Psychotherapy Guidebook

Contextual Therapy of Phobic Behavior

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e-Book 2016 International Psychotherapy Institute

From *The Psychotherapy Guidebook* edited by Richie Herink and Paul R. Herink

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DEFINITION

The psychotherapeutic technique called “Contextual Therapy” is based upon the observation and functional analysis of a person’s disturbed behavior in the natural contexts where it occurs and changes. This approach allows identification of factors and relationships inside and outside the person, and conceptualization of processes that make behavior get better or worse.

HISTORY

Such a contextual approach was originally developed to observe, comprehend, and deal with disturbed motor behavior and learning occurring in the physically handicapped during their rehabilitation programs (Zane, 1962, 1966). In the past eighteen years this approach has been intensively applied to the study and treatment of phobic behavior both privately and in clinics.

TECHNIQUE

People who are phobic automatically develop, in commonplace situations, fear and distress that can intensify uncontrollably to cause unbearable feelings and overwhelming panic. Contextual Therapy finds that in all phobias these terrifying developments are the result of an automatic, fear-generating process. This "phobogenic process" is activated and accelerates as the person involuntarily reacts more and more to growing numbers of imagined dangers and less and less to comforting realities in the phobic situation.

If a trusted person is present or available in reality or in imagination, the phobic person can then react more to comforting realities and less to imagined dangers in the phobic situation. The level of fear then drops or remains controlled and panic is averted.

Recognizing the central role of the phobogenic process in disorganizing body and mental functioning, it is hypothesized that Contextual Therapy slows or inhibits the phobogenic process, and so stops the panic. It does this by creating conditions that reduce the person's disturbing reaction to unmanageable, imagined dangers and builds up his comforting responses to manageable, existing realities. Mainly, this is achieved by creating a trusted, familiar therapeutic presence for the patient to respond to realistically in the phobic situation. Sometimes this is the therapist, or a recollection of him or of

his theory, or of ideas built with his concurrence. The operations of the phobogenic process are then impeded and the rising panic stops. New, constructive experiences and learning can then take place in the phobic situation from which more realistic beliefs, expectations, and behavior can come.

An example might best illustrate the technique. A thirty-five-year-old woman was afraid of and avoided closed-in places, elevators, high floors, tunnels, and airplanes. Traditional office psychotherapy had helped her in many ways but not with her phobias of ten years' standing. At our first meeting I obtained the history of her phobia and its surrounding circumstances. Then I explained my belief that she could help herself best if she could encounter, deal with, and study her phobic reaction in my presence. She then agreed to step into my windowless, unlocked, walk-in closet alone and tell me, when she could, what she felt and thought. Almost as soon as I closed the door she swung it open. She said she became panicky when she thought I might be trying to trick her. Immediately she felt trapped, felt increasing difficulty in breathing, experienced waves of heat and heart palpitations, pictured herself smothering if she continued, and abruptly opened the door. I assured her I was opposed to any tricks and that it was for her to decide if she wanted to undertake the task. She then returned to the dark closet and soon consented to my walking away and leaving her alone. Quickly she felt great fear and strong impulses to bolt. But this time she was

able to stay as she reminded herself that she was safe, that it was a closet in my office with sufficient air, that she could open the door if she so chose, that it was for her good that she was doing this, and that I was a doctor and would help her if she fainted or had any trouble.

Afterward we went over the experience and identified the factors — mostly thoughts, feelings, and imagery — that had made her fear and behavior get better or worse. Alluding to our shared, concrete experience, I pointed out how staying with the realities despite her feelings of fear had helped and getting lost in imagined dangers had created disturbances and panic, compelling her to run out. What had just happened, I said, was a model combining what had always made her problem worse in other phobic situations and what she must now try to do over and over again to help herself.

In steps, she began to practice going into her phobic situations — with me, with a non-professional helper, with her husband, and eventually alone. We kept examining her successes and failures to help her learn how her phobic behavior was affected by many identifiable factors, particularly by her thinking. Gradually, she became less afraid of becoming afraid in the phobic situation. This happened as she learned to keep her fear under satisfactory control in the phobic situation by reacting increasingly to manageable things in the present and less to unmanageable anticipated dangers. After ten visits

over a three-month period, she was able to ride elevators to high floors many times by herself, drove through a tunnel, first with me and then alone, and took an airplane with her husband to Europe. Often, when her fear and distress arose, she could halt or slow the phobogenic process by remembering the successful closet experience, by recognizing that her increasing feelings of fear were coming from her imagined dangers, and by staying connected and responding to comforting realities. She returned to her referring psychotherapist considerably improved and in possession of a method that enabled her to continue to work on her remaining phobic problems.

APPLICATIONS

The same technique is used for all kinds of phobias. Some people will respond more quickly and many will take much more time, requiring the slow buildup of new realistic beliefs that can stand up to the impact of long-standing fear and patterns of distorted thinking. Very similar techniques and methods of treatment have been developed by others, particularly by Claire Weekes of Australia.

Like animal ethnology, Contextual Therapy observes and studies behavior as it changes in its natural contexts. And like the emerging cognitive therapies, this method recognizes the powerful role in human behavior of changing thought and imagery. While the contextual approach also explores hidden mental processes, it differs greatly from contemporary psychoanalysis, which directly observes behavior only in the office. And despite sporadic similarities in technique, Contextual Therapy differs very much from those behavior therapies whose theories are derived from laboratory studies of animals.