.

Discrimination, Hate Crimes, and the “Voluntary” Desire to Change Sexual Orientation

I'd like to expand in this section on a theme that was not fully developed in my original presentation and that may provide the context not only for my holding to my position against sexual conversion therapies but also for the importance I attach to applying the analysis to other psychological issues that come to the attention of health professionals.

Although most states have dropped their sodomy laws, which used to be enforced selectively against homosexual acts, some legal pressure against homosexuality remains. A 1986 U.S. Supreme Court decision (*Bowers v. Hardwick*, 106 S.Ct. 284 [1986]), still valid, refused to find constitutional protection of the right to privacy for consensual adult homosexual activity and thereby upheld a Georgia law that prohibits oral – genital and anal – genital acts, even in private and between consenting adults. (Such laws can be applied to heterosexual sex as well, but straight people don't have to worry about that as much as do gays and lesbians.)

But legal pressures are not the whole story. Research supports the view that gays and lesbians are discriminated against in all kinds of ways and that this discrimination takes a particularly heavy toll on their emotional well-being. So-called “hate crimes” highlight this problem. A hate crime (sometimes referred to as a bias crime) is an assault that is based primarily or solely on a person's (perceived) membership in a group against which the perpetrator is prejudiced. The ultimate modern-day hate crime was, of course, the Holocaust in Germany and other parts of Europe prior to and during World War II. The Nazis sought out for imprisonment and execution millions of Jews and hundreds of thousands of gypsies, Communists, and homosexuals. The more recent “ethnic cleansing” in Bosnia and Kosovo and in many other parts of the world shows us that humankind has not learned much from the Holocaust experience. But hate crimes as well as hurtful discrimination are carried out every day in less organized and less dramatic fashion.

Recent research shows that as many as 92 percent of gays and lesbians have been subjected to verbal abuse and threats – often from members of their own family – and that as many as 24 percent have been physically attacked because of their sexual orientation (Herek, 1989; Herek, Gillis, Kogan, & Glunt, 1996). A quarter of gay youth are ejected from their homes when they come out to their families, and as

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A Proposal Regar

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many as half of the homeless young people in New York City are gay. The lifetime risk of suicide and suicidal behaviors is much higher among homosexual men than among heterosexuals (Herrell, Goldberg, True, Ramakrishnan, Lyons, Eisen, & Tsuang, 1999).

As compared to non-hate crimes, bias crimes and verbal assaults may create more psychological distress, perhaps because they are an attack not just against the person as a physical being but against the person's very identity (Garnets Herek, & Levy, 1990). Furthermore, such crimes may impart to the victim a pervasive sense of danger and even loathing of an aspect of the self that might otherwise be a source of pleasure and pride.

In addition to violence from strangers and acquaintances, lesbians and gay men experience "invisibility, isolation, lack of information, lack of role models, negative attitudes from others, lack of family and social support, uninformed or biased helping professionals, religious prohibitions, workplace discriminations, lack of legal supports, and internalized homophobia" (Fassinger & Richie, 1997, p. 90). Fassinger (1991) concluded that, while growing up, most gays and lesbians acquire the same negative attitudes towards gays as heterosexuals do, and this internalized homophobia makes it all the more difficult for them to confront their sexual orientation and to consider it in a positive light.

Anti-gay attitudes are strong, sometimes virulent, with many people believing that homosexuals are sick and their behavior disgusting (Herek, 1994). These negative attitudes can take the form of open heterosexism – as when people directly insult a gay person with epithets like *faggot* or *dyke* – or a more subtle, indirect kind of anti-homosexual stance – as when people tell jokes that deride homosexuality without knowing (or caring) if a gay person is present. This prejudice creates what has been termed "minority stress", a source of pressure and tension that is a special burden of those in despised or feared minorities (Meyer, 1995) and no doubt is the major factor in gay and lesbian people suffering particularly high levels of depression (Herek et al., 1996).

In light of all this, is it surprising that gays may seek out sexual reorientation treatment? Being subjected to verbal and physical assault for being gay is not likely to enhance one's sense of comfort with and acceptance of one's sexual orientation. Little wonder, then, that questions have been raised about how voluntary is the desire of some gays to change their sexual orientation.

A Proposal Regarding Sexual Reorientation Therapy

These several considerations led me to make a proposal that surprised no one more than myself, an idea that was present for several years in some of the gay activist literature (see especially Silverstein, 1977): *Therapists should stop engaging in change-of-orientation programs, whether the client makes the request or someone else does.* The social pressures, discrimination, and in some cases violent hatred directed toward people with homosexual inclinations make it highly doubtful that client-requests for conversion therapy approach what we regard as voluntary. In a sense, by attending to the reasons for a "voluntary" request for change, we are, I believe, doing nothing

less than remaining true to our deterministic stance. And without entering the free will-determinism morass, we can, I believe, consider more carefully than we have the societal pressures that would seem to underlie "voluntary" requests for conversion therapy.

Long ago, Perry London (1969) warned of an unappreciated danger in behavior control technology, namely clinicians' increasing ability to engineer what we have tended to regard as free will on the part of our patients. In his view, therapists are capable of making patients want what is available and what they believe their patients *should* want. Moreover, even if therapists assert that they do not work against the will of their patients, this does not free them from the responsibility of examining those factors that determine what is considered free expression of intent and desire on the part of our patients. Indeed, I would argue that the therapist sets the goals in therapy more than does the patient.

Halleck put the matter thus:

At first glance, a model of psychiatric [or psychological] practice based on the contention that people should just be helped to learn to do the things they want to do seems uncomplicated and desirable. But it is an unobtainable model. Unlike a technician, a psychiatrist [or psychologist] cannot avoid communicating and at times imposing his own values upon his patients. The patient usually has considerable difficulty in finding the way in which he would wish to change his behavior, but as he talks to the psychiatrist [or psychologist], his wants and needs become clearer. In the very process of defining his needs in the presence of a figure who is viewed as wise and authoritarian, the patient is profoundly influenced. He ends up wanting some of the things the psychiatrist [or psychologist] thinks he should want (1971, p. 19).

Not Can but Ought

As mentioned below in my discussion of a critique by Sturgis and Adams (1978), there is an important and oft-overlooked distinction between being able to achieve a goal and whether it is proper to try to do so. Empirical evidence as to whether we *can* change sexual orientation is not relevant to whether we *ought to* — except that we ought not to engage in a given change effort when there is no evidence that we can actually do so. This may well be the case with conversion therapies. The ethical argument against an ineffective treatment is that patients are bound to be disappointed and likely to feel even worse and "sicker" if they have made an effort to alter something that cannot be changed. The patient has not only failed to achieve a goal that has been set forth by the therapist as important but is likely to come away from the unsuccessful therapy continuing to believe that their behavior is bad and that they are really hopeless and unworthy.

But the two domains — empirical and ethical — are best kept separate.

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To return to 1 immediate aftermath

Psychotherapy, Politics, and Morality

And this takes us to the final aspect of my argument. I hadn't considered myself a community psychologist until the formulation of my brief against conversion therapy, but I think the characterization is apt. In Rappaport's (1977) terms, I am working at an institutional level, which is the domain of community psychology. In contrast, most therapists operate at the individual level. An institutional analysis of human problems examines those values and ideologies that guide the decision-making of a society. Individual therapy work, in contrast, assumes that society is benign and that psychological suffering can best be alleviated by helping the patient adjust to prevailing values and conditions. My underlying assumption is that issues surrounding therapy for homosexuality should be addressed at an institutional level, and that greater societal acceptance of homosexuality as a normal variation of human sexuality rather than as a problem that needs to be fixed will, in fact, redound to the benefit of the individual by reducing the discrimination and oppression described earlier that, I firmly believe, accounts for the distress that can be associated with homosexuality and ultimately the desire of some homosexual individuals to seek sexual reorientation.

Do therapists have some kind of abstract responsibility to satisfy a patient's expressed desires and wishes, as asserted by some (e.g., Sturgis & Adams, 1978)? No. Therapists constrain themselves in many ways when patients ask for assistance, and under some circumstances, therapists are even legally required to break the confidentiality that is inherent in the relationship. In any event, requests alone have never been a sufficient justification for providing a particular service to a patient.

Finally, am I arguing against trying to help homosexuals in therapy? Not at all. It is one thing to argue that therapists should not try to alter patients' sexual orientation; it is quite another to suggest that therapists should not work therapeutically with people who are gay or lesbian. (This seems straightforward enough, but over the years some critics have alleged that I have urged people not to treat homosexuals at all.) Indeed, the implication of my thesis is that therapists consider seriously the problems in living experienced by people who happen to prefer members of their own sex as sexual partners. For example, while a gay person may be depressed because his sexual orientation is mocked or attacked and he feels insecure about standing up for himself, gay people also get depressed because their professional aspirations are thwarted by circumstances having nothing to do with their sexual orientation. And it would be nice if alcohol abusers who happen to be homosexual could be helped to reduce their excessive drinking without having their sexual orientation questioned. Freed of the inclination of trying to alter a homosexual's sexual preferences, therapists will find many other ways that they might help that individual lead a more fulfilling life.

Aftermath of The Paper

To return to the circumstances of my AABT presidential address in 1974, the immediate aftermath was pretty emotional. The audience had been very attentive,

with the silence deepening when I articulated the main point that we should not be engaging in sexual conversion therapy even when the patient asked for it. (Friends commented afterwards that one gets that kind of silence when everyone in a room full of 1,000 people stops breathing at the same time.) There was a reception of sorts right after the talk, and I recall some colleagues seeking me out to shake my hand and others keeping their distance, with looks on their faces too complex to interpret. But the most memorable reaction came from a young woman who approached with glistening eyes and told me that she could not believe what she'd just heard and that she just wanted to thank me. I've been told that other people who have been personally affected by conversion efforts and their promulgation reacted similarly, albeit privately. I have found these reactions very gratifying, especially as the years have gone by and I have seen the argument become, if not universally accepted, at least more mainstream and one that can no longer be ignored.

It may or may not have been assumed by some that I was gay. Besides some occasional heterosexual kidding from a colleague or friend, I'm not aware of this consequence of which I'd been forewarned (not that it mattered to me one way or the other). And of course this admonition assumes that only a gay person would hold the point of view against sexual conversion therapies that I'd articulated – a position that I've always seen as a strategy, perhaps unconsciously employed, to denigrate the message by denigrating the messenger.

More important is what happened a month later when I submitted for publication a manuscript based on my AABT address. For reasons that I hope are obvious, I selected the *American Psychologist*. Only a week or two after sending it in, I received a letter from the editor handling the manuscript (an APA staff person of no scholarly credentials that I was aware of) that he had decided not to send it out for review because it was not "of general enough interest" to warrant consideration for a journal sent to all APA members as part of their dues. Think about this. I was not surprised that he was offended by the content of the paper – and, yes, I am presuming that this was the reason he rejected it without obtaining input from appropriate referees – but I was taken aback at the peremptory judgment that a paper examining the ethical bases of psychotherapy as applied to the case of sexual conversion treatment was not of "general enough interest" to an organization like APA.

Well, no one likes rejection letters, but I did my best to let go of my pique and decided to submit the same manuscript to the *Journal of Consulting and Clinical Psychology*, edited at the time by Brendan Maher. Again I got a very speedy response in a thin envelope, and I feared for the worst as I opened it. But Maher's decision could not have been more different or gratifying. He told me that he wanted to publish it without having it vetted by outside reviewers, provided that I would agree to his inviting several accompanying critiques. I could not have been more pleased. At his request, I made two suggestions: Irving Bieber, who I was confident would excoriate my paper (which he did); and Seymour Halleck, whom I had relied on extensively in formulating my argument on the politics of therapy and whose opinion of my effort I was certain the readership would be interested in. The

commentaries follow (1976). Interestingly, the conclusion I had come to was the result of my effort.

A year after it was a critique of a graduate student's interesting and thoughtful orientations. The question for the therapists *should* be not. So I told Maher I wanted to reject the manuscript (I had asked me to write) do so. Basically "N" (1978) responded that is, that their paper is, that their paper is convincing to the Sturgis that she had the position. Adams, obligation to change. Interestingly, he a research on homosexual research skills.⁴

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commentaries followed my paper, which was published as the lead article (Davison, 1976). Interestingly, Halleck's comments did not, as I read them, fully embrace the conclusion I had come to, but his commentary was, I think, the most supportive of my effort.

A year after its publication, Maher sent me a manuscript to review for JCCP. It was a critique of my article by Ellen Sturgis and Henry Adams (Sturgis was Adams' graduate student at the University of Georgia). I found the manuscript to be an interesting and thoughtful paper on how better to change people's homosexual orientations. The only problem was that I found it irrelevant to my earlier article, for the question to me was not *whether* we can change sexual orientation but whether therapists *should* help people do so. Clearly my belief was and is that we should not. So I told Maher that I would not be an appropriate reviewer because I would have to reject the manuscript out of hand as not relevant. His response was that he wanted to publish the paper provided I write a rebuttal (instead of the review he had asked me to write). This seemed a very sensible editorial decision, and I agreed to do so. Basically "Not Can But Ought: The Treatment of Homosexuality" (Davison, 1978) responded to Sturgis and Adams (1978) in the aforementioned fashion, that is, that their paper was irrelevant to my argument. I don't believe my rebuttal was convincing to the authors, but I found it interesting some years later to be told by Sturgis that she had changed her views on the matter and now agreed with my position. Adams, on the other hand, continued to believe that therapists have an obligation to change people's sexual orientations if they seek such treatment. Interestingly, he and his students conducted some very interesting and ingenious research on homophobia, a focus that I was delighted to see for his considerable research skills.⁴

Importance of My AABT Presidential Address

It is both a treat and an embarrassment to be asked to comment on the importance of one's work. The only thing one can really do is suspend modesty and try to comment on it as if it were the work of someone else. I will try to do that.

Empirical versus Ethical Questions

I think my paper, and the rebuttal to the Sturgis-Adams critique, have contributed to a clearer understanding of the difference between what we as psychotherapists *can* or think we can do and what we *ought* to be doing. It is surprising to me how difficult it is for some folks to see this essential and simple difference. In my teaching I sometimes use an intentionally bizarre example to make the point. I tell students that I have a one-session cure for any mental/emotional/behavioral problem. In fact, it works in much less than one session. Indeed, it works in much less than one minute. It is a bullet in the head of the patient. With death comes an end to all the person's psychological suffering and/or maladaptive behavior. No more panic attacks, no more depression, no more disordered thinking, no more shy withdrawal, no more non-assertiveness, no more autistic aloneness, no more psychopathic finagling, no more aggression. All gone in an instant.

So, what's the problem?

The concepts of values and biases are not as anathema in professional circles now as I found them to be when I was in graduate school in the mid-1960s. This is a good thing, and perhaps my paper has contributed to the clarification of the issue, whether or not people agree with the particulars of my argument.

The Therapist as Secular Priest

Related to this point are Perry London's writings on moral issues in psychotherapy (e.g., London, 1964). This influence from my graduate school days did not show up fully until I became obsessed with the sexual conversion issue. As indicated earlier, his concept of therapist as secular priest defines our role as inherently moral, whether we like it or not. Especially behavior therapists unabashedly try to shape the patient in ways that they believe will benefit the patient and not infringe on the rights and sensibilities of others. But we also are good at engineering what the patient ends up wanting, as Halleck said so eloquently in his 1971 book. I believe that my article has helped sensitize people to the issue, regardless of how they think about it. As a teacher it is enough for me to know that I may have helped frame the debate and made it legitimate, if not actually necessary, to consider the influence that therapists have on their patients, even when therapists think of themselves as hands-off when it comes to therapeutic goals. I just don't believe that patients don't get shaped in this way. At the very least, I think it is better to assume this shaping rather than, as we have been doing, assume its absence.

Liberalization on the part of the APA and ApA re Homosexuality

It's possible that my 1974 address and the publications based on it played some role in discussions that led stagewise to the dropping of homosexuality entirely from the DSM as well as to the recent position of APA against sexual conversion therapies. I am not in a position to know this, but friends and colleagues have suggested this to be the case. Certainly my own "conversion" in 1973-1974 took place at a time that changes in organizational viewpoints were occurring. I cannot help but be pleased if the position I took was at all instrumental.

Fewer Requests for Sexual Reorientation and Fewer Articles in the Professional Literature

Over the past 25 years there seems to have been a sharp decline in people seeking conversion therapy and there certainly has been a decline in articles published on the subject in the professional mental health literature (Campos & Hathaway, 1993). With respect to the latter, one can inspect the tables of contents of journals such as *Behaviour Research and Therapy*, *Journal of Abnormal Psychology*, and *Journal of Consulting and Clinical Psychology*, as well as the titles of psychotherapy books, and readily verify the decline. This does not mean that some therapy efforts do not continue to involve attempts at sexual reorientation — nearly all that happens in therapy settings remains hidden from view, with practically none of it seeing the light of publication. But I suspect the incidence is down, consistent with the decrease in our journals and professional books.

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Psychosocial Interventions as Part of Social Institutions

As I argued in my original paper, an institutional perspective is important in understanding the conduct of psychotherapy. As private and walled-off-from-the-world as outpatient and some inpatient mental health intervention is, therapists and patients do not work together in a social vacuum. As Halleck argued in 1971, the decisions made in the consulting room reflect and have effects on the politics and social fabric of the place and time in which therapy is conducted. Therapists' behavior is constrained by multiple factors – from theoretical orientation, to personal taste, to religious values, to legal requirements and strictures, and most recently to reporting requirements and treatment decisions from insurance companies. Patients' behavior is also influenced by multiple factors, and the emphasis in my writings on homosexuality is on the manner in which societal prejudices and biases shape the very way people come to understand what is wrong and what is right about themselves, what they might wish to change and what they might prefer to leave alone. I continue to focus on the specific issue of homosexuality because so many people have been and continue to be hurt by prejudice and discrimination. But as I hope is clear, the issues are much more general, going to the heart of how researchers and clinicians set their professional agendas, which in turn affect what they learn and the decisions they make. I believe and hope that the position I took in 1974 has contributed to the debate.

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Footnotes

¹ For helpful comments on an early draft of this paper, I thank Asher Davison. This article is dedicated to the memory of one of my mentors and a best friend, Perry London.

² This brings to mind something that Jerome Bruner said in a lecture in his cognitive psychology course back in 1959. He was discussing concept formation and how, once we have attained a concept of something, it is hard to recall what life was like before that understanding. I think his example was that we look at a chair, consider what it is, and try to remember what it looked like before we knew it was a chair. In an analogous fashion, I came away from my yearlong clinical apprenticeship with Lazarus with a new understanding of behavior therapy, different from what I had had before seeing him in action with patients.

³ In those days behavior modification encompassed — in the view of many laypersons like Senator Ervin's committee — psychosurgery and electroconvulsive shock therapy. The reason was that these and other techniques modified behavior. This was the kind of misconception we were dealing with at the time.

⁴ Sadly, Hank Adams died a few months before the present paper went to press.