Behavior Therapy Versus Psychoanalysis

Therapeutic and Social Implications

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ABSTRACT: *Although the specific efficacy of psychoanalytic therapy in the treatment of the neuroses has never been demonstrated, psychoanalytic theory and practices continue to dominate the field of clinical psychology. That psychoanalytic theory has not been displaced by the behavioral theory of neurosis is remarkable in view of the persuasive evidence that exists for the efficacy of behavior therapy. One reason for this seems to be the persistence of widespread misperceptions of behavior therapy. It has been represented to the public as an "inhuman" treatment that routinely resorts to electric shocks and other unpleasant agents and to the profession as a therapy incognizant of the patient's feelings or thoughts and applicable only to neuroses that are "simple," such as phobias—an image regularly reinforced by "authorities" who are misinformed. This article attempts to correct these misperceptions. It also draws attention to the suffering imposed on many by years of psychoanalysis. The promise of widespread availability of behavior therapy as an alternative will only be fulfilled when more high-quality training is funded.*

The present century has seen the birth (Jones, 1924) and the development (Ayllon & Azrin, 1968; Wolpe, 1958) of behavior therapy—methods of psychotherapeutic change founded on principles of learning established in the psychological laboratory. Its results in the treatment of human neuroses have been quite impressive. Paul (1966), on the basis of a survey of controlled studies on systematic desensitization, has stated, "For the first time in the history of psychological treatments, a specific therapeutic package reliably produced measurable benefits for clients across a broad range of distressing problems in which anxiety was of fundamental importance" (p. 159). Nevertheless, it is *psychoanalytic* theory that has continued to be the most pervasive influence in psychotherapeutic practice.

The Reign of Psychoanalysis

According to psychoanalytic theory, mental activity is partly conscious and partly out of reach of consciousness in the "unconscious mind." Neurotic symptoms are regarded as the manifestations of emotional forces that have been "repressed" in the unconscious. Freud (1922/1950) regarded these symptoms as "compromise formations between the repressed sexual instincts and the repressive ego instincts" (p. 107). Psychoanalytic therapy aims to overcome a neurosis by bringing the putative repressed impulses into consciousness, through such means as free association and dream analysis. All the derivatives of psychoanalysis (the theories of Adler, Sullivan, and others) exert their main therapeutic effort toward making the unconscious conscious (Munroe, 1955).

The clinical effectiveness of psychoanalytic therapy has never been established. Eysenck (1966), in a review of 24 studies encompassing over 7,000 cases, concluded that the data failed to show that psychoanalytic therapy facilitates the recovery of neurotic patients. Erwin (1980) has convincingly defended Eysenck's conclusion against challenges by Bergin (1971), Bergin and Suinn (1975), and Brown and Herrnstein (1975). A particularly noteworthy study is that of the Fact-Gathering Committee of the American Psychoanalytic Association (Note 1). Out of 595 patients, 306 were judged to have been "completely analyzed" (in a mean of about 600 sessions); 210 of these were followed up afterwards, and 126 were stated to have been cured or greatly improved. This is 60% of the completely

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analyzed group but only about 31% of the original total.

It is customary to turn a blind eye to such poor results and to contend that the treatment is nevertheless on the right track because the psychoanalytic theory of neurosis is true. In actuality, not a single one of the theory's main propositions has ever been supported by scientifically acceptable evidence (see, e.g., Bailey, 1964; Salter, 1952; Valentine, 1946). But this too is brushed aside. That this happens is a tribute to the expository brilliance with which Freud presented his theories. His writing weaves a magic web from which few can extricate themselves once enmeshed. To the convinced it is sacrilegious to suggest the need for anything so mundane as empirical testing.

After a phase of outraged opposition to psychoanalysis early in the 20th century, converts to it were legion. In 1939, it was officially approved by the American Medical Association. By then it had become widely accepted by Western intellectuals as a philosophy of life. They saw it, in vibrant contrast to the dry abstractions of academic psychology, as a psychology of reality, dealing with things that mattered and revealing dark and mysterious aspects of the mind.

Not everybody was persuaded. There were many who saw the flaws in the theory and some who vigorously criticized it. One of the most noteworthy critics was Wohlgemuth, whose *Critical Examination of Psychoanalysis* appeared in 1923. But critiques like his had little effect—illustrating Conant's (1947) maxim that theories are not abandoned on the basis of contradictory evidence. On the other hand, Conant attests that they *are* abandoned when better theories arrive on the scene. There was no better theory in 1923. But now, in 1981, a seemingly better theory—the behavioral theory of neuroses—has been with us for a quarter of a century. Yet psychoanalysis sits firmly in the clinical saddle. The first step in attempting to explain why this is so is to examine what evidence there is that behavioral theory and the therapy that emerged from it are really better.

Conceptual Origins and Therapeutic Efficacy of Behavior Therapy of Neuroses

I shall now review the foundations of the behavioral theory of neurosis and the evidence of the clinical efficacy of behavior therapy. At the beginning of this century, Pavlov produced "experimental neuroses" in animals—a long-lasting susceptibility to the triggering of strong anxiety responses by particular stimulus conditions, a susceptibility in many respects similar to the neuroses of human beings (Wolpe, 1967). Many experimenters in the United States subsequently confirmed Pavlov's observations, often using variations of his procedure (for a review, see Wolpe, 1952). Using a method described by Dimmick, Ludlow, and Whiteman (1939), I produced experimental neuroses in cats by administering painful but nondamaging electrical stimuli (high voltage, low amperage) of two seconds' duration to an animal in a small cage (Wolpe, 1952, 1958). This stimulation elicited strong fear reactions: The animal's pupils dilated, its hair stood on end, and it breathed rapidly. Repeating the stimulation at irregular intervals of minutes resulted in the animal's becoming very fearful of the cage and surrounding stimuli in between 5 and 20 repetitions. The autonomous power of these stimuli strongly to arouse fear would have lasted the life of the animal if left untreated (Gantt, 1944). The fear was undiminished by exposures, short or long, to the experimental cage, nor was it alleviated by months of absence from the cage. In every animal, however, the fear could be systematically weakened, eventually to zero, by arranging for small amounts of it (evoked at first by generalized stimuli) to be inhibited by the competition of eating behavior. This suggested that a therapeutic principle resided in response competition. Clinical trials showed that the competition of feeding also overcame children's fears (Jones, 1924) but not those of adults (Wolpe & Wolpe, in press). Fortunately, a considerable number of other responses were found to have the ability to inhibit and consequently to overcome adults' fears. Fear can be inhibited by the calmness generated by deep muscle relaxation, by the expression of legitimate anger in the context of certain inappropriate social fears, and by the use of sexual responses in cases of sexual fear, as well as by a number of more esoteric methods, including flooding (Wolpe, 1973).

The important question, however, is whether these experimentally derived methods actually achieve an unusual percentage of favorable results and are significantly more economical of time and effort. The answer lies in a comparison with the well-documented fact that the practitioners of practically any system of psychotherapy obtain recoveries or marked improvements in 40%–50% of the cases they treat (e.g., Eysenck, 1966). If the followers of different systems—Freudian and Jung-

ian analysts, nondirective therapists, encounter groupers, and primal screamers—all achieve this percentage, there must be a common process working for all of them that has nothing to do with their respective techniques. The distinctive procedures of a therapeutic system cannot be said to be helpful unless a recovery rate significantly above the common baseline can be shown.

The question then becomes, Does behavior therapy improve on the common run of results? The first published statistical analysis of behavior therapy was based on my own uncontrolled clinical observations (Wolpe, 1958). In a mean of 30 sessions, 188 (89%) out of 210 neurotic cases I had treated were either apparently recovered or at least 80% improved on the criteria proposed by Knight (1941): symptomatic improvement, increased productiveness, improved adjustment in pleasure and sex, improvement in interpersonal relationships, and ability to handle ordinary psychological conflicts and reasonable reality stresses. It has since that time been commonplace for skilled behavior therapists to report marked improvement in at least 80% of their neurotic cases. A relatively recent development has been the striking success of flooding and response prevention in the treatment of those obsessive-compulsive neuroses in which the patient is preoccupied with avoiding and washing away "contamination" (Foa & Steketee, 1979; Meyer, 1966; Rachman, Hodgson, & Marzillier, 1970). These cases used to be one of psychiatry's knottiest problems; and now the great majority of patients can expect to recover or improve markedly in a matter of weeks.

Further support for behavior therapy comes from a large number of controlled studies, of which I shall mention two of the more notable. Paul (1966) had psychoanalytically oriented therapists treat severe fears of public speaking with three techniques—their own accustomed short-term insight therapy, systematic desensitization, and a control procedure called "attention placebo." The therapists did significantly better with systematic desensitization than with their own techniques or with attention placebo.

The second study is that of Sloane, Staples, Cristol, Yorkston, and Whipple (1975). "Mild" and "moderately severe" neurotic patients were randomly assigned to two treatments—behavior therapy or brief psychoanalytically oriented psychotherapy—or to a waiting-list control group. At the end of the four-month treatment period, on a rating scale of overall improvement, 93% of the behavior therapy patients, in contrast to 77% of the psychotherapy and waiting-list groups, were considered either improved or recovered, a difference significant at the .05 level. Patients treated by behavior therapy also showed significant improvement in work and social adjustment, while psychotherapy patients showed only marginal improvement in work and none in social adjustment. At one year, only those who had been treated by behavior therapy showed greater improvement in target symptoms than waiting-list subjects.

The False Image of Behavior Therapy

The use of procedures similar to those successful in extinguishing strong anxiety-response habits in experimental animals has thus increased our power to overcome unadaptive, learned anxiety-response habits in humans. Behavior therapy does what had been predicted on theoretical grounds. This is a unique achievement in the field of psychotherapy that should surely entitle the behavioral approach to center stage. Why has that position been denied it?

It is a matter of its image, which has been distorted in two major ways. To the public, behavior therapy has been represented as being made up of cruel and degrading treatments that emphasize aversive shocks and include sensory deprivation, brainwashing, electroconvulsive therapy, and psychosurgery. This is the accepted newspaper image. Mitford's (1973) book, *Kind and Usual Punishment: The Prison Business*, is particularly derogatory. This kind of vilification began with reports of treatments in prisons that were actually conducted by persons who were not behavior therapists (for a review, see Friedman, 1975). Although the accusations against behavior therapy were rebutted by Goldiamond (1975), the adverse implications have remained in the public mind. A particularly baneful influence in the same direction was the film *Clockwork Orange*, in which a repulsive and entirely fictional treatment was represented as behavior therapy.

Within the fields of psychiatry and clinical psychology, there is a widespread misperception of behavior therapy as a simplistic and perfunctory enterprise applicable only to phobias and some sexual difficulties. Its practitioners are supposed to be insensitive to and uninterested in the subtleties and complexities inherent in most human problems. One factor that has contributed to this image is the predominance of simple phobias, and especially snake phobias, in reports of research. Most

damaging have been the negative opinions frequently expressed by prominent but ill-informed psychiatrists and psychologists of various orientations. For example, Marmor (1980) recently declared that behavior therapy's major emphasis is on "removing the presenting symptom or symptoms by behavior modification; and the patient's subjective problems, feelings, or thoughts are considered essentially irrelevant to the psychotherapeutic process" (p. 410). Similarly, Lazarus (1977) asserted that behavior therapy is characterized by the "eschewal of most cognitive processes" and by a view of cognitive processes as "entirely secondary to sub-cortical autonomic conditioning as the *real* basis of emotional and behavioral change" (p. 552). And Marks, a British psychiatrist who is very popular with American psychiatrists, has repeatedly proclaimed that behavior therapy is applicable to "perhaps 10% of adult psychiatric outpatients," those with phobias, obsessions, and some sexual problems (Marks, 1975, p. 254). These examples typify the stream of inaccuracies about behavior therapy that pervade the literature.

That behavior therapy is neither indifferent to patients' thoughts nor narrow in its clinical scope is quite evident from its own literature. It has been applied with success not only to phobias and sexual problems but to the whole range of neurotic problems, including the most complex social neuroses and so-called existential problems. Again and again, in a modest time span, it has secured recovery in neurotics for whom lengthy psychoanalyses have failed (e.g., Wolpe, 1958, 1964).

The accusation that behavior therapists consider their patients' "subjective problems, feelings, or thoughts" irrelevant to the psychotherapeutic process is a transparent absurdity, as I showed in detail in a previous article (Wolpe, 1978, p. 442). It is the subjective problem, the complaint, that drives the neurotic patient to seek treatment, no matter of what kind. To the behavior therapist the patient's story is the primary data. The behavior therapist carefully probes all seemingly relevant experiences because consequent therapeutic actions depend completely on an assessment of what triggers what. The patient's "feelings and thoughts" are the main source of information, augmented by various questionnaires that the patient thoughtfully answers. No therapy is more "personalized" than behavior therapy; no other therapist knows as much detail about the patient as the behavior therapist does before commencing treatment; and nobody else tailors the therapy as explicitly to the individual's problems.

The process of acquiring the necessary information, *behavior analysis*, identifies and defines the stimulus sources of anxiety and establishes the causal connections between anxiety and any consequences it may have, such as sexual difficulties, depression, obsessions and compulsions, or antisocial habits like exhibitionism and kleptomania. The behavior analysis determines which neurotic anxieties are based on autonomic conditioning and which on cognitive errors or misinformation. It is the therapist's skill in conducting this analysis that makes it possible for behavior therapy to succeed in even the most complex neuroses.

However, it is unfortunate that a great many people who use behavior therapy techniques have not learned much about behavior analysis or have not understood the need for it. They fail to identify intricate stimulus–response relations, and they do not distinguish conditioned anxiety from cognitively based anxiety. They have trouble with complex cases. They give package treatments for diagnoses like agoraphobia, a practice that Barlow (1979) aptly deplored. Inevitably, these people have much less success with patients than they would with the help of behavior analysis; and then they write articles stating that the favorable reports of the efficacy of behavior therapy are exaggerated.

Social Implications

The failures of psychoanalysis and the rationalizations that are given for them have very serious social consequences. One might complain that I am a biased judge, and of course I am. So let me quote from Schmideberg (1970), a distinguished psychoanalyst:

> From time to time patients come to one who have had years of unsuccessful psychotherapy and are in desperate need of help. They have been made to feel that analysis is the only worthwhile therapy, and that there must be something quite specially wrong with them if it cannot help them as it has helped others; so their depression and sense of failure are reinforced. Often it is not only their psychological condition but also their realistic situation that has deteriorated, sometimes beyond repair. (p. 195)

One of Schmideberg's illustrative examples concerns a 54-year-old man who had first sought treatment in his early twenties for various anxieties and inhibitions that were largely the manifestations of the timidity of an inexperienced young man, the son of poor parents. *Thirty years* of analysis with leading American analysts had not helped him. When he came to Schmideberg, he had spent all

his money on therapy, could not afford to have an office, and had to practice his accountancy at home. Another of Schmideberg's cases was a woman of 28 who had originally had no definite symptoms, but had entered psychoanalysis in the hope of leading a fuller life and making a happy marriage. During her analysis she developed an agoraphobia, which steadily grew worse. She then continued with two other analysts, steadily deteriorating. Schmideberg first saw her after 12 years of treatment, when she was very much overweight and had lost her looks and any chance of getting married—the only thing she really wanted.

I have seen many such cases. Psychoanalytically oriented therapists rationalize lack of progress by saddling the patient with the responsibility for it. The patient is told that failure to improve is due to his or her "resistance" and not to anything wrong or inappropriate about the therapy. An impartial observer would surely question the competence or the integrity of a therapist whose skill is supposed to be to break down resistances but who fails to do this for a patient in 5 or 10 years and recommends more of the same!

To keep patients interminably in chancery is an immoral practice and a social blot on the psychological profession. We are all tainted by it. Perhaps in years gone by, one could have argued that there was nothing better to offer and that the still-suffering patient at least had the benefit of support. But it is a moral requirement of any health professional to know the state of the art in his or her field and to be able to offer patients alternatives when the methods used have failed.

At a symposium at the meeting of the American Psychiatric Association in May 1980, I asked 500 psychiatrists how many of them had *any* acquaintance with the literature of behavior therapy and about 25% raised their hands. If you had pneumonia, would you entrust yourself to an internist who confessed not seriously to have read the literature on penicillin and who, when confronted with evidence of its efficacy, expressed skepticism of that kind of thing?

What is even worse is that the purveyors of the psychoanalytic philosophy continue to control the teaching of psychotherapy in most of our departments of psychiatry and clinical psychology. The saving grace for them is the 40% or more of neurotic subjects who do well in any psychotherapeutic interview situation as a result of emotional arousal by their therapists.

How can this sorry state of affairs be changed? Perhaps to some extent by exposing, as I have here tried to do, the iniquity of these practices. But people are unlikely to change course unless they have something to gain or to lose. Now a threat looms in the recent statements from the National Institute of Mental Health and the insurance companies of their unwillingness to go on paying for psychotherapy without evidence of its efficacy.

So there is hope for tomorrow. But if tomorrow were to give behavior therapy its rightful place in the clinical world, would the abuses end, and would the public be better off? In theory, the answer is *yes*. In practice, the answer is *not yet*. In the whole of North America there are no more than 200 practitioners with adequate skills in behavior analysis. High-quality training is very hard to find. Only about a dozen programs out of more than a hundred being offered include instruction and supervision by teachers skilled in behavior analysis. This can only be remedied by a rechanneling of the mainstream of financial support for psychotherapy so that the programs needed to train good teachers and good therapists can be established. Only then will the state of the art reach and benefit the suffering public.

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