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Dynamic Psychotherapy and Behavior Therapy

Are They Irreconcilable?

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The following article by Marmor is noteworthy because it constituted one of the earliest recognitions by an experienced psychoanalyst of the legitimacy and efficacy of behavioral therapy for certain clinical conditions. Marmor, like others before him, is critical of simplistic theoretical explanations of the behavioral therapeutic process. By focusing on the therapist-patient transactions in three different behavioral techniques-Wolpe's reciprocal inhibition therapy, aversive conditioning in homosexuality, and the Masters-Johnson approach to sexual dysfunction -Marmor demonstrates that what actually goes on in these techniques is much more complex than behavioral therapy implies. He suggests that common denominators are involved in the therapeutic processes of both behavior therapy and dynamic psychotherapy but with differences of emphasis. Thus he considers them to be complementary, rather than antithetical, approaches to therapy.

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In the course of psychiatric training and practice our professional identities become so intimately linked to what we have learned and how we practice that we are prone to extol uncritically the virtues of our own techniques and to depreciate defensively those techniques that are different. The dialogue that has gone on between most behavior therapists and dynamic psychotherapists has been marred by this kind of bias, and claims as well as attacks have been made on both sides that are exaggerated and untenable. Science is not served by such emotional polemics but rather by objective efforts to evaluate and extend our knowledge.

Part of the confusion that exists in discussing these two basic approaches to therapy is that they are often dealt with as though each group represents a distinct entity when, in fact, they are anything but monolithic. The various schools of thought among dynamic psychotherapists are too well known to require elaboration. They cover a wide range from classical Freudians to adherents of other major theorists to eclectics who borrow from all of them to still others who try to adapt their concepts to correspond with modern learning theories, information theory, game theory, or general systems theory.

What is less well known is that among behavior therapists also there is a broad range of differences, from adherents of Pavlov and Hull to Skinnerians to eclectics and to those who lean toward information theory and general systems theory. At one end of each spectrum the theories of behavioral and dynamic psychotherapists tend to converge, while at the other end their divergence is very great. It is because adherents of these two approaches tend to define each other stereotypically in terms of their extremes that so much misunderstanding and heat are often generated between them.

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It would further serve to clarify the discussion of this problem if we distinguish between investigative methods, therapeutic techniques, and theoretical formulations. A good investigative technique is not necessarily a good therapeutic technique, nor is the reverse true. By the same token, as we have long known, the success of a psychotherapeutic method for any particular condition does not in itself constitute a validation of its theoretical framework; indeed, exactly why and how any particular psychotherapeutic method works and what it actually accomplishes within the complex organization of drives, perception, integration, affect, and behavior that we call personality is itself a major research challenge.

In the remarks that follow, therefore, I shall not concern myself with the knotty issues of the comparison of results between behavior and psychodynamic therapies or of their validation. The problem of how to measure or evaluate psychotherapeutic change is still far from clear, and a matter for much-needed research. Moreover, comparisons of results between these two approaches are unsatisfactory because different criteria of efficacy are applied, and different techniques of investigation are employed, even if complete objectivity on the part of the various protagonists could be assumed-which is doubtful!

In addition, I shall not get into the oft-argued issue of whether or not simple symptom removal inevitably leads to symptom substitution. Long before behavior therapists began to question this hoary assumption, hypnotherapists had presented evidence that symptom substitution did not always take place when a symptom was removed by hypnosis.1 Indeed, I would agree, on purely theoretical grounds, that symptom substitution is *not* inevitable. Earlier psychoanalytic assumptions concerning symptom substitution were based on what we now know was an erroneous closed-system theory of personality dynamics. If the conflictual elements involved in neurosis formation are assumed to be part of a closed system, it follows logically that removal of the symptomatic consequences of such an inner conflict without altering the underlying dynamics should result in some other symptom manifestation. If, however, personality dynamics are more correctly perceived within the framework of an open system, then such a consequence is not inevitable. Removal of an ego-dystonic symptom may, on the contrary, produce such satisfying feedback from the environment that it may result in major constructive shifts within the personality system, thus leading to modification of the original conflictual pattern. Removal of a symptom also may lead to positive changes in the perception of the self, with resultant satisfying *internal* feedbacks, heightening of self-esteem, and a consequent restructuring of the internal psychodynamic system.

Psychodynamic theorists have been aware of this possibility for

many years, dating back at least to 1946 when Alexander and French[2] published their book entitled *Psychoanalytic Therapy*. In this volume a number of cases of brief psychotherapy are described, some of them involving only one to three interviews, following which the patients were not only dramatically relieved of their presenting symptoms but were then able to go on to achieve more effective adaptive patterns of functioning than they had previously displayed. In the years that followed this important publication, dynamic psychotherapists have become increasingly involved with techniques of brief psychotherapy and of crisis intervention, with a growing body of evidence that in many instances such interventions can have long-lasting positive consequences for personality integration.

Where I part company with most behavior therapists is not in questioning their therapeutic claims-although I would offer the caution that many of them are repeating the error of the early psychoanalysts of promising more than they can deliver—but in what I consider to be their oversimplified explanations of what goes on in the therapeutic transaction between patient and therapist. The explanations to which I refer are those which assume that the essential and central core of their therapeutic process rests on pavlovian or skinnerian conditioning and, incidentally, is therefore more "scientific" than the traditional psychotherapies. With these formulations often goes a conception of neurosis that seems to me to be quite simplistic. Thus, according to Eysenck, "Learning theory [note that he uses the singular—actually there are many theories of learning] regards neurotic symptoms as simply learned habits; there is no neurosis underlying the symptom but merely the symptom itself. *Get rid of the symptom and you have eliminated the neurosis*."[3] Such an explanation is like evaluating the contents of a package in terms of its wrapping, and represents a regrettable retrogression from the more sophisticated thinking that has begun to characterize dynamic psychiatry in recent years; an approach that recognizes that "psychopathology" does not reside solely in the individual but also has significant roots in his system of relationships with his milieu and with other persons within his milieu. Hence the growing emphasis on family therapy, on conjoint marital therapy, on group therapy, and on dealing with the disordered socioeconomic conditions which constitute the matrix of so many personality disorders. To see the locus of psychopathology only in the individual leads to an emphasis on techniques of adjusting the individual to his environment regardless of how distorted, intolerable, or irrational that environment might be. Such an emphasis brings us uncomfortably close to the dangerous area of thought and behavior control.

However, I do not wish to overemphasize this ethical issue. The fact that a technical method may lend itself to being misused does not conti-

tute an argument against its scientific validity. My major point is that the *theoretical* foundation of Eysenck's formulation is scientifically unsound. Even if we deliberately choose to restrict our focus only to what goes on within the individual himself, the eysenckian point of view has profound limitations. It overlooks all of the complexities of thought, symbolism, and action which must be accounted for in any comprehensive theory of psychology and psychopathology. To assume that what goes on subjectively within the patient is irrelevant and that all that matters is how he behaves is to arbitrarily disregard all of the significant psycho-dynamic insights of the past 75 years. In saying this, I am not defending all of psychoanalytic theory. I have been as critical as anyone of certain aspects of classical freudian theory and I am in full accord with those who argue that psychodynamic theory needs to be reformulated in terms that conform more closely to modern theories of learning and of neurophysiology. Current researches strongly suggest that the brain functions as an extremely intricate receiver, retriever, processor, and dispatcher of information. A stimulus-response theory of human behavior does not begin to do justice to this complex process. It is precisely what goes on in the "black box" *between* stimulus and response that is the central challenge of psychiatry, and no theory that ignores the complexities of the central processes within that "black box" can be considered an adequate one. It is to Freud's eternal credit, regardless of the limitations of some of his hypotheses, that he was the first to develop a rational investigative technique for, and a meaningful key to, the understanding of this uncharted realm that exerts so profound an influence on both our perceptions and our responses.

Evidence from learning theories themselves reveals that neurotic disorders are not necessarily the simple product of exposure to traumatic conditioning stimuli or to the operant conditioning of responses. The work of Pavlov, Liddell, Masserman, and others has clearly demonstrated that neurotic symptoms can ensue when an animal is faced with incompatible choices between simultaneous approach and avoidance reactions, or with confusing conditioned stimuli which it is unable to differentiate clearly. This corresponds to the psychodynamic concept of conflict as being at the root of the vast majority of human neurotic disorders. Once such a neurotic conflict is set up in a human being, secondary elaborations, defensive adaptations, and symbolic distortions may become extensively and indirectly intertwined with almost every aspect of the individual's perceptual, cognitive, and behavioral process.

A behavioral approach alone cannot encompass these complexities. Granting that skinnerians include verbal speech as an aspect of behavior that may require modification, what shall we say about subjective *fantasies* concealed *thoughts*, and hidden *feelings*? Are they totally irrele-

vant? What about problems involving conflicts in value systems, disturbances in self-image, diffusion of identity, feelings of anomie, or even concealed delusions and hallucinations!' Are they less important than specific symptom entities of a behavioral nature? No comprehensive theory of psychopathology or of the nature of the psychotherapeutic process can properly ignore these aspects of man's subjective life.

To illustrate my point that much more goes on between therapist and patient than most behavior therapists generally recognize, I should like now to briefly focus on three contrasting behavioral therapeutic approaches: (1) Wolpe's technique of reciprocal inhibition, (2) aversive conditioning treatment of homosexuality, and (3) the Masters and Johnson technique of treating sexual impotence and frigidity. In discussing these three approaches, I wish to emphasize that it is not my intention to denigrate their usefulness as therapeutic modalities or to question their results, but solely to present some of the diverse variables that I believe are involved in their therapeutic effectiveness.

Wolpe has elaborated his technique in many publications as well as in at least one film that I have seen. Although he considers the crux of his technique to be the development of a hierarchical list of graded anxieties which are then progressively dealt with by his technique of "reciprocal inhibition," the fact is that a great deal more than this takes place in the patient-therapist transaction in the Wolpe technique. Most significantly, in the orientation period of the first session or two the patient is informed not only of the treatment method per se, but also of the fact that it has yielded successful results with comparable patients, and it is indicated implicitly, if not explicitly, that the patient can expect similar success for himself if he is cooperative. Wolpe, moreover, is warm, friendly, and supportive. At the same time he is positive and authoritative in such a way as to reinforce the patient's expectations of therapeutic success. During this introductory period a detailed history is taken and even though the major emphasis is on the symptom with all of its manifestations and conditions for appearance, a detailed genetic history of personality development is usually taken also.

Following this a hierarchical list of the patient's anxieties is established. The patient is then taught a relaxation technique which is remarkably similar to what is traditionally employed in inducing hypnosis. After complete relaxation is achieved, the patient is instructed to create in fantasy these situations of graded anxiety beginning at the lowest level of anxiety, and is not permitted to go to the next level until he signals that he is completely relaxed. This procedure is repeated over and over again in anywhere from 12 to 60 or more sessions until the patient is able to fantasy the maximally phobic situation and still achieve muscular relaxation. Throughout this procedure the patient receives the

strong implication, either explicitly or implicitly, that this procedure will cause his symptoms to disappear.

Wolpe attributes the success of his technique to "systematic desensitization" and explains it on the basis of pavlovian counterconditioning. He asserts that any "activities that might give any grounds for imputations of transference, insight, suggestion, or de-depression," are either "omitted or manipulated in such a way as to render the operation of these mechanisms exceedingly implausible."[4] This kind of claim that Wolpe repeatedly makes in his writings clearly reflects his failure to appreciate the complexity of the variables involved in the patient-therapist transaction. I cannot believe that anyone who watches Wolpe's own film demonstration of his technique would.agree that there are no elements of transference, insight, or suggestion in it. Indeed, one could make as plausible a case for the overriding influehte of suggestion in his technique as for the influence of desensitization. In saying this I am not being pejorative about Wolpe's technique. Suggestion, in my opinion, is an integral part of every psychotherapeutic technique, behavioral or psychodynamic. It need not be overt; indeed, it probably works most potently when it is covert. Suggestion is a complex process in which elements of transference, expectancy, faith, and hope all enter. To the degree that a patient is receptive and perceives the therapist as a powerful help-giving figure, he is more likely to accept the suggestions he is being given and to try to conform to them. This process is most obvious in hypnosis but it is equally present in all psychotherapeutic techniques, where the suggestion is usually more covert. Wolpe's technique abounds in covert as well as overt suggestion. It is questionable, moreover, whether the fantasies that Wolpe has his patients create are actual substitutes for the phobic reality situations, as he would have us believe. It may well be that what is really taking place is not so much desensitization to specific stimuli as repeated reassurance and strong systematic suggestion, within a setting of heightened expectancy and faith.

However, even the combination of *desensitization* (assuming that it is taking place) and suggestion do not begin to cover all the elements that are present in the Wolpe method. There is also the *direct transmission of values* as when Wolpe says to a young patient, "You must learn to stand up for yourself." According to Ullmann and Krasner,[5] Wolpe hypothesizes that if a person can assert himself, anxiety will automatically be inhibited. (Parenthetically, one might question whether this is inevitably so. One frequently sees patients who assert themselves regularly, but always with enormous concomitant anxiety.) In any event, Ullmann and Krasner say: "The therapist provides the motivation by pointing out the irrationality of the fears and encouraging the individual

to insist on his legitimate human rights."[5] Obviously this is not very different from what goes on in dynamic psychotherapy and it is not rendered different by virtue of the fact, according to Ullmann and Krasner, that it is "given a physiological basis by Wolpe, who refers to it as excitatory."[5] Still another variable which cannot be ignored is Wolpe's manner, which, whether he realizes it or not, undoubtedly facilitates a "positive transference" in his patients. In his film he is not only kindly and empathic to his female patient, but occasionally reassuringly touches her. Does Wolpe really believe that a programmed computer repeating his instructions to a patient who had had no prior contact with the doctor himself would achieve the identical therapeutic results?

The second behavioral technique that I would like to briefly consider is that of the aversion treatment of homosexuals. I had occasion to explore this technique some time ago with Dr. Lee Birk, of the Massachusetts Mental Health Center, who was kind enough to demonstrate his technique and go over his results with me.

Dr. Birk's method is based on the anticipatory avoidance conditioning technique introduced by Feldman and MacCulloch.[6] The patient is seated in a chair in front of a screen with an electrode cuff attached to his leg. The method involves the use of patient-selected nude and seminude male and female pictures which are flashed onto the screen. The male pictures (and presumably the fantasies associated with them) become aversive stimuli by linkage with electric shocks which are administered to the leg whenever these pictures appear on the screen. On the other hand, the female pictures become discriminative stimuli signaling safety, relief, and protection from the shocks.

In Dr. Birk's hands, as in others, the use of this method has apparently produced a striking reversal of sexual feelings and behavior in more than one-half of the male homosexuals so treated. On the face of it, this would seem to be the result of a relatively simple negative conditioning process to aversive "male" stimuli, with concomitant positive conditioning to "female" stimuli.

Closer inspection will reveal, however, that the process is considerably more complex. I wonder whether most psychiatrists realize what is actually involved in such aversive conditioning. I know that I, for one, did not, until I asked Dr. Birk to permit me to experience the kind of shock that he administered to his patients-the least intense, incidentally, of the graded series that he employed. I can only say that if that was a "mild" shock, I never want to be subjected to a "severe" one! I do not have a particularly low threshold for pain, but it was a severe and painful jolt-much more than I had anticipated-and it made me acutely aware of *how strongly motivated toward change a male homosexual would have to be to subject himself to a series of such shocks visit after visit.*

The significance of this variable cannot be ignored. Once it is recognized, the results of aversive therapy, although still notable, become less remarkable. The fact is that if other forms of psychotherapy were limited only to such a select group of exceptionally motivated hortrosexuals, the results also would be better than average. Although one might assume that in dynamic psychotherapies the cost of therapy in itself should insure equally good motivation, this is not always the fact. Costs of therapy may not be sacrificial, or they may be borne or shared by others, but no one else can share the pain involved in the aversive conditioning process.

Again, then, it becomes clear that we are dealing with something that is much more complicated than a simple conditioning process. The patient's intense wish to change, and his faith and expectation that this very special technique will work for him-as the doctor himself implicitly or explicitly suggests —are important factors in the total therapeutic ges-talt of this aversive technique, as they are in successful dynamic psychotherapies also.

But more than this, the transference-countertransference transaction between therapist and subject is also of paramount importance. Dr. Birk communicated two interesting experiences he had which underline this point. Two of his subjects who had had very favorable responses to the "conditioning" procedure suffered serious relapses immediately after becoming angry at him. The first patient became upset because of what he considered a breach in the privacy of his treatment. Before this, he had not only been free from homosexual contacts for the first time in many years, but also free of conscious homosexual urges. When he became angry, he immediately went and sought out a homosexual partner because he wanted to see "how really good" the" treatment was. Dr. Birk was aware that his patient obviously wanted to show him up and prove that the treatment was no good. Although the patient remained improved as compared to his previous homosexual behavior, *he was never again,* despite many more conditioning treatments, completely free from conscious homosexual urges and continued to act them out although less frequently than in the past. The second patient became angry with Dr. Birk because he concluded that the therapist seemed to be more interested in the results he was obtaining than he was in the patient as a person. Immediately after expressing this irritation the patient regressed to a series of homosexual encounters.

These striking examples illustrate that a simple conditioning explanation does not fit the complex process that goes on in such techniques of therapy. Aversive conditioning that has been solidly established would not be expected to disappear on the basis of such experiences unless there is something that goes on centrally in the patient that is a

very important factor in the therapeutic modifications achieved. A basic aspect of this central process is in the patient-physician interpersonal relationship and it cannot and must not be ignored even in behavior therapies. I have recently encountered a number of instances where patients who were referred to behavior therapists failed to return to them after the initial sessions because the behavior therapists involved ignored this essential factor and related to the patients as though they were dealing with experimental animals.

Let us now turn to a consideration of the Masters and Johnson[7] technique of treating disorders of sexual potency. In many ways this technique falls midway between a behavioral and a psychody-namic approach and illustrates one of the ways in which a fusion of both can be successfully employed. The Masters and Johnson technique is behavioral in the sense that it is essentially symptom-focused, and that one of its most important technical tools is desensitization of the performance anxieties of the patients.

Conceptually, however, the Masters and Johnson approach to their patients goes considerably beyond simple conditioning or desensitization processes. For one thing, Masters and Johnson recognize that the problem of impotency or frigidity does not exist merely in the symptomatic individual but in his relationship with his partner. Therefore, they insist on treating the couple as a unit, and the symptom as a problem of the unit. This constitutes a systems approach in contrast to a strictly intrapsychic or behavioral one.

Secondly, Masters and Johnson are acutely aware of the influence of psychodynamic factors on the sexual behavior of their couples. In their preliminary interviews they carefully assess and evaluate the importance of these factors, and if they consider the neurotic components or interpersonal difficulties to be too great, they may refuse to proceed with their method and will refer the couple back to their physicians for appropriate psychotherapy.

This kind of selective procedure has an effect, of course, on their percentage of successful results, as does the high degree of motivation that their patients must have to come to St. Louis (who, after all, goes to St. Louis for a two-week vacation?) and to commit themselves to the considerable expense and inconvenience that is involved.

The fact, also, that Masters and Johnson insist that the therapeutic team consist of a man and a woman reveals their sensitivity to the transference implications of their relationship to their couples. They function as a sexually permissive and empathic mother-surrogate and father-surrogate who offer not only valuable technical advice and suggestions concerning sexual behavior, but also a compassion and understanding that constitute a corrective emotional experience for their patients.

Finally, the tremendous charisma and authority of this highly publicized therapeutic team must inevitably have an enormous impact on the expectancy, faith, and hope with which their patients come to them. This cannot help but greatly accentuate the suggestive impact of the given instructions in facilitating their patients' therapeutic improvement. This improvement is then reinforced by subsequent follow-up telephone calls which, among other things, confirm to the patient the empathic interest, concern, and dedication of these parent-surrogates.

I am all too aware that these brief and summary remarks cannot begin to do justice to the three above-mentioned behavioral techniques. I hope, however, that I have succeeded in making the point that in each of these instances, complex variables are involved that go beyond any simple stimulus-response conditioning model.

The research on the nature of the psychotherapeutic process in which I participated with Franz Alexander beginning in 1958 has convinced me that all psychotherapy, regardless of the techniques used, is a learning process.[8-10] Dynamic psychotherapies and behavior therapies simply represent different teaching techniques, and their differences are based in part on differences in their goals and in part on their assumptions about the nature of psychopathology. Certain fundamental elements, however, are present in both approaches.

In any psychotherapeutic relationship, we start with an individual who presents a problem. This problem may be in the form of behavior that is regarded as deviant, or it may be in the form of subjective discomfort, or in certain distortions of perception, cognition, or affect, or in any combination of these. Usually, but not always, these problems motivate the individual or someone in his milieu to consider psychiatric treatment. This decision in itself establishes an *expectancy* in the individual which is quite different than if, say, "punishment" rather than "treatment" were prescribed for his problems. This expectancy is an essential part of *every* psychotherapeutic transaction at its outset, regardless of whether the patient presents himself for behavioral or dynamic psychotherapy. The patient, in other words, is *not* a neutral object in whom certain neurotic symptoms or habits have been mechanically established and from whom they can now be mechanically removed.

Expectancy is a complex process. It encompasses factors that Frank" has demonstrated as being of major significance in psychotherapy —the degree of faith, trust, and hope that the patient consciously or unconsciously brings into the transaction. It is based in large part on previously established perceptions of authority or help-giving figures, perceptions that play a significant role in the degree of receptivity or non-receptivity that the patient may show to the message he receives from the psychotherapist. Psychoanalysts have traditionally referred to these

presenting expectations as aspects of "transference," but regardless of what they are called, they are always present. Transference is not, as some behavior therapists seem to think, something that is "created" by the therapist-although it is true that transference distortions may be either increased or diminished by the technique the therapist employs. The way in which the therapist relates to the patient may reinforce certain maladaptive perceptions or expectations, or it may teach the patient that his previously learned expectations in relation to help-giving or authority figures are incorrect. The latter teaching is part of what Alexander and French[2] called the "corrective emotional experience."

Even in "simple" conditioning studies, experimenters like Liddell, Masserman, and Pavlov have called attention to the significance of the relationship between the experimental animal and the experimenter. In humans the problem is more complex, however. Thus, a therapist who behaves in a kindly but authoritarian manner may confirm the patient's expectancies that authority figures are omnipotent and omniscient. This increases the patient's faith and may actually facilitate his willingness to give up his symptoms to please the powerful and good parent-therapist, but it does *not* alter his childlike self-image in relation to authority figures. Depending on the therapist's objectives, this may or may not be of importance.

What I am indicating, in other words, is that a positive transference facilitates symptom removal, but if the patient's *emotional maturation, rather than just symptom removal, is the goal of therapy,* what is necessary eventually is a "dissolution" of this positive transference-which means teaching the patient to feel and function in a less childlike manner, not only in relation to the therapist but also to other authority figures.

Closely related and interacting with the patient's motivations and expectancies is the therapist's social and professional role, by virtue of which the help-seeking patient endows him with presumptive knowledge, prestige, authority, and help-giving potential. These factors play an enormous role in strengthening the capacity of the therapist to influence the patient, and constitute another element in the complex fabric that makes up the phenomenon of positive transference.

Also, the *real persons* of both patient and therapist, their actual physical, intellectual, and emotional assets and liabilities, and their respective *value systems* enter into the therapeutic transaction. Neither the patient nor the therapist can be regarded as a stereotype upon whom any particular technique will automatically work. Their idiosyncratic variables are always an important part of their transaction.

Given the above factors, a number of things begin to happen more or less simultaneously, in varying degrees, in behavior therapies as well as in dynamic psychotherapies. I have discussed these factors in detail

elsewhere and will merely summarize them here. They are: (1) *Release of tension* through catharsis and by virtue of the patient's hope, faith, and expectancy; (2) *cognitive learning,* both of the trial-and-error variety and of the gestalt variety; (3) reconditioning by virtue of *operant conditioning,* by virtue of subtle reward-punishment cues from the therapist, and by corrective emotional experiences; (4) identification with the therapist; (5) repeated *reality testing,* which is the equivalent of *practice* in the learning process. These five elements encompass the most significant factors on the basis of which change takes place in a psychotherapeutic relation-ship.[10]

As I have mentioned above, suggestion takes place in all of these, covertly or overtly. Furthermore, as can be seen, a conditioning process takes place in dynamic psychotherapies as well as in behavior therapies, except that in the latter this process is intentional and more structured, while in the former it has not been generally recognized. In focusing on this conditioning process, behavior therapists have made a valuable contribution to the understanding of the therapeutic process. It is the thrust of this paper, however, that in so doing they have tended to minimize or ignore other important and essential elements in the therapeutic process, particularly the subtle but critical aspects of the patient-therapist interpersonal relationship.

In the final analysis, the technique of therapy that we choose to employ must depend on what aspect of man's complex psychic functioning we address ourselves to. If we choose to focus on the patient's overt symptoms or behavior patterns, some kind of behavior therapy may well be the treatment of choice. On the other hand, if the core of his problems rests in symbolic distortions of perception, cognition, affect, or subtle disturbances in interpersonal relationships, the source and nature of which he may be totally unaware, then the more elaborate reeduca-tional process of dynamic psychotherapy may be necessary.

Moreover, indications for one approach do not necessarily rule out the other. Marks and Gelder[12,13] and Brady,[14] among others, have demonstrated that the use of both behavior therapy and dynamic therapy in the same patient either concurrently or in cequence often brings about better therapeutic results than the use of either approach alone. Indeed, many dynamic psychotherapists have for years been unwittingly using such a combination of approaches when they prescribe drugs for the direct control of certain symptoms while concurrently pursuing a psychotherapeutic approach.

To conclude, then, in my opinion behavior therapies and dynamic psychotherapies, far from being irreconcilable, are complementary psy-chotherapeutic approaches. The line of demarcation between them is by no means a sharp one. As Breger and McGaugh[15] and others have

shown, behavior therapists do many things in the course of their conditioning procedures that duplicate the activities of dynamic psychotherapists including "discussions, explanation of techniques and of the unadaptiveness of anxiety and symptoms, hypnosis, relaxation, 'nondirec-tive cathartic discussions,' and 'obtaining an understanding of the patient's personality and background.' "[15] The process in both approaches is best explicable in terms of current theories of learning which go beyond simple conditioning explanations and encompass central cognitive processes also. The fact that in some disorders one or the other approach may be more effective should not surprise us and presents no contradiction. Just as there is no single best way of teaching all pupils all subjects, there is no single psychotherapeutic technique that is optimum for all patients and all psychiatric disorders.

Within this total context, it seems to me that behavior therapists deserve much credit for having opened wide the armamentarium of therapeutic strategies. By so doing, they have forced dynamic psychotherapists into a reassessment of their therapeutic techniques and their effectiveness-a reassessment that in the long run can only be in the best interests of all psychiatrists and their patients. The psychotherapeutic challenge of the future is to so improve our theoretical ahd diagnostic approaches to psychopathology as to be able to most knowledgeably and flexibly apply to each patient the particular treatment technique and the particular kind of therapist that together will most effectively achieve the desired therapeutic goal.

Since completing this paper, I have come across the excellent article by Klein et al.[16] in which many of the conclusions I have set forth are confirmed by them as a result of five days of direct observation of the work of Wolpe and his group at the Eastern Pennsylvania Psychiatric Institute. The authors also point out that as a consequence of their increasing popularity, behavior therapists are now beginning to treat a broader spectrum of more "difficult" patients (complex psychoneurotic problems, character neuroses, or borderline psychotic problems) with the result that their treatment procedures are "becoming longer and more complicated, with concomitant lowering of success rates."

REFERENCES

1. Wolberg LR: Hypnotherapy, in McCary JL (ed): *Six Approaches to Psychotherapy.* New York, Dryden Press, 1955, pp 63-126.

2. Alexander F, French TM, et al: *Psychoanalytic Tlwrapy.* New York, Ronald Press Co, 1946.

3. EysenckHJ (ed): *Behavior Therapy and the Neuroses.* New York, Pergamon Press, 1960.

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

5. Ullmann LP, Krasner L (eds): *Case Studies in Behavior Modification.* New York, Holt Rinehart & Winston Inc, 1965.

6. Feldman MP, MacCulloch MI: The application of anticipatory avoidance learning to the treatment of homosexuality. *Behav Res Ther* 2:165-183, 1965.

7. Masters VVH, Johnson VE: *Human Sexual Response.* Boston, Little, Brown & Co, 1965.

8. Marmor J: Psychoanalytic therapy as an educational process, in Masserman J, Salzman L (eds): *Modern Concepts of Psychoanalysis.* New York, Philosophical Library Inc, 1962, pp 189-205.

9. Marmor J: Psychoanalytic therapy and theories of learning, in Masserman J (ed): *Sci ence and Psychoanalysis.* New York, Grune and Stratton Inc, 1964, vol 7, pp 265-279 [See also Chapter 3, this volume.]

10. Marmor J: The nature of the psychotherapeutic process, in Usdin G (ed): *Psycho-neurosis and Schizophrenia.* New York, JB Lippincott Co, 1966, pp 66-75.

11. Frank JD: *Persuasion and Healing.* Baltimore, Johns Hopkins Press, 1961.

12. Marks IM, Gelder MG: A controlled retrospective study of behavior therapy in phobic patients. *Brit]Psychiat* HI: 561-573, 1965.

13. Marks IM, Gelder MG: Common ground between behavior therapy and psycho-dynamic methods. *Brit J Med Psychol* 39:11-23, 1966. [See also Chapter 10, this vol ume.]

14. Brady JP: Psychotherapy by a combined behavioral and dynamic approach. *Compr Psychiat* 9:536-543, 1968. [See also Chapter 15, this volume.]

15. Breger L, McGaugh JL: Critique and reformulation of learning theory approaches to psychotherapy and neurosis. *Psychol Bull* 63:338-358, 1965. [See also Chapter 4, this volume.]

16. Klein MH, Dittman AT, Parloff MB, et al: Behavior therapy: Observations and reflec tions. / *Consult Clin Psychol* 33:259-266,1969. [See also Chapter 14, this volume.]