Behavioral Techniques in Conjuction with Individual Psychoanalytic Therapy

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Psychoanalytic psychotherapy conducted by a competent therapist and an apparently motivated patient sometimes develops an impasse. Much time and thought have been devoted in the literature to dealing with various forms of therapeutic stalemates. Problems in the transference/ countertransference relationship have been discussed; intrapsychic motivations to remain under psychological distress have long been considered part of such problems. In the treatment situation, the analytic therapist and patient look for unconscious motivations that may represent the resistance to change. After extensive exploration, the therapeutic stalemate sometimes remains. The therapist may have no alternative but to stop treatment, or do more of what he has been doing.

When certain impasses present a stalemate in psychoanalytic psychotherapy, the use of certain behavior therapy techniques may be of help. What makes this suggestion startling and unusual is that psychoanalytic theory and behavioristic theory appear to have very different views about the nature or source of symptoms and psychological difficulties. However, a therapist does not have to resolve issues of theoretical difference in order to utilize these procedures. The clinician has to see if a procedure will be of help to his patient. For instance, a therapist may feel that an antidepressant medication would be helpful during psychoanalytic psychotherapy without subscribing to the notion that all neuroses are biochemical in nature. If new procedures are successful, the clinician may modify his theory and find a way to reconceptualize the procedures so that they fit into his slightly altered theoretical position.

There have been a few authors who have attempted to integrate behavior therapy techniques with psychoanalytic psychotherapy (1, 2, 3). For the most

part, however, psychoanalytic therapists have viewed behavioral approaches with alarm, fear, or disbelief. For the most part, analytic therapists are not acquainted with the procedures used in behavior therapy. They often react to what they imagine the procedures consist of and tend to regard these procedures as authoritarian in nature. Wachtel has discussed this issue at several points in his book (2) on the integration of psychoanalysis and behavior therapy.

The number of techniques that can be included under the rubric of behavior therapy is great. It is not possible to discuss all these techniques in the present discussion. This discussion will include only those techniques introduced by Wolpe, which probably represent the major techniques used in outpatient practice.

The techniques include desensitization, assertive training, and sexual retraining. These procedures have in common a gradual approach to a situation that produces anxiety. Be the problem an actual phobia or a fear of direct expression to others, the desired goal is approached in a series of incremental steps. These steps have been discussed with the patient, and the patient actively participates in bringing in material and evaluating how much anxiety would be produced if the patient were actually in the situation in question. The therapist also takes an active role in inquiring about situations related to the problem in question.

When ten to twelve situations related to the problem have been collected and rank-ordered for degree of difficulty, they are presented to the patient. In the desensitization procedure, the patient is taught muscle relaxation and trained to be able to enter a state of extreme body relaxation. In this state the patient is asked to visualize the scenes that were worked out earlier. Each scene is presented a few times, with a rest period between presentations. The scenes are presented in rank order, moving from least anxiety-provoking up the scale until the most frightening scene is finally visualized without anxiety. As each scene is desensitized so that it no longer evokes anxiety, the succeeding scene appears to

be less frightening than it was before the procedure was begun. Thus, when the fifth item is presented for imagination, it does not evoke as much anxiety as it would have if it had been presented at the beginning of procedure. However, the imagined situation still does evoke some anxiety until it is desensitized by being imagined several times in the state of extreme body relaxation.

A typical hierarchy presented by Wolpe (4) contained the following items in a claustrophobic series: the lowest item—reading of miners trapped underground; a middle scene—on a journey by train (the longer the journey, the more disturbing); the highest anxiety scene— being stuck in an elevator (the longer the time, the more disturbing). At the conclusion of the hierarchy in imagination, the patient is expected to be able to confront the actual situations without anxiety.

In the case of assertive training, situations are discussed in the manner outlined above. The capacity of the situation to evoke anxiety is discussed, and the situations are rank-ordered. In ease of assertion it might be easier for the patient to express annoyance to a waiter who brings the wrong order than to ask his boss for a raise or a vacation. The types of situations that create interpersonal anxiety will vary with each individual, as will the order of difficulty different situations produce. The patient is then asked to express himself in the actual situations, moving from least to most anxiety-provoking. If the situations, despite their being rank-ordered, still evoke too much anxiety for the patient to express himself, desensitization of the situation in imagination may be added as a prior step. After desensitization in imagination, the patient may then be able to express himself successfully in the actual situation.

In sexual retraining for a problem with impotence, the patient would be asked to avoid attempting intercourse until less anxiety-provoking sexual activities are accomplished without anxiety. The order of activities might be: lying in bed naked with the sexual partner; caressing in a pleasurable, non-erotic way; erotic stimulation without intercourse; and, finally, intercourse. As in the

case of assertive training, sexual retraining may be combined with desensitization.

The above descriptions of the procedures are necessarily sketchy in this short a space. A more complete description of the procedures, variations in techniques, and other behavior therapy techniques can be obtained from the literature (5, 6).

It is the use of the procedures of systematic desensitization, assertive training, and sexual retraining that will be discussed as techniques that might loosen some of the stalemates that develop in psychoanalytic psychotherapy.

One area of impasse is that in which specific troublesome symptoms do not abate during the analytic inquiry. This may cause continuous pain, anxiety, and/or embarrassment to the patient. It may also interfere with the patient's ability to talk about anything other than his symptoms and their ramifications. From an analytic perspective, the continuous discussion in therapy of problems with symptoms can be viewed as a resistance. However, if the resistance does not yield to interpretation, confrontation, etc., the therapist and patient are left in a painful stalemate. The introduction of behavior therapy techniques may alleviate the symptoms and may allow the psychoanalytic therapy to continue when the symptom is alleviated. Contrary to the thinking of a few years ago, the alleviation of symptoms does not necessarily reduce the patient's motivation for treatment, but may actually increase motivation for further change. It should also be added that symptom substitution has rarely been reported with treatment by behavioral techniques.

A man came to therapy with a primary complaint of impotence. He had been living with a woman for two years. He was clear about the positive qualities of this woman, who was a few years younger than he. She was bright, verbal, lively, exciting, successful in her career, and very attractive. He had had a good sexual relationship with her for over a year when the problem with impotence

began. He could not trace his reaction to any difficulty in his interaction with his partner, nor could she identify any interpersonal difficulty that precipitated the lack of sexual response. Several other potential precipitants were explored in the course of early interviews. The death of a close friend from a lingering illness had occurred around the time of onset of the impotence, but precise relationship in time was vague. Business worries and successes had fluctuated during the past several years. His developmental history indicated both deprivation and a rather strict upbringing, with rather harsh punishments for minor infractions of conduct. However, he was not aware of any resentment, anger, or depression related to parental treatment in the past or present. He was aware that he did not feel very close to anyone in his family, but he remained on pleasant terms with family members and tried to fulfill what he considered his obligations to them.

During sessions he appeared to be cooperative and motivated, but his thoughts did not range far afield from his symptoms. After a few months of twice-a-week psychoanalytically-oriented psychotherapy, I suggested a behavioral approach to the problems of impotence in the form of a graded approach to sexual intimacy. The patient and I discussed the stages of intimacy that would lead finally to sexual intercourse. They ranged from lying naked together, to non-erotic but pleasurable caressing, to several levels of erotic intimacy, and, finally, to intercourse. I explained that he should not shift stages of sexual intimacy too rapidly, so that he could feel pleasure and enjoyment without the anxiety of having to perform. He explained the procedure to his friend, who was agreeable to following the plan. Within a month he was able to have erections and to have intercourse.

At first the patient and his girlfriend were delighted with the change. However, the patient soon began to complain that, although he could perform adequately, he did not enjoy it very much. This led the patient to a more careful evaluation of his relationship with his partner. He began to recognize a pattern in which most ideas about what they should do came from her. He began to be aware that he was both resentful at always pleasing her and chagrined at himself

for not having many desires about what he, himself, would like to do. These issues led to further investigation in therapy.

The point of this vignette is to indicate that the use of a behavioral approach to a symptom is not incompatible with analytic therapy and may facilitate the analytic process. In the above instance, the alleviation of a disturbing symptom led to a closer investigation of the patient's character problems and how these problems affected his relationships.

We cannot know how things would have worked out if I had not employed the behavioral procedures. However, I am indicating that if one's clinical judgment suggests the use of other techniques, behavior therapy techniques may be useful both in alleviating a symptom and in facilitating analytic therapy.

Obviously, there is no guarantee that an attempt to alleviate a symptom by behavioral techniques will be successful. In one case of a married man with a problem of impotence alternating with premature ejaculation, a program similar to the one outlined above was suggested. In that case the patient reported that, although his wife agreed to follow the procedure, she seemed to do everything wrong. The procedure failed to alleviate the symptom, and the analytic therapy continued. However, some information about this patient's capacity to cooperate with his wife and others was obtained and questions about his ability to accept help were raised for the analytic therapy. It did not appear that much was gained in the way of symptom alleviation from the procedure in this instance, but it did not appear that much was lost in the process and some increased awareness of character problems was obtained. Many analytic therapists who are not familiar with behavioral procedures regard them as authoritarian, controlling, and therefore dangerous and stifling of the patient's independence. However, anyone who has actually worked with the more common behavioral techniques is aware that they are quite benign and tend to be simply ineffective when they do not succeed.

An obvious area of concern by therapists would be how the introduction of behavioral techniques affects the therapeutic relationship. If a therapist takes as his exclusive model a psychoanalytic technique in which the therapist tries to remain neutral and vague in order to facilitate the expression of phantasy material in the transference, the introduction of any parameter is obviously incompatible with the procedure.

If, however, one accepts the concepts of psychodynamics and the transference, but is willing to interact with the patient, then the introduction of behavioral techniques should not alter the basic nature of inquiry into the relationship between the patient and therapist.

During the introduction of behavioral techniques, the therapist assumes a more active role of educator and expert. This may be especially helpful where the patient has difficulty in the process of working through certain issues of a long-standing characterological nature. When analytic therapy is working well, the patient recognizes and discusses patterns of interaction with people. Often the patient will attempt to change certain patterns to produce more effective and satisfying relationships. Much of this work is done spontaneously by the patient and may only be mentioned incidentally in the therapy sessions. For instance, a man began to observe in greater detail how he held back at meetings and in initial interactions with other professionals. He began to realize that he automatically expected that, if he appeared confident and competent, people would have excessive and unrealistic expectations of him. His phantasies and dreams indicated that not being able to fulfill these expectations would lead to severe disappointment and anger from others. When further inquiry in this area was pursued in succeeding months, his own competitive feelings began to emerge. The analytic inquiry and discussion led the patient to resonate within himself to the therapy discussions. This led to dreams, phantasies, new observations, recollections, and attempts at new behavior. Although he had employed a variety of defenses over the years to deal with his anxiety over angry, competitive feelings, he could recall having the feelings, and in some cases acting

on these feelings, as a young boy. As he began to differentiate between appropriate and inappropriate reactions within himself, he was able to experiment with new behaviors on his own, with no prompting from the therapist. The patient's activity in his own behalf was of obvious help in changing his patterns of interaction with people and facilitated the working through.

With this type of patient no modification of technique seems to be required.

One of the serious problems in analytic therapy arises when the patient talks over and over about some pattern of interaction with people but makes no attempts at changing these patterns. Often the patient appears to search for new insights which will lead to his understanding why he doesn't change his behavior. The therapist may continue to explore, inquire, and analyze. He may continue to search for the meaning of the patient's resistance to change and hope that a more precise interpretation will lead to a significant insight that will move the patient towards change. However, as a number of therapists have observed, insight often follows change rather than being the cause of change. The search for understanding oneself is the important process of analytic therapy. However, at times the search for understanding can be put in the service of a subtle form of passivity in which the patient secretly hopes that the therapist will provide the correct insight that will magically change the patient. The patient hopes he can be spared the anxiety and struggle that often accompany attempts at change. The therapist's attempts at further understanding and interpretations may collude with the patient's passive orientation. The patient may even derive some gratification from the therapist's attempts to help or may enjoy seeing the therapist frustrated in his attempts to be helpful. In any event, the patient may ultimately be left with the frustrations and anxieties inherent in the types of interactions he has been unable to change. The therapist may be forced to conclude that the patient's resistances were too powerful, that the patient really needed this type of interaction, and that the patient had a powerful masochistic need to remain the same.

However, it may be that therapists with psychoanalytic orientation are at times oversold on the concept that the unconscious processes control all change. They therefore make an *a priori* assumption that attempts to achieve change by methods that do not deal with the unconscious are doomed to failure. However, this assumption does not agree with data that patients present to us.

One patient who came for treatment of depression with feelings of anxiety and sadness had on the occasion of the outbreak of her symptoms also developed a phobia of heights. She had on her own initiative developed a form of desensitization technique in which she gradually moved herself to looking out windows in her house at greater and greater heights. When she came to feel comfortable at one height, she would move on to the next. She continued this spontaneously developed procedure until she was able to endure the various heights without anxiety.

A man who came to therapy with problems centering around his difficulty in communicating and feeling close to a woman reported that a few years before he came to therapy he had developed a severe claustrophobic reaction. He was unable to sit in any small confined area. He was unable to have dinner in a restaurant because of the claustrophobic sensation of being trapped, with ensuing waves of panic. However, when he told one girlfriend about this problem, she suggested that they go to a restaurant and assured him that if he felt anxious she would be willing to leave immediately without finishing the meal. He reported that this produced a sense of security within him, so that when he went to the restaurant he did not feel the anxiety; the claustrophobia abated and had not returned since.

One can certainly wonder about what factors produced the change in this man; in fact, they were profitably explored in therapy. However, the point I am focusing on is that important change takes place without first making unconscious material conscious. In fact, previously dissociated material may become conscious as the patient begins to make changes, especially in his

interaction with others. Under ideal conditions, discussion with the therapist may lead to pointing out of patterns that were not previously noted in a focused way by the patient. This may stir recollections of earlier patterns of interactions and clarification of feelings. The patient may then, spontaneously and without urging from the therapist, begin to behave and interact differently with others, which will lead to the surfacing of other conflicts and dissociated material. However, when this pattern does not occur and when the patient does not put into action any of the insight gained in therapy, the therapist may feel that his only recourse is to try to provide more insight into the unconscious processes. At some point of exasperation or frustration the therapist may ask, "What would be so terrible if you told your mother… father…child…that you didn't feel like doing what they ask?"

The problem with this indirect urging of the patient to action is that the therapist is forced to react to a situation that the patient has spontaneously brought to the therapist's attention. I think it is especially true, where patients have difficulty in asserting themselves and being direct and straightforward, that what they discuss in therapy is only a fragment of the total problem they have with assertion.

There are several problems that are often encountered by people who have serious difficulty in learning to assert themselves. They have often come from homes in which any form of assertion was strongly discouraged. Their families often equated assertion with aggression or hostility. The patients were threatened with loss of love and with being viewed in a negative way if they attempted to assert their feelings and opinions. If this pattern were not modified through interactions with peers, a total state of inhibition of assertion may have developed and been maintained until the patient entered therapy. The patient has become used to rationalizing his lack of assertion. In many, many small incidents he will tell himself that it would be unimportant to say what he felt, or that it might even be petty. There is nothing wrong with the judgment as it is applied to any given incident. However, if many incidents are observed, it could

be seen that there is a compulsive quality to the lack of assertion and that the choice is not voluntary. The patient lacks the option to assert himself. This freedom of choice becomes the goal of the behavioral change. The goal should not be to make the patient an assertive individual. To decide what kind of person the patient should be is clearly a countertransference problem of the worst order and does indicate an authoritarian orientation. The patient who is used to rationalizing his lack of assertion will dismiss incident after incident until a situation develops in which his lack of assertion embarrasses him or causes him a severe problem, such as not asking for a raise.

This type of patient raises the issue only on the rare occasions in which an embarrassing situation has suddenly developed. He does not have the resources to handle such an extreme situation. He may continue to avoid assertions in the milder everyday encounters and probably will have a blind spot regarding these events. His self-image may be dependent on his being a saint. His initial discussion of difficulty in assertion probably will not be followed up spontaneously until a new humiliating incident develops. As in most learning or relearning situations, it is best to progress from the simple to the difficult. However, life's events, especially as observed by the patient with selective inattention, do not present themselves in a way that is orderly enough to be optimal for learning. Events may appear to pop up in a willy-nilly fashion, and it is especially the more difficult ones that capture the patient's attention.

It can be helpful to the patient if the therapist takes a more active behavioral approach with such a patient. In order to do this, the therapist must actively explore situations in which assertion is a possible response. He can use some stock situations requiring assertion that have been compiled in the literature and can use his imagination to raise questions about other situations. He can then rank-order these situations with the patient. The patient can then practice new behaviors in a way that is within his grasp and is conducive to learning. This is not to say that various problems and unexpected issues may not develop. They probably will, and this is all to the good as it probably represents

other characterological issues that are related to the issue of assertion.

I am suggesting that it may be of more therapeutic benefit to develop a detailed analysis of the patient's capacity to assert himself with different people and in different situations than simply to explore his phantasies about assertion. Especially when the therapy is at an impasse, it would seem that the therapist should not do more of the same thing when that procedure has not yielded results. Furthermore, when a therapist addresses an issue as potent as being able to be direct with other people (strangers, friends, family), change in this area is bound to resonate with the total personality and produce new material in the patient's observation of self and others, in his dream life, and in his production of phantasies. This ripple effect, especially as it has its effect on intrapsychic processes, has not been reported in the literature because behavioral techniques are used primarily by behavior therapists and the production of dreams and phantasies is not used much in their work. It has been my observation that, when behavioral techniques are added to the analytic therapy, significant material develops in dreams and phantasies which can be used at the therapist's discretion for further analytic work.

One of the few reports of the interaction between behavior therapy techniques and psychoanalytic therapy is provided by Weitzman (3). In a detailed and thoughtful examination of the relationship between behavior therapy and psychoanalytic psychotherapy, he reports the use of desensitization to be of help in working with dreams. He states that when a patient reported a dream in which he had sparse associations, the patient was asked to use the muscle relaxation used in desensitization. The patient was then instructed to imagine either the last image of the dream or an image in the dream that seemed particularly disturbing. The author reports that the procedure greatly enhanced the patient's capacity to produce further images, free associations, and interpretations of their dreams.

Another example of the interaction between behavior therapy techniques

and psychoanalytic psychotherapy is provided by Rhodes and Feather (1). They distinguish between symptoms that yield directly to systematic desensitization and those that are resistant to this procedure. These latter symptoms are hypothesized to be related to an active current intrapsychic conflict. The symptoms that yield easily are seen as once having been related to intrapsychic conflict but currently not tied to conflict. The symptom is seen as a vestige of the former conflict. The symptoms that do not yield easily to systematic desensitization are hypothesized to be related to a current intrapsychic conflict. The authors describe using a form of desensitization procedure, but the scenes that the patient is asked to imagine are made up of phantasies based on the therapist's hypothesis of the underlying intrapsychic conflict. For instance, in the case of a young man with a problem of transvestism, they hypothesized underlying unconscious sadistic phantasies towards women. They constructed phantasies to match their hypothesis and asked the patient to imagine these scenes in the desensitization procedure. They report rapid alleviation of the symptom in 29 sessions; five months later in follow-up the patient reported no further desire to dress in women's clothing.

This report presents an interesting amalgam of psychoanalytic and behavioral approaches in which psychoanalytic hypotheses are brought in to help the behavioral technique.

Having stated that use of behavioral techniques not only may produce desired change in some behavior or symptom, but will likely have strong reverberations in the rest of the personality, I would like to return to the question of symptom substitution and why it does not seem to occur when a symptom is alleviated by behavioral techniques.

From the analytic perspective, one would have predicted symptom substitution with the rapid alleviation by behavioral procedures. Since the symptom is seen as a result of an unconscious process, then the alleviation of the symptom leaves the unconscious process intact and it would be anticipated that a

new symptom would take the place of the old. On empirical grounds, one would have expected the substitution from early observations of work in hypnosis. However, in early hypnotic technique, direct suggestion using the authority of the therapist and the passive obedience of the patient appear to have been the key factors in symptom alleviation. In using behavioral techniques, the *active* cooperation and participation of the patient are required. He must not only agree to the procedure but must actively help in developing hierarchies, bringing in relevant material and discussing with the therapist his assessment of what is being done. If at any point in the procedure the patient feels that the procedure does not suit him, he can break off the process directly or can sabotage the proceedings unconsciously. I suspect that if the process of change is felt to be threatening, the patient has enough latitude to interfere with the procedure so that change does not take place; therefore, symptom substitution is not an issue.

Viewing behavioral techniques from a psychoanalytic perspective, there has probably been too much emphasis on the older Id psychology. That is, where the unconscious motivations, drives, and conflicts are seen as the powerful, important forces and the primary focus of analytic attention. However, if one thinks more about the newer Ego psychology, much of what is accomplished could be viewed as a strengthening of the ego and the providing of procedures that allow greater adaptation and flexibility. Certainly, if one keeps focused on the patient's relatedness to others, as opposed to a narrow focus on primitive impulses, the learning situation provided by the behavioral techniques will seem more compatible with analytic therapy.

Whenever there is change in one significant area of personality, it is likely that the ripple effect will produce change or the desire for change in other areas. A young woman was afraid to ride in elevators. A new job required that she visit different businesses, requiring that she ride in elevators, which she was unable to do. She had previously been in psychotherapy, which had helped her. Desensitization was considered the technique of choice. She was taught muscle relaxation, and different types of elevators were rank-ordered in terms of the

capacity to produce fear or terror. A large, open-grill elevator in a metal shaft where she could both see and communicate with the world outside the elevator was much less frightening than a small, old, slow-moving elevator. A modern, quick-moving elevator with a telephone that connected to the lobby was somewhere between the other two in ability to produce fear. About ten variations in elevators were developed. With her eyes closed and under muscle relaxation, she visualized being in the elevators. She imagined the least frightening elevator first and moved to the next most frightening when the preceding visualization ceased to produce anxiety. As this desensitization procedure was completed, she was able to ride most elevators without anxiety, or with minimal anxiety.

The sessions had not been devoted exclusively to the desensitization procedure. We spoke about her relationships with her husband, her family, her friends, business associates. We spoke somewhat about her daydreams and I listened to her dreams, making a few comments and observations. I had gotten to know her during the desensitization sessions. As she became more able to get around in elevators, she began to talk about her difficulties in relating to others on her job. She explored these relationships, as well as her relationship with her family. She made connections between the familial patterns and her relationships on the job. She began to sort out what she was entitled to and what she was responsible for.

The alleviation of the symptom gave her motivation for making further change. I think that, at the simplest level, it indicated to her that change was possible. The alleviation of the symptom gave her more energy to deal with other issues. The alleviation of the symptom, I think, also changed her self image. I think it made her feel much less like a frightened little girl and allowed her to see herself as a young adult who was entitled to share and interact in the world of other adults. As a result, she felt more motivated and more entitled to work out her relationships and to solidify her image of herself as a grownup.

It used to be said in analytic circles that the symptoms provided the motivation for self-exploration and change. It was feared that, if there were rapid symptom alleviation, the patient would lose his motivation for analytic therapy. I supposed that this might still be the case where the patient enters analytic therapy, becomes frightened, makes a rapid but illusory recovery, and leaves treatment. This type of flight into health is short-lived, and the symptoms usually return. With the use of behavioral techniques, the patient has not been frightened, but has been cooperating with the therapist in working to alleviate the symptom. Under the latter circumstances, when the system is alleviated, the patient feels he has achieved something that is positive for himself and may want to change other aspects of his life. However, it is possible that with the alleviation of the symptom the patient would feel that life is satisfactory and would not want further treatment. I feel that the patient should be entitled to leave with the option to return if life does not run as smoothly as he anticipates. If the therapist decides how much and what kind of change a person should make (albeit for humane reasons based on psychoanalytic understanding of character structure), the therapist will, nevertheless, begin to play Pygmalion. The therapist has the obligation to state what further change he feels might be indicated and to raise questions about stopping if he feels it is unwise to do. However, to insist on further change, exploration, and treatment is at best to play the role of the parent in deciding what is best for the patient and what type of person he should become. To take things a step further, when the analytic therapy bogs down because the patient becomes focused on a debilitating symptom, it may be an injustice to the patient to avoid the use of new techniques on theoretical grounds or on an aesthetic distaste for some other form of treatment, such as the behavior techniques.

It is often possible for the therapist practicing analytic therapy to refer the patient for behavioral techniques while continuing the analytic therapy. A man was in analytic therapy and had a severe elevator phobia. After two years of therapy, the phobia had gotten slightly worse and the patient spent a great deal

of time talking about his problem of having to walk thirty flights of stairs to work. In addition to this unwanted exercise, the man lived in dread that someone would discover his fear. In therapy he spent more and more time discussing strategies for how to avoid elevators without anyone's discovering his phobia. The analytic therapy became bogged down in endless discussions of his fear, his strategies to avoid detection, and his search for the cause of the phobia. Both he and the therapist became increasingly frustrated and annoyed with each other.

At this point in the treatment the therapist might think of doing something to alleviate the fears. However, reasoning from an analytic point of view, the therapist might have some serious concerns. The increased focus on the troubling symptom could be viewed as a resistance. As such, the resistance should be analyzed. The therapist might fear that the addition of techniques to deal with the symptom would alter the transference and countertransference so that future analytic therapy would not be possible. However, the therapist referred the patient for behavioral treatment of the phobia. Desensitization of the phobia was successful in alleviating the intensity of the symptom; while it did not eliminate the fear entirely, the patient was able to ride the elevator to work. The patient had continued the analytic therapy while going to a second therapist for behavioral treatment. As soon as the behavioral therapy was added, the patient was able to talk to the analytic therapist about other things, feeling that the behavioral therapist would be dealing with the symptom. When the behavioral therapy was concluded, the patient continued to work with the analytic therapist on other analytic issues.

Analytic therapists who feel that they might like to add parameters when therapy is at an impasse often express concern about what the addition of behavioral techniques will do to the transference/countertransference.

If one is committed to remaining neutral and vague as a technique in order to promote and not interfere with the emergence of transference, then no parameter may be introduced without violating the technique. If one is willing to

introduce modifications, then one does have to be alert to the effect on the therapeutic relationship, which includes transference and countertransference. However, if the therapist truly has respect for the powerful force that transference has, then he will not fear that the transference reaction will disappear because he takes a more active role. His activity as an expert who can work in cooperation with the patient in designing approaches to alleviate symptoms or working on procedures that will facilitate the learning of new interactions with others will undoubtedly produce reactions in the patient. Some of these reactions will be distortions based on the patient's prior interpersonal experiences. In working with these procedures, the patient could feel anything from undue gratitude to resentment that he couldn't do it himself. These reactions are worthy of further analysis in treatment, as they would be if the new techniques were not introduced. If transference is the powerful reaction we think it is, it will manifest itself without the special technique of neutrality. More active analytic techniques include working with transference, and analysts who are active, confronting, and spontaneous report a great deal of transference material developing in their work with patients. If the therapeutic atmosphere is open to hearing about these reactions, they will occur and be stated.

In describing what the therapist does when he uses behavioral techniques, there is a tendency to borrow the language of the behaviorists. This can actually be misleading in that the behavioral description is not only operational but includes behavioristic concepts. In behavioristic language, one could say that in desensitization the therapist, through discussion with the patient, develops a series of stimulus situations dealing with whatever the patient is anxious about. These stimuli are presented in rank order, from least to most frightening, while the patient is in a state of extreme relaxation. The presentation is made by asking the patient to imagine the stimulus situations. However, as in any complex activity, there are many things taking place simultaneously. Each therapist is alert to those aspects that his theory suggests are the important and crucial ones. If non-behaviorists used some of the behavioral techniques, they might be alert

to the following phenomena: While imagining the frightening scenes, the patient is in a state of muscle relaxation. Does this effect a change in the character armor of the patient, as discussed by Reik?

In working with a patient who has anxiety reactions or multiple phobias, the therapist accepts that the patient has fears without questioning underlying motivations, wishes, impulses and the like. Is this a form of unconditional positive regard for the patient, as described by Rogers? In desensitization, the patient is asked to imagine a frightening scene that is judged to be at a level that will produce minimal anxiety. He is then asked by the therapist to relax. After relaxing, he is asked to face the next, slightly more anxiety-provoking scene and then asked to relax again. In this situation, is the therapist recreating the situation of the good mother, who encourages the child to face an age-appropriate level of anxiety with the reassurance that the child can return to the mother and feel protected and relaxed? Is the process of desensitization a way of correcting a developmental flaw that psychoanalysts have discussed but have no direct way of treating through analysis? The process of relaxation tends to promote an increase in visual imagery. When patients are asked to visualize a scene, they may visualize the scene for a time but may also visualize other images, while stray thoughts and feelings enter their awareness (3). I have had patients describe that, although they could visualize the scene they were asked to, they also had thoughts and images that they could not remember but that were like images they had in dreams, or while falling asleep. Are these stray thoughts and images free associations that are connected to the fear, and are these associations also being desensitized?

I raise these questions to indicate that there are many phenomena taking place that might be worthy of study in their own right. I do not raise these notions to refute the behavioral theory that a special kind of learning, called conditioning, is taking place. A theory is a model for understanding and predicting. I am suggesting that when therapists of other theoretical viewpoints use the behavioral techniques they may refine their observations and thinking

about their own theoretical point of view.

At a practical level, the introduction of behavioral techniques into analytic therapy may be of help to the patient's problems and may facilitate further therapy. The use of behavioral techniques in analytic therapy may also broaden theoretical considerations.

REFERENCES

1. Rhodes, J. M. and Feather, B. W. The application of psychodynamics to behavior therapy. *Amer. J. Psychiat.,* 1974, 131:17-20.

2. Wachtel, P. L. *Psychoanalysis and Behavior Therapy.* New York: Basic Books, 1977.

3. Weitzman, B. Behavior therapy and psychotherapy. *Psychol. Rev.,* 1967, 74:300-317.

4. Wolpe, J. The systematic desensitization treatment of neurosis. *J. Nerv. Ment. Dis.,* 1961, 132:189-203.

5. Wolpe, J. *Psychotherapy by Reciprocal Inhibition.* Stanford: Stanford University Press, 1958.

6. Lazarus, A. A. *Multimodal Behavior Therapy.* New York: Springer, 1976.