Contents

Understanding Behavioral Change in Psychoanalytic Treatments

This chapter reviews factors that have led psychoanalysts to avoid focusing on behavioral change (Table 1–1) and describes more recent efforts to target behavioral change. Although theorists and clinicians erred in believing that focusing on behavioral change would be inherently damaging to treatment, they identified specific difficulties to be alert to in using these strategies, including potential disruptions in the therapeutic relationship. In recent years, psychoanalysts have described techniques for handling the prescribing of medication, and some clinicians have begun to develop strategies focused on behavioral change. The use of these approaches suggests ways in which targeting behavioral change can aid, rather than disrupt, psychoanalytic goals.

Why Psychoanalysts Have Avoided Focusing on Behavioral Change

The Avoidance of "Suggestion"

The historical reaction in psychoanalysis to more directive interventions, such as behavioral change, can be traced to Freud's wish to minimize

TABLE 1–1. Why psychoanalysts have avoided focusing on behavioral change

Avoidance of "suggestion": interferes with developing insight
Disruptions of neutrality: suggestions take a side in patients' conflicts
Disruptions in abstinence: behavioral suggestions gratify patients
Symptom substitution: behavioral change requires insight
Disruptions in the therapeutic relationship
Pressure to be the "good" patient
Becoming dependent on the therapist
A need to submit to the therapist
An urge to rebel against suggestions

the role of suggestion after he revised his early theories and approaches, such as hypnosis. In elaborating on the need to avoid suggestion, Freud (1917/1963) contrasted it with the effort to identify underlying motivations: "Direct suggestion is suggestion aimed against the manifestation of the symptoms; it is a struggle between your authority and the motives for the illness. In this you do not concern yourself with these motives; you merely request the patient to suppress their manifestation in symptoms" (p. 448). Freud (1923/1955) clearly differentiated psychoanalytic approaches as excluding suggestion: "Psycho-analytic procedure differs from all methods making use of suggestion, persuasion, etc., in that it does not seek to suppress by means of authority any mental phenomenon that may occur in the patient" (p. 250).

Despite these concerns, Ferenczi (1921/1980) developed an "active therapy" that sought change through particular behavioral interventions, for example, by encouraging a patient to sing in psychotherapy. Although he noted that these strategies should only be used when the usual psychoanalytic techniques had failed, his ideas were not welcomed by the psychoanalytic community, particularly Freud. As Freud (1924/1965) averred, "active therapy is a dangerous temptation to ambitious beginners" (p. 481). As with many new theories and therapeutic approaches, Freud's antagonism put a damper on further exploration of these strategies. Targeting behavior, including giving advice, eventually was placed under the heading of "supportive" psychotherapy, which was typically seen as

inferior to "expressive" or insight-oriented psychodynamic psychotherapy (Gabbard 2014).

Disruptions in Neutrality and Abstinence

Psychoanalysts have avoided focusing on behavioral change in part because of its perceived disruption of core components of the analyst's stance, neutrality and abstinence, both of which are considered essential to treatment effectiveness. *Neutrality* refers to the analyst's not siding with the ego, superego, or id, aspects of the individual that are often in conflict; the goal is, instead, to help elucidate these various elements. It subsequently has been interpreted to mean that the analyst is neutral with regard to the patient's behavior or choices (Gabbard 2014; Kelly 1998). According to this understanding of neutrality, because a person is in conflict about what action to take, the analyst would not want to take sides by suggesting or advising that the patient behave in a particular way. If the therapist suggests a specific action, then the patient would be in conflict about whether to enact it, or have an urge to do the opposite behavior. Furthermore, encouraging or advising behavioral change may be viewed as gratifying the patient (Gabbard 2014). Gratification, as opposed to the technical stance of abstinence, is believed to interfere with the patient's motivation to explore unconscious intrapsychic conflicts. However, other psychoanalysts have suggested that these technical concepts have been overextended, problematically limiting the analyst's flexibility in treating patients (Busch and Sandberg 2007).

Symptom Substitution

As noted in the introduction, psychoanalysts generally believe that gaining insight into intrapsychic conflicts is essential to relieve symptoms, inhibitions, and problematic behaviors (Kazdin 1982). If the symptom or behavior was changed without the underlying intrapsychic conflict becoming conscious and being explored, another symptom or problematic inhibition would arise as an expression of the conflict. As cognitive behavioral therapies began to demonstrate that symptoms could be relieved without insight about intrapsychic conflicts (Thoma et al. 2015), clinicians questioned whether this theory was correct. Wachtel (1997) suggested that symptom substitution does not happen in behavioral treatments because patients confront fears in new ways, which may not

include gaining insight. Indeed, empirical research thus far suggests that symptom substitution is not a typical occurrence (Tryon 2008).

Disruptions in the Therapeutic Relationship

Psychoanalysts believe that working directly with behavioral change, with its use of suggestion and distortions in neutrality and abstinence, can lead to the development of problematic patterns in the therapeutic relationship, which can take several forms. Patients, aware that the therapist wants them to make certain changes, could develop a need to please the therapist by trying to change behavior and/or may develop feelings of inadequacy if they are unable to make the change. They may also feel pressured to submit to the therapist's suggestions and view themselves as "bad" patients if they do not follow through or complete the task that they are working on in therapy. Patients could become dependent on the therapist, feeling that they need the therapist's advice to make decisions. Alternatively, as mentioned above, the therapist, by taking a side in a patient's conflicts through giving particular suggestions, could induce a struggle within the patient about whether to follow or rebel against the therapist's suggestions. These distortions can complicate the therapist's interpretation of the transference, a key component of psychoanalytic therapies (see Chapter 4, "Using Psychodynamic Techniques in Addressing Behavioral Change"). In recent years, proponents of targeting behavior have suggested that although it is important to be alert to these risks, positive changes can often enhance the therapeutic relationship.

The Shifting View on Behavioral Interventions

These concerns about adverse consequences have inhibited psychoanalysts from considering what role they may play in more directly helping patients with behavioral change, leaving them at a loss as to how to proceed theoretically or technically in this effort, other than to avoid it. However, in recent years, psychoanalysts have developed approaches for being prescriptive, such as recommending and treating patients with medications (Busch and Sandberg 2007) or obtaining a treatment contract with agreements about such issues as self-destructive behaviors (Levy et al. 2006). Summers and Barber (2010), describing pragmatic psychodynamic psychotherapy (PPP), addressed the importance of fo-