Common Factors of Psychoanalytic Theory and Exposure Therapy for Treating Select Anxiety Disorders

Patrick Nicholas
Pacific University

Recommended Citation

This Dissertation is brought to you for free and open access by the College of Health Professions at CommonKnowledge. It has been accepted for inclusion in School of Graduate Psychology by an authorized administrator of CommonKnowledge. For more information, please contact CommonKnowledge@pacificu.edu.
Common Factors of Psychoanalytic Theory and Exposure Therapy for Treating Select Anxiety Disorders

Abstract
Common factors of different approaches to treatment could potentially reveal what is most effective in psychotherapy. It would seem as though psychoanalysis and exposure therapy would be based on very different theories, but they appeared to have striking similarities. An attempt was made to develop an argument for both theoretical orientations having similar factors for theory and treatment. The format employed for developing the argument was a synthesis and extension of the literature. The similarities of psychoanalytic theory and the theory of exposure therapy provided an impetus for discussing the effective factors for treating select anxiety disorders. The differences between the two approaches provided new opportunities for further research with regard to integrating techniques to improve therapy for anxiety disorders.

Degree Type
Dissertation

Degree Name
Doctor of Psychology (PsyD)

Committee Chair
Johan Rosqvist, PsyD

Second Advisor
James Lane, PhD

Third Advisor
Michel Hersen, PhD, ABPP

Subject Categories
Psychiatry and Psychology

Comments
Library Use: LIH

This dissertation is available at CommonKnowledge: https://commons.pacificu.edu/spp/187
COMMON FACTORS OF PSYCHOANALYTIC THEORY AND
EXPOSURE THERAPY FOR TREATING SELECT ANXIETY DISORDERS

A DISSERTATION
SUBMITTED TO THE FACULTY
OF
SCHOOL OF PROFESSIONAL PSYCHOLOGY
PACIFIC UNIVERSITY, FOREST GROVE, OREGON
BY
PATRICK NICHOLAS
IN PARTIAL FULFILLMENT OF THE
REQUIREMENTS FOR THE DEGREE
OF
DOCTOR OF PSYCHOLOGY
JULY 23, 2010

Approved:________________________
Johan Rosqvist, Psy.D.

________________________
James Lane, Ph.D.

PROFESSOR AND DEAN:________________________
Michel Hersen, Ph.D., ABPP
ABSTRACT

Common factors of different approaches to treatment could potentially reveal what is most effective in psychotherapy. It would seem as though psychoanalysis and exposure therapy would be based on very different theories, but they appeared to have striking similarities. An attempt was made to develop an argument for both theoretical orientations having similar factors for theory and treatment. The format employed for developing the argument was a synthesis and extension of the literature. The similarities of psychoanalytic theory and the theory of exposure therapy provided an impetus for discussing the effective factors for treating select anxiety disorders. The differences between the two approaches provided new opportunities for further research with regard to integrating techniques to improve therapy for anxiety disorders.

Keywords: psychoanalysis, psychoanalytic, exposure therapy, therapeutic action
# TABLE OF CONTENTS

<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>ABSTRACT</td>
<td>ii</td>
</tr>
<tr>
<td>LIST OF TABLES</td>
<td>iv</td>
</tr>
<tr>
<td>LIST OF FIGURES</td>
<td>v</td>
</tr>
<tr>
<td>INTRODUCTION</td>
<td>1</td>
</tr>
<tr>
<td>STATEMENT OF PROBLEM AND PURPOSE OF STUDY</td>
<td>10</td>
</tr>
<tr>
<td>METHODS</td>
<td>11</td>
</tr>
<tr>
<td>THEORIES OF EXPOSURE THERAPY</td>
<td>13</td>
</tr>
<tr>
<td>Posttraumatic Stress Disorder</td>
<td>23</td>
</tr>
<tr>
<td>Obsessive-Compulsive Disorder</td>
<td>25</td>
</tr>
<tr>
<td>Specific Phobia</td>
<td>26</td>
</tr>
<tr>
<td>COMPARISONS OF PSYCHOANALYSIS FOR ANXIETY DISORDERS</td>
<td>31</td>
</tr>
<tr>
<td>Cathartic Theory and PTSD</td>
<td>35</td>
</tr>
<tr>
<td>Revised Theories of Psychoanalysis</td>
<td>58</td>
</tr>
<tr>
<td>Psychoanalysis and Obsessive-Compulsive Disorder</td>
<td>74</td>
</tr>
<tr>
<td>Psychoanalysis and Specific Phobia</td>
<td>89</td>
</tr>
<tr>
<td>Integrative Literature</td>
<td>97</td>
</tr>
<tr>
<td>RESULTS</td>
<td>125</td>
</tr>
<tr>
<td>DISCUSSION</td>
<td>140</td>
</tr>
<tr>
<td>SUMMARY</td>
<td>146</td>
</tr>
<tr>
<td>REFERENCES</td>
<td>151</td>
</tr>
</tbody>
</table>
# LIST OF TABLES

<table>
<thead>
<tr>
<th>Table</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Table 1</td>
<td>21</td>
</tr>
<tr>
<td>Table 2</td>
<td>23</td>
</tr>
<tr>
<td>Table 3</td>
<td>127</td>
</tr>
<tr>
<td>Table 4</td>
<td>130</td>
</tr>
<tr>
<td>Table 5</td>
<td>135</td>
</tr>
<tr>
<td>Table 6</td>
<td>137</td>
</tr>
</tbody>
</table>
## LIST OF FIGURES

<table>
<thead>
<tr>
<th>Figure</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Figure 1</td>
<td>38</td>
</tr>
<tr>
<td>Figure 2</td>
<td>77</td>
</tr>
<tr>
<td>Figure 3</td>
<td>90</td>
</tr>
</tbody>
</table>
INTRODUCTION

Anxiety disorders have been described as a prevalent problem within our society. In fact, Barlow (2002) referred to anxiety disorders as “the single largest mental health problem in the country” (p. 22). It was important to have a complete understanding and develop the best available treatment methods for our most prevalent mental health problem. Posttraumatic Stress Disorder (PTSD) had a lifetime prevalence of approximately 8% in the U.S. population (American Psychiatric Association, 2000), making it a relatively common disorder. Marciniak (2005) determined that PTSD was associated with relatively high treatment costs and was the most costly to treat of all the anxiety disorders. Other costs associated with PTSD were substantial impairment in workforce performance in terms of lost productivity or absenteeism (Greenberg, et al. 1999; Lepine, 2002).

The disorder resulted from people being exposed to an event that posed the risk of real or threatened injury of death, which created intense fear for the person. Violence and war have always been a part of our society, so it was not surprising that researchers found that being exposed to a traumatic event in the United States was not uncommon, but different segments of the population were impacted at different rates. A survey of adult women in the United States (Resnick, Kilpatrick, Dansky, Saunders, and Best 1993) found that the lifetime exposure rate to any trauma was 68.9% and the lifetime prevalence of PTSD was 12.6%. The rate of PTSD was much higher among female crime victims. The researchers reported that female victims of a physical assault had a lifetime prevalence of PTSD of 38.5% and female rape victims had a lifetime prevalence of PTSD of 32.0%.
Hoge et al. (2004) sampled U.S. military personnel and found that 12.9% of Army soldiers met criteria for PTSD following their deployment from the conflict in Iraq. The researchers noted a linear relationship between combat experience in Iraq and PTSD. They reported that 9.3% of soldiers met criteria for PTSD who experienced one or two firefights, 12.7% met criteria after experiencing three to five firefights, and 19.3% met criteria after experiencing more than five firefights. Among the soldiers who reported they were in a firefight, Hoge et al. found that five was the median number of total firefights they experienced. The researchers also found a statistically significant relationship between being injured in combat and PTSD. Clearly then, comprehensive information about the comparative effectiveness of available interventions for PTSD was needed to guide clinicians and inform consumers. Unfortunately, early research on treatment of trauma has methodological flaws (Taylor et al., 2003), other studies have produced conflicting results (e.g., Tarrier et al., 1999; Taylor et al.), and insight therapies had not been empirically tested. However, as will become clear in the following review of the research, several interventions have proven efficacious for reducing PTSD symptoms and clinical experience has supported other methods of treating clients diagnosed with PTSD.

The treatment and study of PTSD has faced some unique challenges. There has been a controversy over whether the PTSD construct and the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (DSM IV) diagnosis was valid. PTSD was one of the few disorders of the DSM where an etiology was not specified. Among the controversies which surrounded the PTSD diagnosis were that it was not a unitary syndrome but a combination of other disorders (Bodkin, 2007), the diagnosis resulted from well-meaning advocates of war veterans (McHugh & Treisman, 2007), and the mechanisms of traumatic memories were not accounted for by the current definition of the disorder (Young, 2000).
The lifetime prevalence rate of obsessive-compulsive disorder (OCD) has been estimated at 2.5% and a 1-year prevalence rate from 0.5% to 2.1% for the U.S. population (American Psychiatric Association, 2000). An examination of the National Comorbidity Survey Replication Study resulted in an estimated 1.6% lifetime prevalence rate of OCD for the U.S. population (Kessler et al., 2005). Another estimate, utilizing the Mental Health Epidemiologic Catchment Area Program data estimated a 2.3% one-year-prevalence rate of OCD with a clinically significant level of symptomatology for the U. S. population (Narrow, Rae, Robins & Regier, 2002). Throughout the course of the disorder symptoms were likely to wax and wane (American Psychiatric Association). For the longest published prospective study on the course of OCD, Skoog and Skoog (1999) reported that 56% of the clients demonstrated this intermittent course of the disorder while 44% had a chronic level of symptomatology. In addition, Skoog and Skoog reported that one-fifth of the participants they surveyed demonstrated a complete recovery and 37% still met criteria throughout their survey. Mataiz-Cole et al. (2002) reported that OCD symptoms were likely to remain in the same subtype (e.g., washers) with some subtypes (hoarding and obsessions with religious, sexual, or somatic themes) remaining more persistent and resistant to change over time. Attiullah, Eisen, and Rasmussen (2000) conducted a literature review and determined that OCD was generally a chronic, lifelong illness, with fluctuations in the severity of symptoms over time. Contributing to the conclusion that OCD was a chronic illness for these authors was their finding that a significant percentage of patients did not respond to treatment.

Mancebo et al. (2002) conducted what they considered a large naturalistic study of people diagnosed with OCD. The authors found that 55% of the participants reported obtaining some type of CBT treatment and “only a handful” reported receiving exposure therapy treatment (p.
These authors concluded that exposure therapy and other types of CBT treatment was underutilized for clients diagnosed with OCD. Mancebo et al. were not fully able to account for the underutilization of exposure therapy, but estimated that 25% to 30% of clients refuse exposure therapy and another 10% to 30% drop out of treatment before completion (p. 1717).

Eisen et al. (2006) reported OCD as a disorder that was likely to significantly impact a person’s quality of life. The authors used what they considered a large sample of individuals diagnosed with OCD to study the disorder with both self-report measures and rater administered measures. The authors found that persons diagnosed with OCD had marked impairment in all domains of quality of life, including the ability to work, perform household duties, subjective sense of wellbeing, social relationships, and the ability to enjoy leisure activities. Masellis, Rector, and Richter (2003) referred to OCD as a chronic, debilitating disorder and reported that 20% of OCD cases could be defined as severe in which obsessive and compulsive symptoms could occupy a person’s entire day.

Specific phobia was described as the most prevalent anxiety disorder (Kessler et al., 2005). The DSM IV listed a lifetime prevalence rate from 7.2% to 11.3% in this country. Utilizing the data from the National Comorbidity Survey Replication study, Kessler et al. estimated the lifetime prevalence of specific phobia in the U. S. population was 12.5%. Magee, Eaton Wittchen, McGonagle, and Kessler (1996) reported that women were twice as likely as men to be diagnosed with specific phobia.

Antony and Barlow (2002) discussed a confounding paradox of specific phobias and their treatment. The authors described specific phobias as one of the better researched, better understood, most common, and most treatable of all psychological disorders. After describing
these facts, Antony and Barlow noted the paradox was that people with specific phobias rarely present to treatment (p. 380). Choy, Fyer and Lipsitz (2007) reported that an important problem with specific phobia treatment was a high number of dropouts. As a result, many people who could benefit from treatment for specific phobia do not receive it, even after initially enrolling in treatment.

There was evidence that simple phobias created serious functioning problems (Magee et al. 1996; Wittchen, LeCrubier, Beesdo, Nocon, 2003). Magee et al. used National Comorbidity Survey data in reporting that 34.2% of people diagnosed with simple phobia experienced significant role impairment, which was defined by a self-report of the disorder interfering “a lot” rather than “some” or “a little” with their life and activities (p. 164). These authors reported 54.2% of people diagnosed with simple phobia would have at least one episode indicative of severity, as defined by significant role impairment, seeking professional help, or use of medications more than once. Magee et al. reported that women were twice as likely as men to be diagnosed with specific phobia. At the same time, the authors reported only 30.2% of the people diagnosed with simple phobia sought help.

In addition, simple phobias were considered highly comorbid disorders. Magee et al. (1996) indicated that 83.4% of people diagnosed with simple phobias reported at least one other diagnosis. Curtis, Magee, Eaton, Wittchen, and Kessler (1998) found that only 24.2% of the people with lifetime specific phobias reported only one fear, with the rest of the participants reporting more than one fear. This high rate of comorbidity has made it more difficult to isolate the debilitating effects of phobic reactions.
Substantial costs were associated with anxiety disorders. Greenberg et al. (1999) estimated that the total economic burden of anxiety disorders was $42.3 billion in 1990 dollars and $63.1 billion in 1998 dollars. An interesting aspect within this research by Greenberg et al. was that the majority (54%) of the costs associated with anxiety disorders were nonpsychiatric medical costs. The authors concluded that the majority of costs were related to nonpsychiatric care because people with anxiety disorders were commonly misdiagnosed, undiagnosed, or received inappropriate treatment. As a result, it was possible to avoid much of the costs associated with anxiety disorders with appropriate diagnosis and treatment. Lepine (2002) reviewed the calculations from Greenberg et al. and determined that 31% of the total costs of anxiety disorders were allocated to psychiatric treatment, which translated to less than one-third of the costs for anxiety disorders being allocated to direct psychiatric treatment. Lepine concluded that people with anxiety disorders seldom receive appropriate treatment due to lack of recognition of anxiety disorders, misdiagnosis, and the complicating factors of comorbidity (p. 7).

Anxiety disorders were common, costly, and limited the quality of life for many people. As a result, it was important to continue assessing existing treatment methods for these disorders. The existing large amount of empirical evidence proved the value of behavior therapies and cognitive-behavior therapies for treating anxiety disorders. Exposure therapy was one particular treatment that was proven efficacious and effective in the treatment of anxiety disorders. Due to the existing empirical support, exposure therapy has reached the status of being the treatment of choice for some anxiety disorders. It had an established theory and researchers established specific aspects of treatment which increased the chances of a positive treatment outcome. Psychoanalytic clinicians had a long and rich clinical history for the treatment of anxiety
disorders and an extensive theory of anxiety within broader theories of human development and personality. There was a limited amount of existing literature comparing or integrating exposure therapy and any psychoanalytic therapy. In addition, researchers associated with each approach have demonstrated a penchant for clarifying the differences or deficits of the other side. The result has been a separation of the two disciplines within the psychological literature. On the surface, exposure therapy and most psychodynamic therapies have obvious differences. These differences include one being a long-term therapy versus a short-term therapy, a developmental focus versus a current behavioral focus, and a structured treatment approach versus an unstructured approach. All of these were considered obvious and major differences.

In contrast to these clear differences, each approach seems to have had some basic similarities. One of these similarities was the idea of therapeutic benefit from confronting what one fears. Before learning about psychoanalytic theory and treatment, I was an admirer of the empirically supported exposure therapy, and I have maintained my respect for this treatment approach. When I first learned of Freud’s early treatment endeavors with the cathartic method, my initial thought was that it seemed a lot like imaginal exposure therapy. Both approaches involved reviewing a past event with strong emotions to alleviate symptoms. I remembered that some prominent researchers had mentioned psychoanalysis as an inspiration for exposure therapy (Barlow, 2002; Foa & Kozak, 1986). I thought they must be referring to Freud’s early work with the cathartic method, but I could not find confirmation of this idea in the psychological literature. In fact, there seemed to be hardly any psychological literature comparing exposure therapy with any psychodynamic therapy. Similarly, there have been only a limited number of attempts at integrating the two approaches, and these attempts have generated little interest in the form of new research (Stultz, 2006). The similarity of theory and treatment
between the two approaches has remained a largely undeveloped topic. After continuing to learn more about psychoanalytic theories, it seemed as though Freud did not completely abandon the techniques utilized in the cathartic method but added more theory and technique to his early treatment method. This could have meant that later versions of psychoanalysis could also have had techniques similar to exposure therapy.

If two seemingly disparate treatment approaches in reality had important commonalities, this would provide information regarding theory and therapeutic action. This study was conducted to determine if this was the case for exposure therapy and psychoanalysis. If two treatment approaches as different as exposure therapy and psychoanalysis shared common aspects of theory and technique, these commonalities would clarify fundamental aspects of therapeutic action within psychotherapy.

This line of reasoning continued by considering the differences of exposure therapy and psychoanalysis. If in fact the two disciplines shared common aspects of theory and both employed exposure as an important clinical intervention, this would mean that similar theories and techniques were being utilized in very different treatment settings. This different application of theory and technique raised questions about the advantages and disadvantages of each approach for applying exposure techniques. As a result, a comparison of exposure therapy and psychoanalysis had the potential to provide new knowledge of therapeutic action. In addition, this study had some auxiliary benefit by expanding the psychological literature to include a thorough comparison of exposure therapy and psychoanalysis. A search for commonalities between the two approaches was considered a departure from much of the existing literature describing differences of each approach and the deficiencies of one opposing approach to treatment. In general, strict segregation of two different approaches in the treatment of the same
disorders, without even one thorough comparison, did not seem like a positive stance for psychological thought. There was potential for a new synthesis of psychological literature by probing for similarities between the two disciplines and clarifying shared aspects of therapeutic action. As a result, potential new techniques for increasing the effectiveness for treating anxiety disorders through synthesizing these two approaches were not being developed. Furthermore, a segregation of the two approaches limited our basic understanding of anxiety. This study provided the first known systematic comparison between psychoanalysis and exposure therapy to assist in illuminating important theoretical concepts and factors of therapeutic action for select anxiety disorders. The results of a comparison between the two disciplines had the potential to improve the theory and treatment of anxiety disorders.
STATEMENT OF THE PROBLEM AND PURPOSE OF STUDY

Exposure therapy was well recognized as an empirically supported treatment for anxiety disorders (Richard, Lauterbach & Gloster, 2007). On the other hand, psychoanalytic therapies had some encouraging evidence for effective treatment of anxiety disorders, but they had neither the targeted empirical evidence for treatment of specific anxiety disorders nor the overall body of evidence of exposure therapy (Leichsenring & Rabung, 2008; Marshall, Yehuda, & Bone, 2000). Both approaches were found as popular treatments for anxiety disorders, but few studies have compared both approaches (Schultz, 2006). In fact, a thorough comparison of psychoanalytic theory and the theories underlying exposure therapy for treating anxiety disorders has not been performed. This void of existing research was particularly notable since psychodynamic therapies were still among the most popular treatment methods for anxiety disorders (Nemeroff et al., 2006). A set of common factors which each approach shares could reveal new information concerning what was most important for treating anxiety disorders. A strict conceptual division without adequate comparison of different approaches was considered unhelpful in advancing our knowledge of effective treatments. The segregation of exposure therapy and psychoanalysis may be limiting our basic understanding of anxiety disorders. This study attempted to fill an existing research void to further our understanding of the most important factors for treating anxiety disorders.
METHODS

I employed a literature review to compare psychoanalytic theory and the foundational theories of exposure therapy. There were two main aspects of this study. First, a thorough explanation of the foundational theories of the two approaches for treating select anxiety disorders was presented. Second, the theories of each approach were compared and contrasted. The anxiety disorders examined were posttraumatic stress disorder, specific phobia, and obsessive-compulsive disorder.

With regard to psychoanalytic theory, I concentrated on Freudian ideas to explain psychoanalytic theory for the set of anxiety disorders. Freud was the creator of psychoanalysis and his theories were still considered the foundation for the practice of psychoanalysis. Additionally, his theories of anxiety were still some of the most influential and well developed psychoanalytic theories of anxiety.

In the case of exposure therapy, I discussed the foundational theories using the literature from the original authors of the theories, and recent literature from researchers highlighting the treatment factors responsible for treatment effectiveness. In addition, a summary of the existing empirical evidence was provided. This summary concisely demonstrated that there was considerable empirical evidence for exposure therapy as an efficacious and effective treatment for this set of anxiety disorders. The actual empirical studies were not reviewed. Examples from exposure therapy and psychoanalysis were described to clarify the similarities of each approach. Previous attempts for integrating the two approaches were reviewed. As a result of exposure therapy having significant empirical support, it was considered the standard that psychoanalysis
was compared against. Some consequences of setting the empirically supported exposure therapy as the standard were that many of the important elements of psychoanalysis were not explicated within this study. For example, the theory of development and symbolic nature of symptoms, which were significant aspects of psychoanalysis, were not fully explored. An advantage of setting exposure therapy as the standard was that the similarities of the two disciplines could be highlighted.

Common factors of theory and treatment for both approaches were viewed as potential sources of new information regarding the main factors of therapeutic action for treating this set of anxiety disorders. These common factors were considered as future research topics on the main factors of therapeutic action within the narrow segment of psychotherapy reviewed within this study or for research within broader aspects of psychotherapy. Next, highlighting the similarities of each approach created ideas for integrating the different treatments. If significant similarities were clarified, this would be an initial stage for abridging the process of combining the two approaches. Lastly, the differences of the two approaches provided more ideas for future research. Exposure therapy and psychoanalytic therapy had significant differences. These differences may have enhanced or detracted from the critical factors of therapeutic action that each approach shared for treating a set of anxiety disorders. As a result, the differences within each approach provided interesting ideas for future research.
THEORIES OF EXPOSURE THERAPY

Learning theory provided the basis for the development of exposure therapy. In order to present a complete explanation of the foundational theories of exposure therapy, an early learning theory approach explaining how anxiety disorders developed was provided before moving on to contemporary theories. The initial learning theory explanation for anxiety disorders of Mowrer (1947) and the more recent model of Foa and Kozak (1986) were delineated below.

Mowrer’s (1947) two-factor theory provided a conceptualization of anxiety for the behaviorist. Mowrer proposed that a person learned fear and anxiety through classical conditioning, and the anxiety was maintained through operant conditioning. A person who experienced a traumatic event would also have experienced intense emotions associated with the trauma that would be linked in memory to the cues he or she witnessed as part of the traumatic event. The cues may be sights, sounds, or any other sensation associated with the trauma. The first part of Mowrer’s theory proposed that the cues associated with the trauma tended to increase over time. Things that were similar to the original cues of the trauma became generalized. Also, when a person experienced anxiety associated with a past trauma, new cues were added as a result of the anxiety. Leahy and Holland (2000) provided a clear example of Mowrer’s first factor concerning how cues increase over time:

For example, a woman who was raped while walking home alone at night may begin to fear not only being out at night (the original cue), but also any dark place (generalization). She may also come to fear her therapist’s office, where she has been discussing the rape (higher-order conditioning). It should be noted that anxiety-arousing cues can be external (places, sights, sounds) or internal (thoughts, memories, or emotional states). (p.183)
The second part of Mowrer’s theory provided assistance in understanding the dynamics of the avoidance behavior observed in many anxiety disorders. A person will naturally try to avoid the cues associated with the trauma, because when the cues are avoided, a person’s anxiety will decrease. The decrease in anxiety was a powerful reward, so the person would likely attempt to avoid cues of the traumatic event in the future. Remembering the first factor in which the number of cues increased over time and the fact that cues were internal or external, Mowrer’s theory explained why a person utilized avoidance more and more frequently over time. In addition, internal cues may lead to emotional numbing, which was a symptom of PTSD but also recognized as a part of other anxiety disorders (McWilliams, 1994).

Rosqvist (2005) explained how the dynamics of human learning associated with trauma were such a powerful force and why they are so resistant to change. Rosqvist stated that Mowrer’s two-factor theory described a “primitive” form of learning:

Such basic learning is conducted at a primitive, nonconscious substrate. This means the information learned is more directly stored in emotional defense and safety networks, which are more closely related to survival behaviors than in consciously aware centers of reasoning. (p.30-31)

As a result, a person naturally does not focus on his or her cues of fear and anxiety, because that would engender too much thinking and slow down the human instinct devoted to self-preservation. The information was only used when a person experienced cues associated with the trauma and felt threatened, which produced a reflexive reaction. In addition, Rosqvist noted that negative reinforcement dynamics associated with trauma and cues of anxiety created a more powerful learning process than positive reinforcement or punishment, which supported the conclusion that a person’s learned reactions from trauma would be difficult to change.

According to Rosqvist (2005), the main challenge in creating change for the therapist treating a person diagnosed with PTSD was to access information the patient had stored in
memory associated with his or her traumatic experience. The information resided in the unconscious, not part of rational thought but part of the primitive autonomic response system, and was guarded by powerful learning systems that block access to information which prevents change. Mowrer’s (1947) theory described avoidance learning and the rationale for anxiety symptoms that do not dissipate long after a person has been removed from a traumatic experience. The powerful learning process described by Mowrer delineated why a person would not confront his or her anxiety or fear, even when having been long removed from the feared stimulus. Exposure therapy was simply the opposite of avoidance learning; the client directly confronted trauma cues to provide direct access to the primitive autonomic reactions and emotions where the information was stored.

Accordingly, the basis of exposure therapy was to have a client confront his or her feared stimulus over and over again. Through this repetitive process, a person eventually stopped responding with fear and anxiety when he or she did not experience harm when confronting the feared stimulus. In vivo, or in a natural or live setting, was the preferred approach for exposure, but for obvious safety reasons it was not practical when treating PTSD clients. Imaginal exposure, or working through the client’s imagination, was the next best option. Rosqvist (2005) cautioned that in-imagination work had to seem real if the powerful potential of exposure therapy was to be achieved. The objective of exposure therapy was habituation, and Rosqvist succinctly explained habituation as “the decrease in arousal in the presence of what is feared” (p.41).

Rosqvist explained the importance of habituation:

Habituation and extinction make up the backbone on which all exposure treatment is built. Habituation and extinction are the pivotal parts that collectively represent the mechanism of change contained within exposure exercises. They are distinct aspects of change, but both are required for long-term and meaningful reduction in anxiety and fear. Habituation and extinction are why exposure ‘works’ and can only be achieved through exposure and repeated exposure. (p. 41-42)
Another important aspect of exposure therapy was that the client experienced a decrease in anxiety during the actual exposure exercises. Leahy and Holland (2000) stated it was “crucial that exposure not be terminated until the patient has experienced some decrease in anxiety” (p.197). The main reason for this was that a client who terminates exposure prematurely would continue the avoidance learning process of stopping before a decrease in anxiety had been experienced. In contrast, a decrease in anxiety during exposure provided new information about a client’s ability to cope with distressing memories. Among other benefits of decreased anxiety, a person would likely have more motivation to continue if he or she notices such improvement.

Various researchers have stressed different aspects of exposure therapy that they perceived as important for successful treatment. Some researchers (e.g., Leahy & Holland, 2000; Smucker & Dancu, 1999) considered the memory and images of past traumatic experiences to be the most important aspects to address in exposure therapy. Rosqvist (2005) has described several aspects of exposure therapy that may contribute to successful treatment. He explained that in-session habituation was a necessary threshold to achieve, but he noted that between-session habituation was more important because it demonstrated a deeper level of integrating new information. Rosqvist also outlined four factors for success of exposure therapy that included (a) increased frequency with which a person came into contact with the feared stimuli, which would accelerate the process of deconditioning fears; (b) increased duration of time in exposure exercises, which was critical because it was closely related to habituation; (c) increased severity of the exposure exercise so the client did not stay within a comfortable range of trauma memories; and (d) attention to latency or timing, which meant starting the exposure immediately after the command to begin because any delay will further solidify the credibility of the fear.
reasoning for CBT therapists assigning homework was clear given the importance of the frequency of exposure and between-session habituation.

Foa and Kozak (1986) developed a model that attempted to deliver a theoretical understanding of the efficacy of exposure therapy. The authors used data from outcome studies which explained the mechanisms of therapeutic action and developed an emotional processing theory. For Foa and Kozak, emotions were created by information stored within memory. A stimulus triggered access to information stored in memory, and an emotion emerged which represented this information. The anxiety found in patients with PTSD was representative of information activated from memory that pertains to avoided danger or the need to escape. These researchers considered anxiety and fear as a mental program, or “fear structure,” designed to escape or avoid danger which contained three types of information: (a) information about the stimulus situation, (b) information about behavioral responses, (c) and information about the meaning concerning the stimulus and response elements (p. 21). Foa and Kozak described this fear structure by stating, “Thus, a fear structure is distinguished from other information structures not only by response elements but also by certain meaning or information it contains” (p.21). The researchers believed that much of a fear structure was contained within unconscious memory, but altering the fear structure could be accomplished through conscious thought processes. The goal of emotional processing for Foa and Kozak was to change the information stored in memory that created certain emotions. Information and emotions regarding trauma were important and interrelated aspects of trauma treatment. Exposure, or confronting the feared object or situation, was thought to be an effective intervention to alter the important information stored in memory that created pathological thought and behavior patterns which resulted from experiencing anxiety. During exposure therapy sessions there were two important indicators of
emotional processing: physiological response and habituation. For change to take place, the emotion needed to be activated during the therapy session. In the case of PTSD, a person’s fear needed to be engaged. A therapist could determine if the client’s fear was activated by the client’s physiological response. Change would take place when new information was incorporated into memory that was incompatible with the original information that created the emotional response of fear.

Foa and Kozak (1986) proposed that exposure alone may provide the incompatible information to existing memory in a client tolerating in vivo or imaginal exposure to feared stimuli. The authors contended that only after the emotions were activated in the therapy session was there an opportunity to change the information that created the emotion. Foa and Kozak believed that traumatic experiences often created two troubling cognitions that supported and perpetuated the anxiety experienced by clients diagnosed with PTSD: that the world was an extremely dangerous place, and that the sufferer must have been incompetent.

Altering the cognitions and other information stored in memory advanced the client toward habituation to the feared stimulus, which was the objective of exposure therapy. Habituation was demonstrated when the client suffering from PTSD experienced reduced initial physical response to the feared stimuli. Additionally, habituation was also demonstrated by the client’s reduced response to the feared stimuli across sessions. If initial and across session habituation to feared stimuli was achieved, exposure therapy was deemed to have succeeded.

There were several factors that complicated the achievement of successful emotional processing, habituation, and successful treatment outcomes following exposure therapy. A common symptom of anxiety was avoidance, and, by definition, a person suffering from PTSD would want to avoid most memories or situations associated with the traumatic event. To assess
the emotional processing of a client during exposure therapy, Foa and Kozak (1986) recommended assessing physical response to relevant stimuli several times over the course of therapy. Also, for avoidant clients, Jaycox and Foa (1996) recommended the utilization of stress inoculation training or other CBT techniques.

Jaycox, Foa, and Morral (1998) emphasized the importance of habituation in achieving successful treatment outcomes. However, habituation was a difficult objective to achieve, and there appeared to be many unknown factors that may account for why some clients achieved habituation and others did not. Jaycox et al. described the dilemma by stating, “at present we do not know why one client habituates and another does not. In the absence of such information, it is possible that some clients need more exposure sessions than others” (p. 190).

The idea that some clients need more exposure than others presented another complicating factor in the effort to achieve successful treatment outcomes with exposure therapy. Foa and Kozak (1986) found support for the idea that lengthening the duration of exposure treatments can improve outcomes for difficult clients. However, tests of this hypothesis have produced inconsistent results. Minnen and Foa (2006) did not find a difference between participants diagnosed with PTSD that were treated with 30 min or 60 min prolonged exposure sessions as part of an efficacy study testing the effects of the length of imaginal exposure on treatment outcomes. Likewise, in another clinical trial (Jaycox et al., 1998) in which female rape victims diagnosed with PTSD were treated with exposure therapy, no difference in treatment outcomes were found when the number of exposure therapy sessions varied. Thus, the increase in the number of exposure treatments has produced mixed results for treatment outcomes.

As stated above, one important factor of emotional processing (Foa & Kozak, 1986) was the ability to change the information in memory that anxiety and other emotions represent. How
best to approach the creation of new cognitions and beliefs raised another important issue. Researchers (e.g., Foa et al., 2005; Marks, Lovell, Noshirvani, Livanou, & Thrasher, 1998; Paunovic & Ost, 2001) have attempted to add cognitive restructuring techniques to exposure therapy but have failed to improve treatment outcomes. However, one clinical trial (Bryant, Moulds, Guthrie, Dang, & Nixon, 2003) achieved success by adding cognitive restructuring to exposure therapy treatment of people diagnosed with PTSD. In general, the addition of other interventions to exposure therapy when treating people with PTSD has not increased treatment outcomes (e.g., Foa, Dancu, Hembree, Jaycox, Meadows, Street, 1999; Foa et al., 2005). In sum, several important components of exposure therapy have been identified that contribute to successful outcomes: the activation of emotions, habituation, the alteration of cognitions and beliefs, and length of exposure sessions.

There seemed to be general agreement among researchers with regard to the reasons exposure therapy fails to work (e.g., Foa & Kozak, 1986; Leahy & Holland, 2000; Rosqvist 2005; Smucker & Dancu, 1999). The main reason given for unsuccessful therapy was that clients were not participating in the exposure exercises long enough to sufficiently activate the intense emotions associated with their traumas. The natural reluctance for a person to engage their emotions associated with a traumatic event coincided with Mowrer’s (1947) two-factor learning theory. Also, coinciding with Mowrer’s theory, as described above, was the difficulty in activating emotions and reaching the information concerning trauma which individuals have stored in their memories.

Table 1 provided a summary regarding first section of the theoretical foundations of exposure therapy. Mowrer (1947) developed his two-factor theory from fundamental principles of learning theory and his learning theory model was the foundation of exposure therapy.
Rosqvist (2005) emphasized several theoretical points underlying exposure therapy. One important point discussed by Rosqvist was the need to access primitive-nonconscious-autonomic-type memories. Rosqvist emphasized the learning theory principles of habituation and extinction. For effective exposure therapy, Rosqvist developed four critical factors: frequency, duration, severity, and latency.

---

Table 1

*Theoretical Foundations of Exposure Therapy: Two-factor Theory and Important Factors*

<table>
<thead>
<tr>
<th>Mower’s Two-Factor Theory</th>
</tr>
</thead>
<tbody>
<tr>
<td>Classical Conditioning</td>
</tr>
<tr>
<td>Operant Conditioning</td>
</tr>
<tr>
<td>Two Factors</td>
</tr>
<tr>
<td>Cues increase over time</td>
</tr>
<tr>
<td>Avoidance increases over time</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Rosqvist’s important factors</th>
</tr>
</thead>
<tbody>
<tr>
<td>Access information from nonconscious autonomic memories</td>
</tr>
<tr>
<td>Repeated exposure</td>
</tr>
<tr>
<td>In vivo preferred, imaginal also effective</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Four critical factors</th>
</tr>
</thead>
<tbody>
<tr>
<td>Frequency</td>
</tr>
<tr>
<td>Duration</td>
</tr>
<tr>
<td>Severity</td>
</tr>
<tr>
<td>Latency</td>
</tr>
</tbody>
</table>
Table 2 provided a summary regarding the next section of the theoretical foundations of exposure therapy. Foa and Kozak (1986) contended that emotion was created by information stored in memory; therefore, anxiety represented some stored memory of fear. The resulting goal of their emotional processing theory was to change information by activating emotions. Repeated exposure allows the opportunity to activate emotions and alter the information stored in memory. Foa and Kozak cautioned that avoidance, along with the unexplained phenomenon of some people not readily habituating to painful stimuli, were common complicating factors of exposure therapy. The researchers were somewhat more equivocal on the need to add cognitive restructuring to exposure therapy, but appeared to finalize their research with the notion that exposure therapy alone would be effective treatment for PTSD. There appeared to be a general consensus that the inability to activate emotions was the main factor responsible for why a clinician utilizing exposure therapy might fail to alleviate PTSD symptoms in his or her patients.
Table 2

*Theoretical Foundations of Exposure Therapy: Emotional Processing*

**Foa and Kozak Model**

- Emotion created by information in memory
- Anxiety represents information in memory
- Activating emotions was a critical treatment factor
- Repeated exposure necessary to change information in memory

**Complications of treatment for Foa and Kozak**

- Avoidance
  - Some people do not readily habituate
  - Cognitive restructuring may be needed

**Consensus on reason exposure therapy fails**

- Failure to activate emotions associated with trauma

---

**Posttraumatic Stress Disorder**

Researchers have found encouraging results from testing several different treatment approaches for trauma, including Edna Foa (1999) who has published several studies concerning the efficacy of exposure therapy in the treatment of PTSD (e.g., Foa, Keane, Friedman, 2000; Foa & Meadows, 1997; Nemeroff et al., 2006). Foa was also part of the Expert Consensus Guideline Series for the treatment of PTSD (1999) which recommended a treatment of choice according to the type of symptom presentation that was most prominent for people diagnosed
with PTSD. Exposure therapy was selected as the treatment of choice for PTSD when intrusive thoughts, flashbacks, and trauma related fears, panic or avoidance were most prominent.

The International Society for Traumatic Stress Studies (ISTSS) prepared a book of practice guidelines for effective treatments of PTSD (Foa et al., 2000). This monograph contains a chapter on psychodynamic therapy in which Gestalt and psychodynamically oriented therapies were not included in the discussion of effective treatments. However, the authors (Shalev, Friedman, Foa & Keane, 2000) who summarized the guidelines provided a plausible explanation for exclusion:

This is partly due to the fact that typical goals of psychodynamically oriented psychotherapy are to affect factors such as the capacity for human relatedness or one’s incomplete view of one’s past rather than reduction of symptoms of specific disorders such as PTSD (which is the aim of therapies such as CBT and medication), for which we do not have satisfactory assessment methodology. (p. 367)

Shalev et al. contended that psychodynamically oriented therapies in treating PTSD were omitted from the treatment guidelines because there was little empirical research to support their inclusion. “It should be clearly stated, therefore, that the effectiveness of psychodynamic psychotherapies for ‘complex PTSD’ and related problems is simply not addressed in this book. This is yet another, open question requiring further research” (p. 367).

If psychoanalytic approaches were left out of the analysis of state of the art treatments for trauma, it became important to understand what the recommended treatments were and what aspects of those approaches created effective treatments. Exposure therapy was considered the most empirically supported treatment for PTSD by the ISTSS guidelines (Foa et al., 2000) and by a more recent examination of state of the science discussions (Nemeroff et al., 2006). The authors (Rothbaum, Meadows, Resick & Foy, 2000) of the cognitive behavioral therapy section of the ISTSS guidelines explained why exposure therapy received the most favorable
recommendation by stating, “In summary, the evidence is very compelling from many well-controlled trials with a mixed variety of trauma survivors that EX [exposure therapy] is effective. In fact, no other treatment modality has such strong evidence for its efficacy” (p. 321). Exposure was considered the most empirically supported treatment for reducing symptoms of PTSD, so it received the most favorable recommendation from ISTSS. It has been tested in more trials and under more varied conditions than any other treatment method. In contrast, psychoanalytic therapies have not been analyzed by researchers interested in empirical analysis. From this perspective, psychoanalytic approaches to therapy have fallen a considerable distance behind. To achieve the status of a highly recommended treatment such as exposure therapy, psychoanalytic researchers will need to accumulate much more evidence.

**Obsessive-Compulsive Disorder**

Meyer (1966) provided an early outcome study for OCD and exposure therapy. The author utilized an early form of exposure therapy to treat two inpatient clients diagnosed with OCD. Meyer worked with an inpatient population to help monitor the clients for the purpose of persuading them to cease their compulsive behaviors. One of the client’s of the study engaged in compulsive cleaning rituals. Meyer described the inpatient treatment with this client as follows:

“making the patient perform activities which persistently presented difficulties for her (e.g., touching door knobs, handling dust bins, her child’s toys, milk bottles; using public transport; shopping)” (p. 277). In addition, Meyer utilized hospital staff to assist with preventing the compulsive behaviors. He stated, “Persuasion, reassurance and encouragement were used to prevent the patient from unnecessary and excessive washing and cleaning” (p. 277). The treatment greatly reduced the compulsive behaviors of both clients of the study. Thus, exposure therapy with response prevention was established as an efficacious treatment for OCD. Recently,
Leahy and Holland (2000) described the continued research of exposure therapy and response prevention for treating OCD as follows: “In the years since Meyer’s paper was published, the combination of exposure and response prevention has been extensively studied; it is currently regarded as the gold standard in treatment for OCD” (p. 246).

Stanley and Turner (1995) compared exposure therapy with response prevention to pharmacological therapy for treating OCD. The method utilized by the authors for developing their comparison was a review of outcome studies. Stanley and Turner analyzed differential treatment response rates in terms of drop-out rates and relapse prevention. The authors’ main findings for exposure therapy and response prevention were that 30% of clients did not complete treatment, 36% of clients had at least a 70% reduction in symptoms, 27% had a 31 to 69% reduction in symptoms, and 7% did not benefit from treatment. Stanley and Turner concluded that 63% clients diagnosed with OCD could expect to respond favorably to exposure therapy with response prevention (p. 164). The authors also emphasized that many of the clients who responded positively to treatment were not symptom free and cautioned their readers that “many patients continue to have some symptoms of the disorder despite classification as treatment responders, thus highlighting the chronicity of the disorder and the continuing need for treatment refinement” (p. 169-170).

Specific Phobia

The treatment of specific phobia seems to have a somewhat more complicated situation. This mainly appears to be due to the fact that there are many different phobic objects. Some researchers classify effective treatment per phobic object associated with the disorder and not for the disorder as a whole. Despite these complications, exposure therapy had significant evidence as an empirically supported treatment for specific phobia. Choy, Fyer, and Lipsitz (2007)
conducted a comprehensive review of published specific phobia studies from 1960 to 2005.

From their comprehensive review of the literature, the authors concluded the following:

The goal of this review was to comprehensively examine outcomes of evidence-based treatments for specific phobia in adults. Based on the acute clinical trials, the most robust treatment for most of the specific phobia types appears to be in vivo exposure therapy, with most studies finding it more effective than placebo or wait-list control, and a few studies supporting a response rate of 80 to 90%. (p. 282)

Choy et al. seemed to have provided the most comprehensive review of treatment for specific phobia and endorsed exposure therapy as the treatment which created the most robust results.

Ost and his colleagues (Ost, 1989; Hellstrom & Ost, 1995, 1996; Hellstrom, Fellenius, & Ost, 1996) have provided a series of research studies on the treatment of specific phobias with a short, intensive form of exposure therapy. The successful outcome studies established by these researchers have created important questions about the mechanisms of therapeutic action in the treatment of exposure therapy. In his 1989 outcome study Ost described his intensive-one-session treatment for specific phobia. The author’s “first criterion” was that the client’s phobia was “circumscribed” or concerned only one phobic object or situation (p. 2). Ost described “motivation” as the most important factor for determining if a client was suitable for his intensive form of exposure therapy. The author discussed the need for a strong desire to get rid of the phobic symptoms in order for the client to be prepared to tolerate the high anxiety which occurs during treatment. Ost believed that all animal phobias would be suitable for one-session treatment. The author expressed some doubts about flying phobia and claustrophobia being suitable for one-session treatment. Ost had the following two goals for his one-session treatment:

(a) the client will progress to the point of being able to manage the phobic object in a natural
setting without undue anxiety, (b) the client should “overlearn” the fact that the phobic object was not harmful (p. 2). Ost added modeling to the one-session in vivo exposure therapy. He described modeling as the client receiving instructions about the procedures and the therapist actively demonstrating to the client how to interact with the phobic object. In fact, Ost recommends assuring the client they will never have to interact with the phobic object without first receiving instructions and a demonstration from the therapist.

Ost’s study began with 25 participants. The author chose another treatment for a client with a flying phobia and a client with claustrophobia. In addition, three clients rejected the option for one-session treatment. As a result, one-fifth of the original subjects did not participate in the study. Of the 20 participants, only one needed more sessions to complete treatment. The participants averaged 2.1hrs to complete the treatment. Ost utilized a specific phobia scale and the Fear Survey Schedule-III to monitor results, and the results were encouraging for Ost’s study. For example, at post-treatment, spider phobic clients had an average improvement of a 65% decrease in symptoms. The long-term results were also impressive. With an average of four years for a follow-up period, Ost indicated that 10% of the participants had some improvement, 25% were much improved, and 65% were completely recovered. Ost concluded that 90% of the participants had a significant improvement from the intensive-one-session treatment. Choy et al. (2007) emphasized considering all original participants, including dropouts. If Ost’s results were recalculated to include all of the original subjects, 28% did not receive any benefit from treatment, 20% received some benefit, and 52% were completely recovered, which were still encouraging results.

In another study with 52 participants, Hellstom and Ost (1995) compared their therapist directed one session exposure therapy treatment with four different versions of self-directed-
manualized-exposure therapies. The one session exposure treatment which was directed by a therapist created clinically significant improvement for 80% of the participants at a one-year-follow assessment. The therapist directed treatment had significantly better outcome than self-directed treatments. The authors concluded that their “one-session therapist-directed treatment is the treatment of choice for spider phobia” (p. 959).

The research performed by Ost and his colleagues has provided considerable evidence for one session exposure therapy treatment for specific phobia. The one-session treatment seemed to rely purely on exposure to obtain a positive treatment outcome due to the fact that the treatment was so short. It appeared that other factors such as a therapeutic relationship are minimized during the one-session treatment. Interestingly, Ost believed that extensive learning was still involved to obtain a positive treatment result. He believed that clients could obtain a thorough amount of information concerning their phobic reactions during a one-session treatment.

Chambless (1990) considered exposure therapy to be an efficacious treatment of specific phobia and developed an outcome study to determine if there was a difference between daily exposure sessions or weekly exposure sessions for treating simple phobia. As part of a more extensive study, 17 subjects were divided between the daily and weekly groups and treated with exposure therapy. Both groups of participants demonstrated significant improvement. The author concluded that exposure therapy was an efficacious treatment for specific phobia and that there was not a significant difference between weekly or daily exposure sessions. Unlike Ost’s research, participants also received skills training with a variety of coping skills during their treatment. As a result, it was difficult to isolate the effects of exposure therapy for this study.

In sum, it appeared that there was not one generally accepted treatment of choice for all specific phobias. As the phobic object varies, different researchers may have different opinions
about what would be the most effective form of treatment. Nevertheless, there seems to be considerable evidence that exposure therapy is an effective treatment for specific phobia. Choy et al (1990) have provided a review indicating exposure therapy as the treatment of choice for specific phobia. In addition, Ost and his colleagues (Ost, 1989; Hellstrom & Ost, 1995, 1996; Hellstrom, Fellenius, & Ost, 1996) have provided a series of studies demonstrating the effectiveness of exposure therapy in the treatment of specific phobia. As a result of this evidence, exposure therapy for specific phobia was included in this study.
COMPARATIVE ASPECTS OF PSYCHOANALYSIS FOR ANXIETY DISORDERS

Studies on Hysteria (1895) contained Freud’s first major publication and represents his work which most clearly matches the principles of exposure therapy (Strachey, 1974a). Strachey pointed out that Studies on Hysteria was generally considered the beginning of psychoanalysis. To fully understand the ideas presented by Breuer and Freud, it is helpful to understand the major influences of the authors and within the field of psychology during the late nineteenth century. In addition, a thorough comparison with the fundamental theories of exposure therapy was much clearer after Freud’s major influences were outlined.

During the late nineteenth century, psychological thought was influenced by prominent ideas in philosophy. John Locke (1690) wrote that simple ideas were created through the senses. After the simple ideas were created, reasoning could begin by consciousness moving from one element to the next and building associations between elements. Locke’s ideas helped provide a foundation for associational psychology (Makari, 2008). According to Makari, the concept of associational psychology was well established when Freud began his work studying anxiety. Further, Olsen and Koppe (1988) described the concept of associations as one of the foundations of psychoanalysis. Hearnshaw (1987) credited David Hartley with establishing the associational psychology tenet that one idea or sensation was able to trigger a host of other ideas. Associational psychologists relied on all of the sensory perceptions to create human experience and functioning. Associationalist tenets that applied directly to Freud’s theories rejected what were then considered inborn faculties, such qualities as morality, reason, and imagination, to explain human functioning. The hedonistic principle that man acts to gain pleasure and avoid
pain had been well debated by philosophical greats such as Hobbes, Hume, and Herbert long before Freud began to develop his psychological theories (Olsen & Koppe, 1988). Makari (p. 13) noted that associational psychologists incorporated the ideas that humans were pleasure seeking and pain avoidant long before Freud began his work on hysteria. Associational psychology represented an important shift in psychology as a scientific study grounded in empirical evidence. These basic laws of associational psychology established a foundation for ideas about the unconscious and the treatment techniques of free association.

Freud followed the path set by associational psychologists and steadfastly claimed a strict alliance with natural science throughout his career (Hearnshaw, 1987). Strachey (1974a) and Makari (2008) agreed that a major influence within psychology in general and upon Freud specifically (before he wrote of Studies on Hysteria,) was positivist ideology which grounded psychology in scientific principles, as opposed to religious ideas or ideas about the complex interplay of human emotions or ideas. Strachey noted the empirical emphasis of one of Freud’s teachers, Herman von Helmholtz, who was an important early influence on Freud. Helmholtz gained prominence by developing arguments regarding human life and knowledge as products of biological forces and Newtonian physics (Makari p. 57-60). Makari emphasized the empirical foundations of Freud’s early years in psychology, beginning with Freud’s early career working as a laboratory scientist. Freud also worked as a zoology researcher in the laboratory of Ernest Wilhelm von Brucke, and in the laboratory of Theodor Meynart, a psychiatrist who studied brain science. Meynart theorized that mental disorders emanated from brain disease (Makari, p. 25).

Strachey (1974a) summarized how Freud’s early career experiences resulted in a scientific and empirical foundation for his theory building:

Breuer and Freud owed a fundamental allegiance to the school of Helmholtz, of which their teacher, Ernest Brucke, was a prominent member. Much of the underlying theory in
the Studies on Hysteria is derived from the doctrine of that school that all natural phenomena are ultimately explicable in terms of physical and chemical forces. (p. xxii)

Freud continued his scientific approach to research after making his career move from laboratory scientist to investigator of nervous disorders.

Freud began his career in psychology studying nervous disorders under Jean-Martin Charcot in 1885. Makari (2008) explained that Theodule Ribot had established a framework for French psychological inquiry well before Freud’s arrival in France. The framework described by Makari included a scientific approach, examining human inner experience and the hereditary causes of psychological disorders. Ribot transformed psychology into a respectable scientific discipline in France by maintaining strict positivist principles of study during a period when psychology contended with religious doctrines for providing an understanding of mental disorders. At the same time, he focused his attention on ideas, the unconscious, and other aspects of the mind while maintaining a scientific approach and proclaiming heredity as the cause of mental disorder.

The famous physician Charcot inherited Ribot’s framework for psychological inquiry when he began his own study of nervous disorders (Makari 2008). Charcot made considerable advancements in the study of nervous disorders which would remain an important influence for Freud throughout his career (Strachey, 1974a). Charcot continued with a positivist approach in order to define neuroses and hypnotism in scientific or behavioral terms while simultaneously producing a more specific definition of hysteria in terms of physical and behavioral symptoms. Additionally, he utilized the physiological reactions of his clients to frame hypnotism and unconscious ideas in acceptable scientific terms. Charcot’s formidable reputation and research on neuroses resulted in a transformation of the concepts of hysteria, the unconscious, and hypnotism from folklore and quackery into objective scientific research. Moreover, the model Charcot used
for treating hysteria had a lasting impression on Freud and for the treatment of anxiety long after Charcot’s career ended. From an early lecture of Freud’s (Breuer & Freud, 1893) and from *Studies on Hysteria* (Breuer & Freud, 1895), it was possible to outline the model in which Freud established his own theory of hysteria from Charcot’s preliminary ideas. The model began with a person having a genetic vulnerability to mental health problems and experiencing a traumatic event. The person experienced a series of emotions and the self suggested negative thoughts about an ability to react to the trauma, which was similar to Foa and Kozak’s (1986) model. The emotions and autosuggestions were dissociated. The consequence of emotions and autosuggestions being kept out of awareness in the unconscious was that they were not released or available to other associations in memory. The results were the physical and behavioral symptoms of hysteria.

It should be noted that the exact origins of this first model to treat hysteria and other anxiety disorders was under debate. Researchers (Makari, 2008; van der Kolk & van der Hart, 1989) have lamented the translation problems and lack of historical knowledge regarding Charcot’s work and that of his protégé Pierre Janet. It was beyond the scope of this study to enter this debate, so I chose to accept Freud’s description (Breuer & Freud, 1983) and other well known sources (Jones, 1981; Strachey, 1974a; Makari, 2008) of how his model was developed.

In sum, the foundation of Freud’s early theories for the treatment of anxiety could be traced from several sources. The most direct sources were associational psychology, the popularity of the positivist approach, Ribot’s theories, and finally Freud’s work with Charcot in 1883 (Jones, 1981; Makari, 2008). Additional foundational and obscure sources for his intellectual development influenced his theory and treatment of anxiety (Watson, 1968).
Cathartic Theory and PTSD

In *Studies on Hysteria*, Freud and Breuer established the key elements of the exposure principle and the therapeutic action of many forms of psychotherapy. According to some prominent theorists (e.g., Wachtel, 1997; Yalom & Laszcz, 2005), Freud and Breuer also established an idea of psychotherapy which has been difficult to extinguish. The idea that the client should review the original causes of his or her problem became a common element of psychotherapy. Their method for healing was to uncover the original trauma or event which created symptoms of anxiety and have the client review the original event with strong emotion. This could be viewed as the original exposure therapy. The following famous quote from Breuer and Freud (1895) clarifies this crucial point:

> For we have found, to our great surprise at first, that *each individual hysterical symptom immediately and permanently disappeared when we had succeeded in bringing clearly to light the memory of the event by which it was provoked and in arousing its accompanying affect, and when the patient had described that event in the greatest possible detail and had put the affect into words.* Recollection without affect almost invariably produces no result. (p. 6)

Other theorists and researchers have noticed the connection between Freud’s early idea of therapeutic action and current therapies. Barlow (2002) noticed the ongoing influence of Freud’s early ideas and described it as follows:

> From a historical perspective, the work of Janet (1889) and Freud (1936) has most influenced the treatment of PTSD. The objectives of each approach have much in common with contemporary models of treatment, including the cognitive-behavioral treatments of today. Thus current models of treatment owe a substantive debt to these pioneers. (p. 441)

Further evidence of the relation between psychoanalytic theory and the theories of exposure therapy was provided by Edna Foa and her colleagues (Foa & Kozak, 1986). These researchers viewed exposure as a fundamental element of therapeutic action from Freud’s era to the present.
Foa and her colleagues have promoted exposure as a historically important factor of psychotherapy across theoretical orientations:

Despite their theoretical differences, a common principle for the treatment of neuroses has emerged across schools of psychotherapy: the principle of exposure. Indeed, if neurotics are avoiders who fail to recognize and/or retrieve discomfort-evoking information about themselves or their environment, psychotherapy might be construed as providing a setting in which confrontation with such information is promoted so that changes in affect can occur. Psychodynamically oriented therapists expose their patients to information about unconscious conflicts, painful memories, and unacceptable wishes through interpretation of their behavior in therapy, of dreams, or of free associations. Likewise, Gestalt therapists use imagery, role-enactment, dream interpretation, and group-interaction to coax a person into “the here-and-now,” that is, to promote confrontation with information that has been avoided. Techniques that more directly promote confrontation with fearful events have been developed by behavior therapists.

(p. 20)

Foa and her colleagues are one set of many researchers who equate exposure therapy with certain psychoanalytic techniques. Foa and Kozak also alluded to the differences between psychoanalytic therapy and behavior therapy when they discussed avoidance and the directness of behavior therapy. Many modern-day researchers recognize the historical importance of exposure techniques from Freud’s early theories to current behavior and cognitive-behavioral therapies. For this study, when discussing exposure I will adopt Foa and Kozak’s terminology for the principle of exposure, i.e., confronting what is feared or avoided, whether it be memories of past events or some other sort of information.

Freud’s trauma model, diagramed in Figure 1, started with an external event, i.e., the original trauma. In a jointly written chapter from *Studies on Hysteria*, Breuer and Freud (1985) reported learning about the effects of trauma from cases in which they used hypnosis as the treatment, stating, “They are valuable theoretically because they have taught us that external events determine the pathology of hysteria to an extent far greater than is known and recognized” (p. 3-4). Freud wasted little time dwelling upon trauma as the cause of any pathology; he was
much more concerned with internal life than with external events, as evidenced by statements such as, “In traumatic neurosis the operative cause of the illness is not the trifling physical injury but the affect of fright – the psychical trauma” (Breuer & Freud, p. 5-6). A person’s particular cognitive and emotional reaction to a trauma was what created pathology, which Freud (1909) described as follows:

Not only do they remember painful experiences of the remote past, but they still cling to them emotionally; they cannot get free of the past and for its sake they neglect what is real and immediate. This fixation of mental life to pathogenic traumas is one of the most significant and practically important characteristics of neurosis. (p. 13)

Freud’s theories were based on human sexuality, so the original traumas in his case studies were normally of a sexual nature. The person who lived through a traumatic event had two types of internal experiences: a pathogenic idea and intense affect. The internal pathogenic idea was one important factor of this trauma theory which explained the creation of the mental health problems for the client. Freud’s version of a pathogenic idea was a thought which caused intense psychological pain and which was incompatible with the person’s ego or sense of self. It was a severe criticism directed inward or toward the self. Anytime this thought neared consciousness it aroused severe shame and self-reproach. The other type of experience a traumatic event generated for a person was an intense affect. Breuer and Freud (1893) found that intense affect was a main cause of hysterical symptoms, stating, “there is an affectively coloured experience behind most, if not all, phenomena of hysteria” (p. 10).
Following the intense affects and pathogenic ideas created from a traumatic experience, was the crucial step of repression, which was most influential for creating pathology. Freud (1915a) stated, “the purpose of repression was nothing else than the avoidance of unpleasure” (p. 153). It was a means for someone to defend themselves against the painful experience caused by the intense affects and pathogenic ideas generated by a traumatic experience. For Freud (1914a), repression was what created the problem for hysterics, and he noted its importance by stating, “The theory of repression is the cornerstone on which the whole structure of psycho-analysis rests” (p. 14). Repression can be straightforwardly described as a “motivated forgetting or ignoring” (McWilliams, 1994, p. 118). Freud (1915a) noted the core factors of repression by stating, “the essence of repression lies simply in turning something away, and keeping it at a distance, from the conscious” (p. 147). The particular manner in which a person defended him- or herself against emotional or cognitive pain determined what symptoms were experienced. In other words, the form of repression a person utilized determined the type of disorder from which the person suffered. Freud was clear that both the cognitions and affect associated with a traumatic experience were repressed, or held out of consciousness. However, repression was not a neat and simple task. For example, with regard to hysteria there was the relatively complete
task of keeping cognitions and affects out of consciousness, but many thoughts and feelings still leaked into consciousness. To help accomplish the arduous task of keeping thoughts and feelings related to trauma out of awareness, the affect was separated from the cognitions related to the event, which reduced the distress generated by the affect. Once the intense affect and pathogenic ideas were separated and repressed, the person gained considerable ability for keeping the trauma at a distance, or out of consciousness. The unfortunate result was the formation of pathological symptoms. The affects and cognitions associated with the trauma were out of consciousness, but they did not disappear. They remained in the person’s psyche and exerted constant pressure. The intense affect associated with a traumatic experience generated considerable energy. This affective energy sought some sort of release. To achieve a relatively healthy resolution to a traumatic event, a person experienced some sort of reaction to release the affective energy. Breuer and Freud (1895) were open to almost any strong reaction to release the intense affect; anything from “tears to acts of revenge” would suffice to relieve the person of such pressure (p. 8). Because of repression, the original affect related to the traumatic event was displaced. Without a proper reaction to the trauma, the affective energy remained within the person and ended up in the wrong channel. It was then displaced to some type of somatisized symptom, which Freud referred to as somatic innervation. Freud (1909) explained the process as follows:

One was driven to assume that the illness occurred because the affects generated in the pathogenic situations had their normal outlet blocked, and that the essence of the illness lay in the fact that these ‘strangulated’ affects were then put to an abnormal use. In part they remained as a permanent burden upon the patient’s mental life and a source of constant excitation for it; and in part they underwent a transformation into unusual somatic innervations and inhibitions, which manifested themselves as the physical symptoms of the case. (p. 15)

An example of somatic innervation or a conversion symptom would be the partial paralysis experienced by Anna O, Breuer’s client described in Studies on Hysteria. After her emotions
were denied an outlet, they became much more intense when stored as somatic symptoms. Current terminology which closely approximates Freud’s (1909) idea of “constant excitation” was increased arousal (p. 15). Freud noted that the emotional aspect of the experience of trauma was the most important, writing, “we are on the point of arriving at a purely psychological theory of hysteria, with affective processes in the front rank” (p. 15). With regard to hysteria, or the pathology created after a person experienced a traumatic event, Freud (1894) simultaneously explained his idea for the differentiating diagnostic feature of hysteria and separated himself from his contemporaries of Breuer and Janet, stating, “Thus we see that the characteristic factor in hysteria is not the splitting of consciousness but the capacity for conversion” (p. 50). Repressed affects and conversion symptoms were critical factors for Freud.

Similar to affective energy, the repressed cognitions associated with traumas create problems for the person as he or she attempted to avoid all thoughts of the traumas in order to prevent psychological pain. Memories were weakened because they were separated from the corresponding affect. During a healthy reaction, the thoughts related to a traumatic event remained in awareness. Even if a person was ashamed of his or her thoughts and reaction during a trauma, he or she could utilize other memories and associated thoughts in order to ease the psychological pain which corresponded to a traumatic event. It could be one event that stood in comparison to other past events along with the hope of an improved reaction during future events. Freud’s roots in associational psychology helped him to create a similar theory as Mowrer’s learning theory. During the pathological reaction, cues of the original trauma expanded over time. Freud (1915a) explained as follows:

“The second stage of repression, repression proper, affects mental derivatives of the repressed representative, or such trains of thought as, originating elsewhere, have come into associative connection with it. On account of this association, these ideas experience the same fate as what was primally repressed. (p. 148)
A person used repression to defend against thoughts of the original trauma, pathogenic ideas created from traumatic experiences, and any associated thought that could possibly remind him or her of the former two cognitions. This process continued and the person built a large amount of material that was repressed for the purpose of avoiding thoughts of the trauma. Avoiding these thoughts became a draining and complex task. Freud’s (1895) individual work from *Studies on Hysteria* portrayed the complexity of this learned process:

> To begin there is a nucleus consisting in memories of events or trains of thought in which the traumatic factor has culminated or the pathogenic idea has found its purest manifestation. Round this nucleus we find what is often an incredibly profuse amount of other mnemonic material which has to be worked through in the analysis and which is, as we have said, arranged in a threefold manner. (p. 288)

In *Studies on Hysteria*, Freud placed great emphasis on the complicated process of working through all of the learned associations of the traumatic experience. He continued to emphasize the importance of cues expanding over time and avoidance of all cues associated with the trauma. Note this warning from his essay *Repression*:

> Moreover, it is a mistake to emphasize only the repulsion which operates from the direction of the conscious upon what is to be repressed; quite as important is the attraction exercised by what was primally repressed upon everything with which it can establish a connection. (p. 148)

The last phase of repression was the return of the repressed. Psychoanalysis was generally a dynamic theory and repression followed this theme. It required a continual assertion of energy to ensure that a memory remained repressed. Repression created an ongoing struggle for the psyche which drained energy from the person. The enervation and the vast associative networks of repressed material were difficult to manage and this resulted in the leaking out of the repressed material. The ego’s task was complicated and draining, and it became more and more difficult for it to consistently maintain the repression. Freud (1894) noted the instability of repression and the results of this incomplete process:
The distribution of excitation thus brought about in hysteria usually turns out to be an unstable one. The excitation which is forced into a wrong channel (into somatic innervation) now and then finds its way back to the idea from which it has been detached, and it then compels the subject either to work over the idea associatively or to get rid of it in hysterical attacks and chronic symptoms. (p. 50)

The type of defense employed determined the person’s pathology, but it was normally an imperfect or inconsistent process.

For clarity, repression was summarized with the following points: (a) The defense created the disorder by preventing a reaction and preventing an associative working over of the traumatic memories, (b) hysteria used the energy draining process of repression of affects and cognitions, (c) affects were converted to somatic symptoms and increased in intensity, (d) the memory of the trauma and pathological ideas associated with the trauma were also repressed, and (e) in order to keep the original trauma memories suppressed, a nucleus of repressed ideas along with a large amount of material associated with the original memories became repressed as well.

Following the effects of repression, a description of a client diagnosed with hysteria would begin when the client who experienced at least one traumatic event and his or her mental life had become fixated on the trauma. Repression of emotions and cognitions created pathology in the form of conversion symptoms and the energy draining process of keeping traumatic memories and associations out of awareness. This entire process was condensed to the epigrammatic declaration of, “Hysteric suffers mainly from reminiscences” (Breuer & Freud, 1895, p. 7). The critical factor for healing in Freud’s theory was returning to the original upsetting event in a particular manner. The client needed to recall the traumatic event, describe it in great detail, and release the intense emotions associated with the event. A description of the event was required along with all of the person’s cognitions associated with the event. Freud emphasized affects and he believed the main problems of hysteria were created by the abnormal
use of emotions and the increased intensity in which the emotions were converted within the body. In order to heal, this process needed to be reversed, and intensity of emotion was necessary in order to produce the desired effect of relieving somatic symptoms. An intellectual description of past traumas would not produce healing. The past traumas had to be recalled in the same intense emotional manner in which they had been converted to somatic symptoms. Freud (1909) described this critical step for treatment: “Thus it was what happened to these affects, which might be regarded as displaceable magnitudes of affect, that was the decisive factor both for the onset of illness and for recovery” (p. 15). Breuer and Freud (1895) termed this process abreaction and the result was the termination of symptoms related to the traumatic event. The two basic components of abreaction were the detailed description of the trauma and the corresponding intense release of the emotions associated with the traumatic event.

As Breuer and Freud (1895) explained, abreaction was initially used with hypnosis in order to alleviate the symptoms of clients diagnosed with hysteria. The treatment method for a client diagnosed with hysteria consisted of placing the client under hypnosis and asking the client to recall when his or her symptoms started. This line of questioning would lead to the original trauma. Once the original trauma was uncovered, the clinician could use abreaction to cure the client of the symptoms associated with that trauma. There were five case studies described within Studies on Hysteria, one was Breuer’s client and the other four were Freud’s. Breuer’s client Anna O. was a convenient case to explicate the abreaction method. For a period Anna O. refused to drink fluids; this was one of her hysterical symptoms. During hot summer days she would feel thirsty and bring a glass of water to her lips, but ultimately turn it away in disgust and decline to quench her thirst. Using hypnosis, Breuer had Anna O. described the original scene in which she became disgusted by drinking fluids. She described a scene in which she witnessed a
dog drinking out of her water glass and she became disgusted thinking she may have drank from
the same glass as a dog may have already used. Once the scene was described in fine detail and
with strong emotion, the symptom was alleviated and Anna O. was able to freely drink fluids
once again.

The idea that hysteria developed after a traumatic experience and that the cure for
hysteria was abreaction was seemingly straightforward; however, Freud’s description of his
trauma theory within his individual chapter of *Studies on Hysteria* (1895) outlined a complex
theory and an incomplete treatment. A discussion of defenses was an important complicating
factor to consider when examining Freud’s work with abreaction and hysteria. As stated, the
particular manner in which defenses were used determined the form of pathology, and the
treatment was partly a struggle to overcome these defenses. A considerable portion of Freud’s
individual writings within *Studies on Hysteria* concerned defenses. For example, in the last
chapter of *Studies on Hysteria* Freud described defenses as both an important part of the
treatment process and part of the etiology of pathology:

I had to overcome a resistance, the situation led me at once to the theory that by means of
my psychical work I had to overcome a psychical force in the patients which was
opposed to the pathogenic ideas becoming conscious (being remembered). A new
understanding seemed to open before my eyes when it occurred to me that this must no
doubt be the same psychical force that had played a part in the generating of the psychical
force that had played a part in the generating of the hysterical symptom and had at that
time prevented the pathogenic idea from becoming conscious. (p. 268)

During the early years of Freud’s career, he managed a client’s defenses mainly by establishing a
relationship with the client and then employing “insistence,” using his early techniques to urge
the client to remember the traumatic event. His ideas about transference were still in nascent
form during the time that he mainly employed trauma theory to understand neurosis, but he still
placed great importance upon the client’s relationship with the clinician. Freud (1895) explained the importance of the relationship:

I say it is almost inevitable that their personal relation to him will force itself, for a time at least, unduly into the foreground. It seems, indeed, as though an influence of this kind on the part of the doctor is a sine qua non to a solution of the problem. (p. 266)

A strong therapeutic relationship was indispensable for an effective outcome using the cathartic treatment. Conversely, Freud stated that a lack of a good working alliance with the client was “the worst obstacle we can come across” (p. 301).

Along with a good therapeutic relationship, Freud was developing new treatment techniques to deal with defenses at the time when he conceptualized clients using the trauma theory and when the cathartic method was his treatment of choice. As stated previously, hypnosis was used in conjunction with the cathartic method to alleviate symptoms, but Freud did not have complete confidence in hypnosis as a treatment method. The therapeutic technique for the cathartic method was complicated by the addition of new techniques. Freud attempted to apply a slight pressure to the client’s forehead with his hand and urged the client to remember as treatment techniques to move past the client’s defenses. Freud (1895) explained his treatment techniques as follows:

I inform the patient that, a moment later, I shall apply pressure to his forehead, and I assure him that, all the time the pressure lasts, he will see before him a recollection in the form of a picture or will have it in his thoughts in the form of an idea occurring to him; and I pledge him to communicate this picture to me, whatever it may be. (p. 270)

This example of early treatment techniques can be viewed as not merely a rudimentary attempt to overcome defenses, but also as an early form of imaginal exposure. Freud frequently requested that his clients picture the scenes in which their traumas occurred and encouraged them to imagine past scenes in which they experienced traumatic events. In fact, Freud “became insistent” (p. 268) with clients and asked them to use their imaginations to picture the traumatic
experiences that resulted in their distressing symptoms. Pressure to the forehead, insistence, and hypnosis were all techniques Freud used to overcome defenses and effectively employ the cathartic method. The clients’ defenses were major challenges to circumvent and required Freud to develop new techniques, so that he could effectively apply the imaginal exposure approach of the cathartic method.

The complexity created by the client’s natural use of defenses was only one issue that complicated the application of the cathartic treatment method. Most of Breuer and Freud’s clients presented with a complicated array of symptoms. To obtain a full understanding of Freud’s trauma theory, it was helpful to have an understanding of the clients he and Breuer treated most often during the 1890’s. Again, the case of Anna O. was illustrative because her symptoms were described in detail by Breuer in *Studies on Hysteria* (1895). Anna O. presented with a bewilderingly long list of symptoms. At different times she suffered paralysis of three out of four limbs. She experienced frequent hallucinations, many of which occurred while being treated by Breuer. At times she was unable to speak her native German and mainly spoke in English. She frequently experienced hearing problems and partial aphasia. Anna O. often felt weak and was easily fatigued. She experienced tremors and coughs. There was a period of several weeks in which she refused to drink fluids. She was unable to leave her bed and unable to take in nourishment. For many years Anna O. was unable to care for herself and eventually had to be hospitalized (Makari, 2008). The study of Neuroses was a prominent topic for clinicians studying psychology in the 1890’s and hysteria was a common diagnosis during that period. Anna O. represented a severe case of hysteria and how it could become a disabling and life threatening disorder.
When viewed from the perspective of treating a severe mental illness such as with the case of Anna O., the complexity of Freud’s trauma theory became more understandable. Throughout *Studies on Hysteria* the two authors emphasized the complexity of all neuroses and the fact that hysteria was normally a very complex disorder. Freud (1895) noted the complexity of most of his patients diagnosed with hysteria, stating, “A monosymptomatic traumatic hysteria is, as it were, an elementary organism, a unicellular creature, as compared with the complicated structure of such severe neurosis as we usually meet with” (p. 288). An important factor to consider in understanding Freud’s trauma-based treatment model is his view of multiple traumas being associated with the etiology of hysteria. He was not expecting to uncover one traumatic memory; rather, he was expecting to uncover a series of traumatic memories. Freud clarified this point when he stated, “We must not expect to meet with a single traumatic memory and a single pathogenic idea as its nucleus; we must be prepared for successions of partial traumas and concatenations of pathogenic trains of thought” (p. 288).

One factor that added to the complexity of Freud’s treatment model was that the client experienced multiple traumas. Another factor which contributed to its complexity was his conceptualization of most forms of neuroses as mixed disorders. His view of hysteria, and of most neuroses, was as normally manifesting as amalgamations of different disorders. It was normally a combination of hysteria and other disorders, such as anxiety neurosis, and obsessional neurosis. Freud (1895) clarified this idea by stating, “Pure forms of hysteria and obsessional neurosis are rare; as a rule these two neuroses are combined with anxiety neurosis” (p. 259). For Freud, the etiologies of anxiety problems were sexual problems from early development and people generally experienced a variety of problems during development. The following
description of the complex etiology and conceptualization of hysteria was a good example of this theory:

As regards hysteria, however, it follows that that disorder can scarcely be segregated from the nexus of the sexual neuroses for the purposes of study, that as a rule it represents only a single side, only one aspect, of a complicated case of neurosis, and that it is only in marginal cases that it can be found and treated in isolation. (p. 259)

Hysteria and other neurotic disorders were complicated mental illnesses which had their genesis during early development and which were exasperated by the client experiencing traumatic events.

Likewise, symptoms were not the result of one incident within Freud’s early trauma theory, but were the result of multiple incidents occurring during development and after experiencing traumatic events during adulthood. Freud (1895) summarizes this perspective of anxiety symptoms by stating, “To put this in other words, it is very remarkable how often a symptom is determined in several ways, is ‘overdetermined’” (p. 290). Most symptoms were caused by more than one process.

A client would find relief from symptoms by concurrently recalling the trauma and pathogenic ideas along with the associated affect. A person relieved of debilitating symptoms would seem like a successful conclusion to a treatment experience, but there was no assurance against the generation of new symptoms. In the last chapter of Studies on Hysteria, Freud (1895) explained the incomplete treatment afforded by the cathartic method, writing, “It cannot affect the underlying causes of hysteria; thus it cannot prevent fresh symptoms from taking the place of the ones which had been got rid of” (p. 261). Unfortunately, the cathartic method did not prevent new symptoms or cure the neurotic client. The original anxiety disorder remained intact even after a successful cathartic treatment was able to stop certain symptoms. During Freud’s early career, the idea of recalling the trauma alone as a cure was thought to be an insufficient
treatment. As stated previously, Charcot and Janet experimented with treatments similar to the cathartic method prior to Breuer and Freud’s work. All of these early pioneers of psychological research believed that uncovering memories or recalling memories was not enough to cure an anxiety disorder. Makari (2008) explained the existing consensus of opinion during Freud’s era about recalling past traumas and treatment in the following passage:

In 1887, Freud began to experiment with suggestive treatments, including Josef Breuer’s method. While others such as Alfred Binet and Joseph Delboeuf had advised that in cases of traumatic paralysis one should urge patients to recall their trauma so the doctor could suggest all was well, no one thought that remembering alone would cure. (p. 41)

Similarly, van der Kolk and van der Hart (1989) translated and summarized Pierre Janet’s work, which occurred during the same period as Freud’s early work, and reported the following:

Janet thought that merely uncovering memories was not enough; they needed to be modified and transformed, i.e., placed in their proper context and reconstructed into neutral or meaningful narratives. Janet saw memory as an act of creation, rather than as a static recording of events. (p. 1537)

Freud viewed the cathartic method as an incomplete treatment. It was helpful for relieving clients of their symptoms at the time of treatment, but it was not a reliable cure in the sense of permanently preventing hysterical symptoms. There was an important set of background information which helped in understanding the multifarious process of Freud’s trauma model. Symptoms had more than one cause, each client would likely have experienced more than one trauma, and the neuroses were normally not pure disorders but a combination of more than one mental illness. In addition, the trauma model was designed to meet the needs of certain clients. Many of these clients were similar to Anna O. in that they could be viewed as suffering from a severe mental illness by current standards. People suffering from disabling neurotic disorders were common clients for Breuer and Freud during the late 1890’s.
A summary of the main points of Freud’s treatment model would begin with a traumatic event, which could be any event the person subjectively experienced as painful both emotionally and cognitively. The traumatic experience generated painful affect and intolerable pathogenic ideas, and both of these were repressed. The main cause of pathology for Freud was repression. A person’s natural defense from psychic and emotional pain, namely avoiding his or her fears, was the main problem. Conversion symptoms were created from unreleased affect associated with a traumatic event. Repressed memories of the traumatic event were kept out of consciousness through an energy-draining process which created further repression. The cure for hysteria was abreaction, or a person facing their fears in a particular manner. The person needed to recall the event in great detail while simultaneously expressing the intense affect associated with the traumatic event. Unfortunately, abreaction was an incomplete cure in the sense it did not prevent new symptoms from occurring.

Fraulein Elisabeth Von R. Case

The case of Fraulein Elisabeth Von R. from Studies on Hysteria provided a good example of Freud’s trauma treatment and his perspective of trauma. Since this case was “the first full length analysis of a hysteria” by Freud (1895, p. 139), it provided a thorough example of the details of the cathartic method. The start of Freud’s therapy model was a traumatic event. He believed it was rare for a person to develop serious problems by experiencing one traumatic event. Instead he believed that most serious pathologies were created after a series of traumatic events. Elisabeth Von R. experienced a series of ongoing difficult life circumstances and traumatic events which led to her conversion symptoms. Her first trauma was a problem associated with the loss of her first love. The particular situation for her was the moral transgression of choosing to spend an evening out with a young man at the expense of leaving
her duties of attending to her ailing father. Her next trauma was the actual nursing of her dying father. This trauma was especially interesting because it could not be distilled to one event. It was a life situation Elisabeth Von R. experienced for several months. Another traumatic event for Elisabeth Von R. was the death of her sister. Adding to the difficulty of losing her sister was another moral conflict. Elisabeth Von R. was unaware of the critical condition of her sister and unknowingly planned a vacation with her mother just before her sister died, leaving the young woman without her closest relatives for her last painful days and eventual death. The final and most serious trauma for Elisabeth Von R. was falling in love with her sister’s husband. As the most serious moral transgression for the client, this last trauma created the more serious physical symptoms.

Freud’s interest in internal experiences and belief that traumatic events were usually common life experiences or insignificant events was readily apparent from his first complete case study of hysteria. He referred to Elisabeth Von R.’s case history as merely “made up of commonplace emotional upheavals” (Freud, 1895, p. 144). Freud considered her life experiences to be common problems seemingly insufficient to create serious pathology; however, he considered her psychical conflicts to be intense experiences. Each one of her life problems created a moral conflict which led to intense mental and emotional pain. The life events could be objectively traumatic or not; the most important factor for creating trauma was one’s internal experience of life events.

The next step in Freud’s model was a traumatic event generating pathogenic ideas and intense negative affect. Elisabeth Von R. experienced a variety of painful emotions after enduring the traumatic events outlined above. She suffered grief and sorrow after the death of family members, but it was the painful emotions generated from pathogenic ideas that created
the conversion symptoms she experienced. For example, when Elisabeth Von R. realized she was in love with her sister’s husband, she experienced a severe moral conflict. Freud (Breuer & Freud, 1895) explained the emotional pain as follows: “This girl felt towards her brother-in-law a tenderness whose acceptance into consciousness was resisted by her whole moral being” (p. 157). Her thoughts of violating her morals were intolerable pathogenic ideas which produced intense emotional pain.

Repression was the natural solution for Elisabeth Von R. to find relief from the painful pathogenic ideas and negative emotions which followed what she considered a moral transgression. According to Freud’s (Breuer & Freud, 1895) perspective, she willfully forced the memories of her moral transgressions out of her consciousness to avoid painful mental and emotional experiences. Freud described the process as follows: “The motive was that of defence, the refusal on the part of the patient’s whole ego to come to terms with this ideational group” (p. 166). At that time, defense was a common technical term for psychologists, but Freud also described his view of repression using several colloquial terms, such as an “act of will” or “’fending off’ of an incompatible idea” (p. 157). It was interesting to note that Freud did not believe Elisabeth Von R. completely removed the painful memories from all conscious thought. For example, at times she would have some awareness of her feelings for her sister’s husband. Freud described her inconsistent repression of past memories as “the peculiar situation of knowing and at the same time not knowing” (p. 165). Several times after the original traumatic event of realizing her feelings for her brother-in-law, new events triggered associations within her memory which generated fresh awareness of the feelings she considered immoral. During each occasion of awareness of the moral conflict, emotional pain was felt, repression occurred to alleviate the emotional pain, and conversion symptoms were generated. The vast majority of the
time the defense of repression was effective at keeping any memory of the trauma out of the client’s awareness. Freud reported that Elisabeth Von R. had no awareness of her past trauma when she first started as his client, writing, “She had no recollection of any such sufferings; she had avoided them” (p. 165). It should be noted that avoidance was a recognized symptom of Posttraumatic Stress Disorder according to the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (American Psychiatric Association, 2000). Repression was not a single event but an avoidance strategy that Elisabeth Von R. utilized many times to avoid painful thoughts and emotions.

The avoidance strategy of repression caused the pathogenic ideas generated from traumatic events and their corresponding emotions to become split from one another. The thoughts associated with past traumas did not have emotions connected to them as a result of repression. Freud (Breuer & Freud, 1895) explained Elisabeth Von R.’s experience as follows:

According to the view suggested by the conversion theory of hysteria what happened may be described as follows. She repressed her erotic idea from consciousness and transformed the amount of its affect into physical sensations of pain. (p. 164)

Thoughts and emotions remained psychically split within Freud’s trauma theory. The mental gymnastics of Elisabeth Von R. which Freud outlined existed for one simple reason: to avoid pain. Anything that created severe mental and emotional pain was considered traumatic by Freud. Repression benefitted Elisabeth Von R., “which had the advantage that the patient escaped from an intolerable mental condition” (p. 166). A thought without any emotion associated with it was much easier for a person to tolerate and much easier to keep out of consciousness. The ideas Elisabeth Von R. had of establishing a relationship with her sister’s husband originally generated great emotional pain, but after repression they were reduced to “no more than a weak idea” as a result of being detached from her emotions (p. 167). This
detachment of ideas from emotion created less intensity of emotion for the client, which made repression much easier according to Freud, who wrote, “This reduction of strength would then have been the only thing which made possible the existence of these unconscious feelings as a separate psychical group” (p. 167). Repression caused ideas to become detached from their emotional power to help alleviate distress and allow the turbulent process of repression to continue with less difficulty.

The intensity was softened from thoughts related to trauma along with the emotions related to the ideas, but they both still remained after repression. The intensity of emotion attached to a thought generated from trauma was determined by how painful that thought was. For example, a traumatic event in which a person believed they would die could produce intense fear. Elisabeth Von R. had erotic and loving thoughts of her sister’s husband in violation of her morals, which generated intense emotion within her. Freud attempted a scientific approach to explain human thoughts and emotions and developed his idea of quota of affect. Freud (1895) applied this theory to the case of Elisabeth Von R. as follows:

If we venture a little further and try to represent the ideational mechanism in a kind of algebraical picture, we may attribute a certain quota of affect to the ideational complex of these erotic feelings which remained unconscious, and say that this quantity (the quota of affect) is what was converted. (p. 166)

A painful idea generated a correspondingly painful emotion with a similar intensity. The emotions were what became converted to physical symptoms. The emotions were repressed with some intensity reduced, but the energy attached to the emotion was not released and must be channeled to some location. Freud explained the process of conversion and the advantages for Elisabeth Von R. as follows:

She succeeded in sparing herself the painful conviction that she loved her sister’s husband, by inducing physical pains in herself instead; and it was in the moments when this conviction sought to force itself upon her (on her walk with him, during her morning
reverie, in the bath, by her sister’s bedside) that her pains had come on, thanks to successful conversion. (p. 157)

As stated above, the critical factor for creating pathological symptoms was the conversion of emotions to physical symptoms. In the case of Elisabeth Von R., Freud believed the pain she experienced and difficulty walking were created through the ongoing process of conversion. She was subject to a traumatic experience when reminded of affectionate feelings toward her sister’s husband. Freud refered to Elisabeth Von R. as experiencing “only partial conversion” because her memory of her past traumas were not completely repressed; the memories of traumatic events became conscious after cues associated with the original trauma were activated from her memory (p. 167). Unfortunately for Elisabeth Von R., her routine family relations subjected her to contact with her brother-in-law, which Freud described as “fresh traumas” (p. 168). The result was a large group of associative memories which reminded Elisabeth Von R. of her feelings toward her brother-in-law. She attempted to avoid all the traumatic memories through the process of repression. For Freud, each individual memory within a nucleus of associative memories related to the original trauma Elisabeth Von R. experienced caused further pathological symptoms, “Once again it was a circle of ideas of an erotic kind that came into conflict with all her moral ideas” (p. 164). As with Mowrer (1947), the cues of memory expanding from the original trauma were an important factor for Freud’s theory. Freud explained this in the case history as follows: “The energy for the conversion had been supplied, on the one hand, by freshly experienced affect and, on the other hand, by recollected affect” (p. 173). Freud noted that the case of Elisabeth Von R. was exemplary of a more general phenomenon of how pathological symptoms were created by many traumas as opposed to one traumatic event.

To help Elisabeth Von R. recover from several traumatic events and alleviate her somatic symptoms, Freud (Breuer & Freud, 1895) used the cathartic method to lessen somatic symptoms
and other methods to help the client cope with the external problems she experienced. The critical point of the cathartic method resembled exposure therapy. This occurred when defenses were breached enough to discuss the original trauma of the client. After the original trauma for Elisabeth Von R. was identified and briefly discussed, Freud summed up the pivotal juncture of treatment as follows:

Everything was now clear. The analyst’s labours were richly rewarded. The concepts of the ‘fending off’ of an incompatible idea, of the genesis of hysterical symptoms through the conversion of psychical excitations into something physical and the formation of a separate psychical group through the act of will which led to the fending-off—all these things were, in that moment, brought before my eyes in concrete form. Thus and in no other way had things come about in the present case. (p. 157)

Freud had struggled for months to circumvent his client’s defenses enough to understand what created her somatic symptoms. For interventions, he employed a combination of hypnotism and talk therapy using his pressure to the forehead technique. Identifying the original trauma allowed the treatment to make significant progress in alleviating the client’s somatic symptoms. It should be noted that Freud did not describe a dramatic end to the client’s symptoms as the original trauma was verbalized and vented with intense emotions. On the contrary, he emphasized the emotionally painful experience which followed for both treatment participants, stating, “The period that followed, however, was a hard one for the physician. The recovery of this repressed idea had a shattering effect on the poor girl” (p. 157).

The client’s suffering continued after the original trauma was brought to the forefront using the cathartic method, so Freud continued his cathartic method treatment along with helping the client to alter cognitive distortions and cope with external events. Freud (1895) outlined his varied treatment approach with the cathartic method as his main technique as follows:

In order to mitigate the patient’s suffering I had now to proceed along more than one path. In the first place I wanted to give her an opportunity of getting rid of the excitation that had been piling up so long, by ‘abreacting’ it. We probed into the first impressions
made on her in her relations with her brother-in-law, the beginning of the feelings for him which she had kept unconscious. (p. 157-158)

Each significant memory of Elisabeth Von R. and her brother-in-law was discussed in detail with the client expressing strong emotion at some point during the discussion. Working through the previous scenes of the client’s life resulted in a decrease in symptoms. Elisabeth Von R. relived her past experiences in imaginary form while verbally delineating to her therapist the many events that were part of her traumatic history.

Freud (1895) explained that he did not stop the treatment after alleviating the client’s painful somatic symptoms with the cathartic method, writing, “This process of abreaction certainly did her much good. But I was able to relieve her still more by taking a friendly interest in her present circumstances” (p. 158). Freud helped his client cope with a family dispute and a financial problem. From the beginning of the treatment he adopted an integrated treatment. Freud described the medical procedures he recommended for helping to alleviate Elisabeth Von R.’s somatic symptoms:

We recommended the continuation of systematic kneading and faradization of the sensitive muscles, regardless of the resulting pain, and I reserved to myself treatment of her legs with high tension electric currents, in order to be able to keep in touch with her. Her question whether she should force herself to walk was answered with a decided ‘yes.’ (p. 138)

Freud employed a variety of therapeutic techniques after alleviating most of the client’s symptoms with the cathartic method. He provided information, which could be viewed as psychoeducation, on various experiences including coping with difficult feelings. For example, he stated to Elisabeth Von R., “we are not responsible for our feelings” (p. 157). Freud helped to ensure Elisabeth Von R. had enough coping skills to manage her life stressors, such as when he wrote, “On the other hand I encouraged her to face with calmness the uncertainty about the future which it was impossible to clear up” (p. 159). Employing the cathartic method alleviated
the client’s painful symptoms, but Freud used several other techniques to treat Elisabeth Von R. and produce a positive outcome.

The combination of interventions produced significant improvement, but it did not provide complete remission of all of the client’s symptoms. Freud (Breuer & Freud, 1895) reported that “some weeks” after the termination of treatment for Elisabeth Von R., she had a relapse and her painful symptoms returned (p. 160). In addition, approximately two months after the treatment, the client periodically experienced painful somatic symptoms. These relapses lasted only short periods and the client was able to continue making progress toward her life goals. Two years following the termination of treatment, Freud learned that Elisabeth Von R. was healthy and had achieved some of her important goals in life. The success of the treatment was allowing the client to reach more of her life goals than she was capable of prior to the treatment, not in preventing all additional symptoms. The final outcome was described as a success by Freud, but it was likely that the client would not remain free of painful somatic symptoms all her life.

Revised Theories of Psychoanalysis

The trauma theory and the cathartic method were just the beginning for Freud and psychoanalysis. Freud made major changes to his theory and technique shortly after developing his ideas contained within Studies on Hysteria (1895). For the purposes of this study, the major revisions were outlined and the topics most relevant for comparing with exposure therapy were highlighted. A short review of the major concepts of classic psychoanalysis were reviewed: the consistency of the main task of treatment, the increased importance of defenses, significant aspects of transference, relevant treatment ramifications of theoretical changes, symptoms as part of the self, and updates to the theory of anxiety.
Although an attempt has been made to minimize the use of esoteric terms belonging to Freud’s theory and technique, a short discussion of some of the main concepts of psychoanalysis and technical terms was necessary to explain Freud’s theory. These main concepts were readily available in psychoanalytic literature, and the sources I relied on were Gabbard, 2004; Kahn, 2002; McWilliams, 1994; and Olsen and Koppe, 1988. A central tenet of this theory was that behaviors, symptoms, and pain were the result of unconscious, internal conflict. Freud conceptualized the person as being comprised of three mental structures: the id, the ego, and the superego. The id operated according to the pleasure principle, which was to seek pleasure and avoid pain, and was fueled by sexual and aggressive drives. The ego operated on the reality principle and sought appropriate means for satisfaction. The superego was one’s conscious and represented internalized parental or societal values. For a healthy person, the ego maintained a balance between the id and superego, limiting both by employing defenses in a flexible manner. Psychopathology and anxiety arrived when there was not a healthy balance or when there was a rigid use of defenses.

Defense mechanisms were critical to drive theory. The ego used defenses to decrease anxiety. Examples of common defense mechanisms were displacement (redirecting a drive instinct from its original object to a different and less threatening object) and repression (forcing conflicting events or feelings into the unconscious). In drive theory, unresolved internal conflict and anxiety were part of most mental disorders and were likely to be rooted in one of the psychosexual stages: oral (infancy to 18 months, when pleasure was sought from the mouth), anal (18 months to 3 years, when pleasure was sought through the anus), phallic (3 years to 7 years, when pleasure was obtained by masturbation), latency (7 years to puberty, when pleasure was not sought), or genital (puberty through adulthood, when pleasure was sought through
genital sex with another person). At any stage a person could become fixated by trauma or their needs being denied or overindulged. The fixation created conflict and the person had a tendency to replay the most painful aspects of their relationships with caregivers. This replay of past events was called the repetition compulsion, and it often manifested in the therapeutic alliance.

Patterns of relatedness established from early childhood were repeated in life and in therapy through a phenomenon called transference. Regression was a defense and a common aspect of transference. It occurred when a person was under pressure and reverted back to an earlier stage of development, often the point at which they were fixated. These experiences within the transference provided information and helped the therapist move past defenses in order to allow the client to recreate past painful experiences. Unresolved internal conflicts, the rigid use of defenses, and repeating past events were how symptoms and other problems were maintained.

The most significant aspect of Freud’s final theories for this study was what ideas remained the same from his early ideas within trauma theory. Freud remained firm in maintaining the main goals of psychoanalysis as uncovering past memories and exposing them with strong affect. As previously mentioned, many current theorists (Wachtel, 1997; Yalom, 2005) believed these ideas have remained an important part of modern psychotherapy. After developing the trauma theory found within Studies on Hysteria (1895), Freud’s next major work was The Interpretation of Dreams (1900), which contained many new theories and techniques for psychoanalysis, but the main goal of treatment remained the same: “psychotherapy can pursue no other course than to bring the Ucs. under the domination of the Pcs” (p. 578). The italics were provided by Freud to emphasize his point. He referred to unconscious aspects of the mind as Ucs., and Pcs. was the abbreviation for preconscious. He chose to use his esoteric
terminology from his topographical model of the mind, but the main point of therapy as bringing unconscious memories to awareness remained clear. Freud thought it important to continue to make this distinction regarding the major goal of psychotherapy throughout his career, so it was important to dwell on this distinction by examining some of his statements. Freud’s technical papers were written from approximately 1911 to 1919, and these were the works in which he most explicitly defined the interventions of psychoanalysis. In the following passage, Freud (1914) distinguished psychoanalysis from hypnosis by discussing his technique for working through resistance:

This working-through of the resistances may in practice turn out to be an arduous task for the subject of the analysis and a trial of patience for the analyst. Nevertheless it is a part of the work which effects the greatest changes in the patient and which distinguishes analytic treatment from any kind of treatment by suggestion. From a theoretical point of view one may correlate it with the ‘abreacting’ of the quotas of affect strangulated by repression—an abreaction without which hypnotic treatment remained ineffective. (p. 156)

Freud clarified his belief that working through defenses may be difficult along with taking up much of the treatment, but that this work allowed abreaction to take place. Recalling past memories with strong affect was the distinguishing feature of therapeutic action which made psychoanalysis more effective than other treatments of his time.

Joseph Wortis was a young doctor and aspiring psychoanalyst when Freud provided him with a training analysis in 1934. Wortis (1954) wrote one of the several accounts of being analyzed by Freud, and as Freud’s analsand, he received treatment and instruction on how to perform psychoanalysis as demonstrated by this account of one of the short lectures he received from Freud:

I am glad you brought the question up, because I can clear up the misunderstanding: the positive transference is not part of the psychoanalytic therapy. The psychoanalytic cure consists of bringing unconscious material to consciousness; to this end the positive transference is used, but only as a means to an end, not for its own sake. It’s the same
with suggestions. It’s true that the analyst uses suggestion, but only to help the psychoanalytic procedure. (p. 64)

Freud clarified to Wortis that the cure was bringing unconscious material to consciousness. There were many techniques the analyst could use, but the goal of having the client confront his or her past was still the main goal. The most salient description of this crucial point was provided by Freud in 1917 with the publication of his *Introductory Lectures on Psychoanalysis*, in which he distinguished psychoanalysis from hypnosis by explaining, “Hypnotic treatment seeks to cover up and gloss over something in mental life; analytic treatment seeks to expose and get rid of something” (p. 450). Freud viewed the cure, or therapeutic action, found in psychoanalysis as exposing someone to the memories they were avoiding; this exposure would alleviate the client’s symptoms. As I compared psychoanalysis to exposure therapy, I did not wish to exploit Strachey’s choice of words for translating Freud’s work too much; however, it was not completely coincidental either that the word “expose” was used when translating Freud’s description for the therapeutic action of psychoanalysis. This early version of exposure therapy entailed the arduous task of reducing a client’s defenses and having them confront their memories of past events.

A person confronting his or her past memories remained as the main task of psychoanalysis, but strategies to reduce defenses were much revised following Freud’s work with *Studies on Hysteria* (1895). Freud’s publishing of *The Interpretation of Dreams* in 1900 started a major theoretical shift for psychoanalysis. There were many new theoretical concepts contained within this book, and a small set of them were particularly relevant for this study. Freud was often misquoted as describing dreams as the royal road to the unconscious (Lear, 2002). However, Freud’s (1900) actual statement was, “The interpretation of dreams is the royal road to a knowledge of the unconscious activities of the mind” (p. 608). The pithiness of the
quote is reduced in the accurate version, but it provided much more information. As Lear stated, Freud was actually concerned with existing thought, or the “active mind,” which makes an impact upon the dreamer (p. 90). Lear continued by noting that Freud was focused on “practical knowledge of how to take split-off aspects of one’s own imaginative activity and incorporate them into a living investigation of how to live” (p. 90). The royal road of dream interpretation was used so a person could confront his or her unconscious thoughts that were having a current impact on their life. Freud believed that a person’s defenses were reduced at night, explaining, “We conclude that during the night the resistance loses some of its power, though we know it does not lose the whole of it, since we have shown the part it plays in the formation of dreams as a distorting agent” (p. 526). Because defenses were reduced but did not vanish completely, unconscious thoughts appeared in the form of condensed and distorted images. A dream appeared to us as an mental image, but it still represented a thought, which Freud noted as follows: “Here we have the most general and the most striking psychological characteristic of the process of dreaming: a thought, and as a rule a thought of something that is wished, is objectified in the dream, is represented as a scene, or, as it seems to us, is experienced” (p. 534). Freud focused on the maturational process, and dreams consisted of thoughts kept out of awareness regarding an experience from childhood. He theorized, “a dream might be described as a substitute for an infantile scene modified by being transferred on to a recent experience” (p. 546). If we returned to the main task of psychoanalysis, which was to bring suppressed memories into awareness, we could see the utility of the dream. The discussion of a person’s dream was for Freud the fastest means to expose memories of childhood events, or bring the memories into a person’s awareness.
Dream analysis was one important method for dealing with defenses within Freud’s theory. As in trauma theory, a person’s natural defense against mental pain, or their natural avoidance of the unpleasant, was what created psychopathology. The publishing of *Interpretation of Dreams* (1900) marked the point at which Freud moved on from hypnosis, pressing a person’s forehead, and urging them to remember. He shifted his main technique to free association. Freud (1900) defined free association as the client “noticing and reporting whatever comes into his head” (p. 101). In his technical papers, Freud (1912b) referred to free association as the “fundamental rule” of treatment and something to which the client must agree for the treatment to proceed (p. 112). For this study, the function of free association was expressed well by the following conclusion from Person, Cooper, and Gabbard (2005):

> Our interest in free association here is not so much as a technique in psychoanalysis, but as a medium for the expression of the dynamic unconscious. One of the purposes of the associative approach is to facilitate access to unconscious and repressed mental content. (p. 35)

It was important to note that Freud’s fundamental technique had changed, but it was more important for the purposes of this study to remember that the main purpose of treatment remained the same: exposing the client to the mental content he or she was trying to avoid in order to alleviate mental and emotional pain. Freud’s background in associational psychology allowed him to develop the free association technique. As a client continued to free associate in session, the therapist could notice any type of symbolic content which may represent some unconscious thought the client had been avoiding, and which would hopefully lead to the original thought the client has forced out of conscious memory. Freud’s theory of repression included the idea of cues of past traumas expanding over time, so more and more mental material was repressed over time. When framed by Freud’s fundamental theories, free association was a logical technique for Freud to develop.
After free association, the next technique most relevant for this study, which Freud developed after moving on from trauma theory, was transference. It was a phenomenon in which patterns of relatedness learned since childhood were repeated in the present with the therapist (Gabbard, 2004). Freud (1912a) described the development and function of transference as follows: “the combined operation of his innate disposition and the influences brought to bear on him during his early years, has acquired a specific method of his own in his conduct of his erotic life” (p. 99). Freud referred to transference as a “stereotype plate” that was “constantly reprinted afresh” during the course of a person’s life, including during psychotherapy with the therapist (p. 100). It was partly innate and partly learned, and comprised the manner in which a person conducted his or her relational life. In addition, there was a tendency for transference to intensify during psychoanalysis, or for transference to appear in a more direct form, which was referred to as transference neurosis (Gabbard, 2004). Freud viewed transference as a form of resistance and also as a phenomenon the therapist could use to help the client change. Bauer (1994) outlined the resistance aspect of transference in the following passage:

The patient is viewed as resisting conscious recognition of repressed, conflict-laden impulses by acting them out in his relationship with the therapist. This resistance to awareness, understanding, and change is thought to be omnipresent and to accompany the treatment step by step. Every act of the patient is seen to reflect a compromise between forces striving for recovery and those wishing to maintain the status quo. (p. 5-6)

For Freud, transference was a ubiquitous phenomenon in all of a person’s relationships. As Freud’s ideas matured, the use of transference became the most important intervention for the therapist. In fact, for Freud (1912a), it was the main intervention for curing neurosis, as he dramatically described using a war metaphor in the following passage:

This struggle between the doctor and the patient, between intellect and instinctual life, between understanding and seeking to act, is played out almost exclusively in the phenomena of transference. It is on that field that the victory must be won – the victory whose expression is the permanent cure of the neurosis. (p. 108)
An important change with Freud’s later work was the proposal that psychoanalysis could permanently alleviate the painful symptoms of neurotic disorders. Freud did not originally believe that applying the cathartic method could provide a permanent cure for neurotic disorders, but this changed as his theory of the human mind matured. Generally speaking, his perspective developed from working with one traumatic event to the maturational development of the person’s psyche. Freud (1900) commented on this larger issue when discussing the significance of bringing unconscious memories from youth into awareness:

They [memories] can be made conscious, but there can be no doubt that they develop all their influences in the unconscious state. What we term our character is based, to be sure, on the memory traces of our impressions, and indeed on these impressions that have affected us most strongly, those of our early youth – those that almost never become conscious. (p. 427)

His task had advanced in scope and difficulty to changing a person’s character structure, so he added new interventions such as dream analysis and transference. Transference was part of most sessions, so it became the most important intervention. As the most important aspect of Freud’s treatment model during his final years of work, transference needed to be examined further to allow a thorough comparison with exposure therapy.

Freud described several forms of transferences and nuances of working with transference as part of psychoanalysis. For this study, only the aspects of transference which were most relevant for a comparison with exposure therapy were examined. According to Freud’s theory of transference, relational patterns were acted out during the therapy session. To make the distinction of acting out clear, he compared it to the ideas of his trauma theory and hypnotic treatment. Freud (1914b) referred to hypnosis as “a very simple form” of treatment (p. 148).

There was an imaginal component of the cathartic method which Freud described: “The patient put himself back in to an earlier situation, which he seemed never to confuse with the present
The cathartic method relied on memory and imagination. In the following passage, Freud described his second approach to treatment utilizing transference:

> If we confine ourselves to this second type in order to bring out the difference, we may say that the patient does not remember anything of what he has forgotten and repressed, but he acts it out. He reproduces it not as a memory but as an action; he repeats it, without, of course, knowing that he is repeating it. (p. 150)

The crucial distinction was that the person acts out the crux of their problem right in the therapy session. The therapeutic frame changed from imaginal to in vivo. The italics of the quote were Freud’s, and he stressed that the problem was repeated many times throughout the course of the treatment. One of Freud’s examples helped clarify what was meant by the acting out of transference: “For instance, the patient does not say that he remembers that he used to be defiant and critical towards his parents’ authority; instead, he behaves in that way to the doctor” (p. 150). The client was not aware of his or her behavior, but still acted out his or her main patterns of relating to others in session. This example also clarified the point that the client’s patterns of relatedness were transferred toward the therapist, or the therapist was treated in a similar manner as the client’s early caregivers.

Before progressing to describe further alterations to Freud’s theoretical model, a summary of theoretical changes to this juncture and the resulting ramifications for treatment would be helpful. First, the main task remained the same, as Freud (1914b) reminded us in one of his technical papers, writing, “we are led along the familiar paths to the awakening of the memories, which appear without difficulty, as it were, after the resistance has been overcome” (p. 155). Next, defenses became a prominent aspect of Freud’s theory. One example of this was transference being described as resistance. Lastly, transference was not something remembered but repeatedly acted out by the client during the session.
Freud’s theoretical concepts regarding transference, acting out, and repetition, led him to a new form of treatment. In the following passage, McWilliams (2004) described noticing a characteristic change in Freud’s treatment after his last technical paper was published:

Interestingly, Freud was the first therapist to advocate moving beyond the customary interpretive stance into an “active” problem-solving approach. In 1919, noting that standard analytic technique arose from work with hysteria and must be adapted flexibly to the treatment of other problems, he recommended an early version of exposure therapy. (p. 150)

The cause of McWilliams’ comparison of Freud’s treatment method to exposure therapy was Freud’s new theoretical concept of transference and the treatment implications it created. The acting out of transference was the method to start the curative process of psychoanalysis. As McWilliams noted, a more active approach of working with what the client acted out in session, or outside the session if possible, was what Freud proposed after he developed his theoretical concepts regarding defenses and transference. Freud (1919) explained this active approach in the following statement of his last technical paper:

One can hardly master a phobia if one waits till the patient lets the analysis influence him to give it up. He will never in that case bring into the analysis the material indispensable for a convincing resolution of the phobia. (p. 165-166)

Freud made clear his intention to become more active as opposed to being patient with the free association method. He continued his thoughts with these comments:

With these last [people with severe agoraphobia] one succeeds only when one can induce them by the influence of the analysis to behave like phobic patients of the first class – that is, go into the street and to struggle with their anxiety while they make the attempt. (p. 166)

Freud’s recommendation in 1919 for the anxiety stricken client to make progress by going into the street was what some prominent researchers (McWilliams, 2004; Wachtel, 2008) have seen as a direct reference to an early form of exposure therapy. Freud clearly preferred the direct method of a client confronting his or her fears. He provided more direct references to his active
and direct form of treatment when discussing the significance of the client acting out during transference. The importance of acting out the problem described by transference and directly confronting current thoughts and behaviors was exemplified by Freud’s final statement of his essay titled *The Dynamics of Transference* (1912a): “For when all is said and done, it is impossible to destroy anyone *in absentia* or in *effigie*” (p. 108). Freud seemed to be making clear his preference for the in vivo situation of a client acting out his or her problem during the therapy session as opposed to the imaginal situation of reviving memories of past events. As part of working with transference, the client was confronted with the genesis of his or her pathology: his or her current relational patterns or how he or she related to others. After Freud revised his theoretical concepts from his initial trauma theory, he continued to provide direct references to an early form of exposure therapy.

After his technical paper and direct recommendations for an early form of exposure therapy, Freud continued to make changes to his theory that drew his theoretical conceptions of anxiety nearer to current theories. In 1926, Freud published his last major innovations to his theory of anxiety with the publication of *Inhibitions, Symptoms and Anxiety*. The relevant changes for this study that were outlined included Freud’s idea of the human template for anxiety, anxiety causing repression, avoidance learning, and symptoms becoming part of the self or part of a person’s character structure.

Freud’s final alteration to his theory of anxiety began with the very beginning of life, the moment the child was born. The infant does not have to wait long for the first experience of anxiety, because birth represented the first dangerous situation and the first anxious moments. Freud (1926) described the trauma of birth as the prototype for future dangerous situations and similar experiences of anxiety, writing, “Affective states have become incorporated in the mind
as precipitates of primaeval traumatic experiences, and when a similar situation occurs they are revived like mnemonic symbols” (p. 12). As a result, our initial experience outside the womb prepared us to experience danger and anxiety. In addition, the newborn infant’s trauma at the first separation from the mother and overstimulation from the first experience outside the womb caused intense anxiety and the first primal repressions. From the very beginning, humans have had a template to experience anxiety. Freud cautioned us to not go too far and attempt to associate all dangerous situations with the prototypical birth situation, but rather emphasized certain key aspects, including the loss of the object, the mother, and danger.

After considering the birth trauma, Freud’s further theoretical changes became comprehensible. The next major shift of theory Freud (1926) described in Inhibitions, Symptoms and Anxiety was the fact that anxiety caused repression, rather than the reverse. Freud explained, “It was anxiety that produced repression and not, as I formerly believed, repression which produced anxiety” (p. 32). The prototype of anxiety, or birth trauma, led to repression. Within Freud’s (1926) revised theory, anxiety functioned as a “signal of unpleasure” from an internal or external stimulus (p. 11). Freud described his reformulated idea of anxiety as follows:

If the structure and origin of anxiety are as described [modeled after the birth trauma prototype], the next question is: what is the function of anxiety and on what occasions is it reproduced? The answer arose originally as a reaction to a state of danger and it is reproduced whenever a state of that kind occurs. (p. 63)

Anxiety was a response to danger that was “automatic and involuntary” after the indelible learning experience of the birth trauma (p. 67). A person’s defenses were similar to a fight or flight reaction, as Freud clarified in this statement: “from the nature of repression, which is, fundamentally, an attempt at flight” (p. 87). He described the automatic physical reactions to anxiety, such as “accelerating the heartbeat” and an “activity of the lungs” (p. 62).
Freud’s concept of anxiety continued to expand from the birth trauma and an automatic physical reaction to danger. At this juncture, it was helpful to remember the concepts of after pressure and repression. As the infant encountered new situations which could result in danger, anxiety was signaled and more repression could occur. Considering the concepts of repression and anxiety as a reaction to danger, Freud expanded his concept of anxiety. As a person aged and went through a learning process started from birth, anxiety changed from a reaction to the loss of a caretaker to an anticipation of the loss of a caretaker. Freud was mainly concerned with internal states, so his theory of anxiety expanded further to match his focus on internal problems developing during the maturational process. Freud (1926) described how external dangers experienced from birth provide a model for a person’s sense of anxiety to expand:

Here we may be assisted by the idea that a defence against an unwelcome internal process will be modeled upon the defence adopted against an external stimulus, that the ego wards off internal and external dangers alike along identical lines. In the case of external danger the organism has recourse to attempts at flight. (p. 11)

For Freud, each step of the maturational process came with a potential danger. The clearest example would be castration anxiety found within the phallic phase of development, but there are a myriad of other potential dangers of the maturational process. Anxiety grew from a signal of external danger to something that triggered a defensive response during development.

As a result, anxiety became an organizing force for the person’s psychological development. Glick (1995) captured the broad role of Freud’s conceptualization of signal anxiety, writing, “Signal anxiety thus becomes the ego’s most essential tool; signal anxiety makes it possible to remember, think, fear, and arbitrate drives, punishments, ideals, and reality” (p. 4). The role of anxiety was also strengthened by the fact that people benefited from their psychological symptoms. Possible direct benefits were freedom from danger or a reduction from anxiety. In addition, Freud believed that people obtained some relief or even some form of
satisfaction or pleasure from their symptoms. Some examples were a hysterical client’s somatic symptoms as a form of release of repressed affect, and an obsessional client obtaining some alternative form of pleasure from his or her thought process. Somatic symptoms such as paralysis of hysteria and the repetitive thoughts of an obsessional client were prevalent enough that the symptoms changed a person’s way of life. In addition, Freud (1917) proposed the concept of “secondary gain” in which a person received some indirect benefit from their symptoms (p. 477).

An example provided by Freud (1926) helped clarify this concept: “The systems which the obsessional neurotic constructs flatter his self-love by making him feel that he is better than other people because he is specially cleanly or specially conscientious” (p. 20). Freud believed that neurotic symptoms impacted a person’s life in many ways, so a person eventually incorporated the symptoms into his or her sense of self. Freud made this point when discussing the complex results of neurotic symptoms: “Nevertheless, the ego, it appears, cannot be accused of inconsistency. Being of a peaceful disposition it would like to incorporate the symptom and make it part of itself” (p. 21). The illness became a part of a person’s sense of self, which created larger goals for treatment. Freud’s conceptualization of anxiety meant that the treatment of anxiety disorders had to change some core aspects of a person’s character. Within Freud’s theory of anxiety, a person had something to lose by stopping his or her symptoms. Freud (1917) clearly noted that this situation caused problems for therapy, writing, “But of course you will easily realize that everything that contributes to the gain from illness will intensity the resistance due to repression and will increase the therapeutic difficulties” (p. 476). Thus, anxiety and symptoms had an important role for maturational development and establishing a person’s sense of self, which made treatment of neurotic disorders more difficult.
If anxiety had an important function for the developmental process for Freud, then it was a crucial factor for the development of psychopathology. In his revised theory (1926), anxiety was the main force creating psychological disorders: “Thus anxiety would be the fundamental phenomenon and main problem of neurosis” (p. 75). The logical conclusion for Freud was that the same force organized a person’s personality and created either a healthy situation or psychopathology. Freud explained the main cause of symptoms as follows: “Since we have traced back the generating of anxiety to a situation of danger, we shall prefer to say that symptoms are created in order to remove the ego from a situation of danger” (p. 76). Anxiety was the main force followed by psychological symptoms of this process for keeping a person safe from some type of internal or external danger. Freud continued this explanation by stating:

We can also add that the generating of anxiety sets symptoms formation going and is, indeed, a necessary prerequisite of it. For if the ego did not arouse the pleasure-unpleasure agency by generating anxiety, it would not obtain the power to arrest the process which is preparing in the id and which threatens danger. (p. 76)

From this perspective, anxiety started the process toward psychopathology by creating a signal of danger which forced a person to employ psychological defenses for protection from some real or perceived threat. Anxiety and defenses then became part of the same process of protection, something that was analogous to the biological instinct of flight from danger for Freud. The purpose of anxiety and symptoms was to avoid anxiety. In essence, anxiety created avoidance learning. Levis and Brewer (2001) made the point that Freud was proposing a theory in which all anxiety was learned as a conditioned reaction to pain.

This task of avoiding what was feared was not a short-term process for Freud. When considering the concepts of repression proper and after pressure, it became clear that avoidance was not a static event but a continuous process. Even a remote association to a trauma from the distant past could cause an increase in anxiety. Freud (1926) made this clear in the following
passage in which he discussed the dangers commonly experienced during maturational development:

Nevertheless, all these dangers-situations and determinants of anxiety can persist side by side and cause the ego to react to them with anxiety at a period later than the appropriate one; or, again several of them can come into operation at the same time. It is possible, moreover, that there is a fairly close relationship between the danger-situation that is operative and the form taken by the ensuing neurosis. (p. 72)

The forces of anxiety and repression could cause seemingly irrational behavior, such as a person feeling anxious about a past trauma long after the trauma has passed. A person remained alert to any association to a past trauma even at times when there are no realistic dangers.

In sum, anxiety was the main force creating psychopathology in Freud’s revised theory. Elaborate and energy-draining defenses helped maintain psychological disorders as a person continued to learn to avoid associations with past traumas. Exposing the client to what he or she feared remained the goal of the psychoanalyst, but due to anxiety signaling danger and persistent defenses, the task became more complicated than it had been in previous version of Freud’s theory.

Psychoanalysis and Obsessive-Compulsive Disorder

Freud’s mature theories could be readily applied to the treatment of Obsessive Compulsive Disorder (OCD). First, a description of Freud’s general theory of OCD was provided. The following description contained enough detail to provide a thorough comparison with the theory and technique of exposure therapy. Some details relating to Freud’s theory of development were not fully described, and an effort was made to minimize the use of esoteric terms of Freudian psychoanalysis. These items were not described in great detail because there were no relevant corollaries with exposure therapy. Next, one of Freud’s cases, commonly referred to as the Rat Man case, was described to help clarify the theoretical concepts and
provided an example of interventions to compare with exposure therapy. A quick note on terminology was necessary. Freud’s conceptualization was similar to the current DSM IV classification in which a person can demonstrate obsessive or compulsive symptoms separately or in combination; however, Freud focused more on obsessive symptoms within his theoretical writings, and the case chosen for this study was a client who demonstrated obsessive symptoms much more frequently than compulsive behaviors. The terms OCD, obsessional, or obsessive were used interchangeably throughout this study.

Figure 2 was provided for a visual aid to assist in comprehending Freud’s intricate theory of OCD. The reader may notice that the beginning section (left side) of Figure 2 started with a traumatic event in the same manner as Figure 1. That was because different neurotic disorders had similar etiologies within Freud’s theory; specifically, hysteria and OCD both started with a traumatic event. Freud (1894) described trauma as “an occurrence of incompatibility took place in their ideational life” (p. 47), creating a broad definition based upon the intensity of subjective distress. Using a broad interpretation of Freud’s mature theory, a trauma could still take place at any time throughout a person’s life, but Freud clearly focused on traumatic events during maturational development. In the case of OCD, he had a particular type of trauma in mind which usually created the problem. A typical developmental scenario for creating OCD for Freud was an early sexual development of a child, and the child enduring some harsh negative consequence for acting on their sexual impulses. Freud (1909b) described a typical case in this manner, “sexual activity appears to reach its climax and often comes to a catastrophic end owing to some misfortune of punishment” (p. 206). The child began life by feeling a loving bond with his or her caretaker, but a dramatic shift occurred after the child was treated harshly by the caretaker. As a result of the harsh treatment for a pleasure-seeking activity, the child felt intense anger or hatred
toward his or her caretaker, which created a traumatic and ambivalent reaction because of the infant’s simultaneous need and love for the caretaker. The child’s normal love and need for their caretaker was then linked or “inseparably bound up” with an intense hatred (p. 241). In the following passage, Freud described this traumatic ambivalence as one of the main causes of OCD:

But in whatever way this remarkable relation to love and hatred is to be explained, its occurrence is established beyond any possibility of doubt by the observations made in the present case; and it is gratifying to find how easily we can now follow the puzzling processes of an obsessional neurosis by bringing them into relation with this one factor. (p. 240)

The original developmental trauma for OCD was characterized by strong feelings of hatred or aggression imposed upon existing loving feelings, which normally occurred during the anal stage of development. The child was originally seeking pleasure but was thwarted by punishment from a caretaker, and the search for pleasure was transformed to a painful experience. Olsen and Koppe (1988) summarized the importance of this concept by writing, “The transformation of affect of pleasure to unpleasure thus became the core of the process of repression” (p. 237). The essential characteristic of OCD within the theory of psychoanalysis was ambivalence resulting from pleasure being changed to unpleasure.
The intense conflicting feelings toward a caretaker created a traumatic experience for the child, which generated more intense feelings and pathogenic thoughts. In Figure 2, affect and pathogenic ideas were represented as originating simultaneously but beginning to diverge because the traumatic experience would be difficult for the child to assimilate. Thoughts of hatred or aggression toward the needed caretaker along with the intense emotion generated by the situation became overwhelming for the child. Anxiety was not a part of Freud’s trauma theory and is not represented in Figure 1, but it was depicted in Figure 2 as leading to repression. The child has the prototypical anxiety experience within his or her memory, and this experience combined with intense ambivalent feelings toward a caretaker resembled the fear of separation which occurred at birth. This resemblance was enough to activate memory associations with the prototype experience of anxiety. As a result, anxiety was generated as a signal against danger. The child then used the natural defense of repression, and the thoughts of the aggressive feelings toward a caretaker were pushed out of awareness.

Repression remained the determining factor in Freud’s mature theory for a healthy resolution or for determining what type of pathology developed following a developmental problem. As Freud developed his final theories, defenses became increasingly prominent and
more complex. In Figure 2, the most important aspects of defenses leading to a diagnosis of OCD were represented in three boxes under repression, representing the critical aspects of the repression process. Some important concepts for the psychoanalytic conceptualization of OCD were that repression was effective early, a strict conscious (or superego) exacerbated developmental problems, the reaction formation defense was employed, and all defenses were prominent in forming the character structure of a person. Freud (1915a) described repressing hatred toward a caregiver and summarized the initial stage of repression in creating OCD as follows:

It is this hostile impulsion against someone who is loved which is subjected to repression. The effect at an early stage of the work of repression is quite different from what it is at a later one. At first the repression is completely successful; the ideational content is rejected and the affect made to disappear. (p. 156-157)

The intense negative feelings and pathogenic ideas associated with the traumatic event during development were completely repressed at an early age. Freud described successful repression at this early stage, meaning the thoughts and feelings associated with the event were held completely out of awareness.

After a complete repression of an initial reaction to a trauma and the danger signal of anxiety, the child continued to develop, which made the pleasure seeking instinct and aggressive associations linked to it more difficult to keep out of consciousness. At this point, a brief reversion into the esoteric terminology of Freud’s structural theory of the mind explicated in *The Ego and the Id* (1923) was necessary. After the trauma occurred, the child moved on to the next stage of development: the phallic phase. In this stage, the child’s early pleasure-seeking instincts reappeared once again and their superego was developed. As the reader may recall, the superego is roughly equivalent to a person’s conscience and represented internalized values from one’s
Freud (1923) narrated the development of OCD during this stage development as follows:

Let us consider the obsessional neurosis for a moment. The state of affairs is different here. The defusion of love into aggressiveness has not been effected by the work of the ego, but is the result of a regression which has come about in the id. But this process has extended beyond the id to the super-ego, which now increases its severity towards the innocent ego. (p. 57)

Freud summarized a few important points within the above passage. Further along in development the aggressive feelings toward a caretaker resurfaced and needed more extensive efforts to remain out of awareness. The child developed a conscience and a set of values, or a superego; consequently, aggressive feelings toward a caregiver produced strong self-criticism. This was represented in Figure 2 by the second box under repression representing the harsh superego. This self-criticism produced additional intense negative emotions and pathogenic ideas. A person oriented toward pleasure and pain avoidance sought to repress thoughts and feelings associated with the original trauma and the harsh self-criticism. Freud explained that regression and a reaction formation were needed to keep these thoughts and feelings out of awareness. The reader may recall regression as feeling pressure and reverting back to a stage in development, often to the stage in which the original problems started. For a person to develop OCD as conceptualized by Freud’s theory, there would be a strong tendency to revert back to the early stage of development in which the trauma marked by ambivalent feelings occurred. When feeling anxious or when experiencing some other form of pressure, the person would have a strong tendency to revert back to the earlier phase because that portion of growth was not fully accomplished. To help understand regressive tendencies I preferred McWilliams’ (1994) description of an “uncomplicated defense” with her examples of a child reverting back to behavior from a prior stage of development when hungry, or anyone starting to “whine” if they
become tired enough (p. 120). In addition to regression, an obsessive person would utilize the reaction formation defense, or “intensifying an opposite” (Freud, 1915a, p. 157). An example of a reaction formation would be a person who was ashamed or afraid of their homosexual desires taking a strong and active moral stand against gay rights. To obtain a diagnosis of OCD, a person would have had an active set of defenses which included repression, regression, and reaction formation to manage a harsh superego. This model of OCD included additional defenses, which added complexity, but the model was still readily translated to a learning theory. A trauma was experienced, and all the cues associated with the trauma were classically conditioned. Due to this conditioning, all of these cues were avoided using the elaborate set of defenses outlined by Freud. As time passed, the cues associated with the trauma expanded, and these were also avoided using the elaborate set of defenses. It continued to be reinforcing for the person to avoid all the cues associated with the original trauma, so the person continued to avoid all these associations due to the effects of operant conditioning. According to Freud’s theory of obsessional neurosis, the set of elaborate defenses was not enough to keep the strong emotions and thoughts associated with the original trauma completely out or awareness.

This phenomenon was represented in Figure 2 by arrows leading to affect and memory of the original problem that remain in consciousness following repression. As in hysteria, ideas become separated from affect and lose their power due to the effects of repression. When separated from their accompanying affect, even pathological ideas had little impact on a person, although they have may remained in awareness. In fact, the frequent use of the isolation of affect defense was an indication of an obsessive character structure (McWilliams, 1994, p. 123). Emotions were most important for creating symptoms for Freud, and OCD was no exception (Freud, 1895). Freud (1894) summarized the process of forming symptoms as follows:
If someone with a disposition [to neurosis] lacks the aptitude for conversion, but if, nevertheless, in order to fend off an incompatible idea, he sets about separating it from its affect, then that affect is obliged to remain in the psychical sphere. The idea, now weakened, is still left in consciousness, separated from all association. But its affect, which has become free, attaches itself to other ideas which are not in themselves incompatible, and, thanks to this ‘false connection’, those ideas turn into obsessional ideas. (p. 52)

To form an obsession, affect became separated from the original pathological idea through the defense of repression. The affect and the idea remained in a person’s conscious awareness; they were not completely repressed. The affect became linked to another idea, which was what Freud called a false connection. To minimize the emotional and cognitive impact on a person, the affect usually attached to “something very small or indifferent” (Freud, 1915a, p. 157). This explained why a person diagnosed with OCD may be overly concerned with things such as cleanliness and neatness.

Compulsions, or “obsessional acts”, would be a second step after the substitute idea has been created (Olsen & Koppen, 1988, p. 236). A review of some theoretical concepts of psychoanalysis and OCD was necessary to understand compulsive symptoms. The problems of someone diagnosed with OCD began during the anal-sadistic phase when pleasure was sought through untidy and somewhat painful avenues. Next, the child was traumatically thwarted from seeking pleasure. A reaction formation emerged against some type of untidy or sadistic pleasure and affect was attached to some substitute idea, usually an everyday concern (e.g., cleanliness). A person would attempt to repair or undo anything that violated the new idea to which their affect has become attached. For example, a compulsion to wash hands would be undoing an occurrence of messiness. The compulsion actually defended against the original trauma. Undoing the messiness was a means of preventing the trauma from occurring again. Freud (1926) explained undoing in the following passage:
As the neurosis proceeds, we often find that the endeavour to undo traumatic experience is a motive of first-rate importance for the formation of symptoms. We thus unexpectedly discover a new, motor technique of defence, or (as we may say in this case with less inaccuracy) of repression. (p. 47)

Compulsions were another means to keep the conflictual trauma out of awareness within Freud’s theory of psychoanalysis. McWilliams (1994) referred to a person who utilizes undoing as their predominant defense as having a compulsive personality profile.

As with hysteria, the particular types of defense mechanisms which were employed to keep painful memories out of awareness determined the symptoms, character profile, and diagnosis. From the particular set of defenses and symptoms a person adopted, he or she obtained some sort of satisfaction which was incorporated within his or her character structure and sense of self. For example, common advantages for people with OCD would be feeling they were especially clean, organized, or conscientious as compared to many other people. As a result, there was some reward or reinforcement for continuing the symptoms. The symptoms were manifested through the use of multiple defenses and reinforced, or overdetermined in the terminology of psychoanalysis. Toward the end of his career, after finalizing his theory of anxiety, Freud (1926) summarized the repression process, which created psychological disorders, as a more complicated version of the fight or flight response to danger, writing, “This [changes in ego functioning] is inevitable from the nature of repression, which is, fundamentally, an attempt at flight” (p. 86).

*Rat Man Case*

The Rat Man case provided a good example of Freud’s theory of anxiety, OCD, and his final treatment method. All the essential elements of his theory in treatment were represented in the case. Freud referred to the client as Paul to protect his anonymity, but his real name was Ernst Lanzer (Buckley, 1989). He was 29 years old, and his treatment lasted approximately 11
months. Freud described his obsessive thoughts and actions as interfering with his schooling, work, and personal relationships. The treatment was considered a success. Unfortunately, the client was killed in World War I and a long-term outcome study was not possible.

Lanzer’s developmental problems clearly matched the typical pattern for developing OCD. Lanzer was quoted as reporting his “sexual life began very early” and he described some fondling and seeing some of his nannies naked starting at the age of four (Freud, 1909, p. 160). The critical developmental trauma, and genesis of his problem, began after he was harshly punished by his father for some pleasure seeking activity and retaliated with vituperative childish statements directed toward his father. In congruence with his own theory, Freud produced a diagnosis of Lanzer, collected a history of his problem, and hypothesized the following:

Starting from these indications and from other data of a similar kind, I ventured to put forward a construction to the effect that when he was a child of under six he had been guilty of some sexual misdemeanor connected with masturbation and had been soundly castigated for it by his father. (p. 205)

Freud was not disappointed by the actual data of Lanzer’s case history as he describes below:

To my great astonishment the patient then informed me that his mother had repeatedly described to him an occurrence of this kind which dated from his earliest childhood and had evidently escaped being forgotten by her on account of its remarkable consequences. (p. 205)

The pleasure seeking activity was most likely the precocious young Mr. Lanzer’s activities with one of his nannies, but the essential elements for developing OCD were well accounted for with the case history. Freud noted the impact of the traumatic event, writing, “The patient believed that the scene made a permanent impression upon himself as well as upon his father” (p. 205).

Mr. Lanzer reported no recollection of this event during the initial stage of treatment. The developmental trauma was complete with all the essential elements of OCD, including occurring during the anal stage of psycho-sexual development. The client was punished harshly for his
developmentally early pleasure seeking and had to cope with angry and hateful feelings toward one of his main caretakers. The trauma contained an intense emotional ambivalence toward a caretaker.

Following the initial trauma, the client was never fully able to assimilate the intense affect and pathological ideas associated with the experience, which was demonstrated by the fact he would not initially engage in a detailed discussion of the event and disregarded its significance. The fear and anxiety produced by the trauma triggered associations of the prototypical traumatic event of the birth trauma; consequently, the client repressed the developmental trauma. The event, along with the pathological ideas and emotional ambivalence, were all completely repressed initially. Any person diagnosed with obsessional neurosis utilized a variety of defenses to keep traumatic events out of awareness. Regression was a common defense for Lanzer. In fact, the rat torture which the case derives its name provided an example of regression. Throughout Lanzer’s life he was susceptible to relying on regression when under pressure. Lanzer was told the story of the rat torture during his military training, and he clearly described wanting to prove his worth as a military officer. The combination of his military training and attempting to prove his worth resulted in a stressful situation, and listening to a torture technique added to the pressure he felt. Freud interpreted this as an instance of the client reverting back to the time of his developmental problem, or regressing back to the anal stage of development when the original trauma occurred (Grunberger, 1966). Freud developed his ideas of a harsh superego several years after writing the Rat Man case, so he did not explicitly define the role of the Rat Man’s superego. However, Freud (1909b) described adult manifestations of a harsh superego with intense self-reproaches the client experienced, including “treating himself as a criminal” for not attending to his father at the moment he died (p. 175). Similarly, reaction
formations were not defined by Freud in the case analysis, but were possible to identify. The client attempted to establish legal and military careers to adhere to his father’s standards. Perhaps the most important reaction formation for Lanzer was the unequivocal and intense love he claimed for his father. His stance of pure love and respect for his father was the opposite of his partially repressed aggressive feelings toward his father.

This conflict the client held toward his father was the main cause of his OCD symptoms. Freud (1909b) stated, “The conflict at the root of his illness was in essentials a struggle between the persisting influence of his father’s wishes and his own amatory predilections” (p. 200). The client tormented himself with ruminations concerning his adult life, including debts, suicidal ideation, and the possible death of his loved ones. The emotions associated with the ambivalent feelings toward his father were not fully repressed; instead, they were transferred to the ideas of his adult life, which created his obsessive thoughts. A critical factor for an obsessional neurosis was that the ideas and affects associated with the trauma remained in consciousness. Freud described the etiology of the client’s illness to him in therapy to no effect. Through the effects of the series of defenses, affect and ideas associated with the original cause were separated. This allowed the client to use the isolation of affect defense to protect himself against full awareness of his aggressive feelings toward his father. In his case history meant for publication and original record, Freud expressed his bewilderment that he could describe the etiology of Lanzer’s illness directly to him with no apparent effect on him. In his original notes Freud recorded, “Strangely enough, his belief that he really nourished feelings of rage against his father has made no progress in spite of his seeing that there was every logical reason for supposing that he had those feelings” (p. 307). Insight or understanding alone did not alleviate the client’s symptoms.
The client’s obsessive thoughts and compulsive behavior were the cynosure for discovering the etiology of the problem. Freud noted that the client’s symptoms could not be alleviated with the use of transference. Dreams may have been the royal road to the unconscious but transference was the painful road. Alleviating Lanzer’s symptoms required the use of transference as Freud (1909b) described in the following passage:

And so it was along the painful road of transference that he was able to reach a conviction that his relation to his father really necessitated the postulation of this unconscious complement. Things soon reached a point at which, in his dreams, his waking phantasies, and his associations, he began heaping the grossest and filthiest abuse upon me and my family, though in his deliberate actions he never treated me with anything but the greatest respect. (p. 208)

Within the transference situation, Freud had taken on the role of the client’s father, and the client developed aggressive feelings toward his transferred father figure. Next, the client would walk around the consulting room when discussing his aggressive dreams for fear that Freud would physically lash out at him. In other words, the client was acting out his unconscious conflict within the session. Freud had previously warned Lanzer “that it was scarcely possible to destroy a person in absentia” (p. 182). The client needed the in vivo-type experience of transference to make significant progress in therapy (Lipton, 1977; Schwartz, 1998). After acting out some of the past problems with his father, Lanzer was able to recall more information regarding past events. Freud (1909b) described the situation as follows:

He recalled that his father had had a passionate temper, and sometimes in his violence he had not known where to stop. Thus, little by little, in this school of suffering, the patient won the sense of conviction which he had lacked – though to any disinterested mind the truth would have been almost self-evident. (p. 209)

Remembering flaws of his father meant that defenses such as his reaction formation were easing, and he could recall memories directly related to traumatic experiences. After acting out past traumatic situations within the therapy session, Lanzer’s defenses were reduced enough so he
could understand what was creating his feelings of fear and aggressive impulses. Freud described this experience of transference regarding the client’s central conflict as the critical juncture within his treatment, writing, “The treatment had reached its turning-point, and a quantity of material information which had hitherto been withheld became available, and so made possible a reconstruction of the whole concatenation of events” (p. 210).

The “turning point” within Freud’s treatment model and theory of OCD was worth examining in detail. To begin, it took much time and work for Freud to reach the point at which his client could confront his anxiety-provoking situation. Freud’s original notes recorded the first four months of treatment, and he had not reached the critical juncture of therapy during that time period. As a result, we know it took more than four months for Freud to arrive at the point at which the client could recount traumatic events from his developmental years. Lanzer’s memories of the traumatic event from development were stored in autonomic memory and many cues associated with the event had been established and stored in the same nonconscious system as the original trauma. Before discussing the traumatic developmental event, Freud discussed many topics related to his main conflict. The client and Freud discussed defenses, symptoms, dreams, and recent problems of the client’s life. When defenses were diminished, the client discussed his dreams and fantasies, topics close to the original trauma. Freud was working with a type of fear hierarchy in which material at the bottom of Lanzer’s fear hierarchy was discussed prior to approaching the dreams and fantasies near the top of Lanzer’s fear hierarchy. The Rat Man case was far from an example of flooding and more of a long fear hierarchy.

The anxiety provoking event was Lanzer’s experience of rage against his father. Through the transference with Freud, this was what the client acted out in session. The transference was a type of in-vivo exposure to Lanzer’s anxiety provoking event. Lanzer discussed past traumatic
events while expressing a great deal of strong emotion, as demonstrated by the following passage from the case (Freud, 1909b):

If he stayed on the sofa he behaved like someone in desperate terror trying to save himself from castigations of terrific violence; he would bury his head in his hands, cover his face with his arm, jump up suddenly and rush away, his features distorted with pain, and so on. (p. 209)

From Freud’s description of the case, it was clear he and Lanzer discussed many incidents and details of the transference with the client acting out his transferred rage toward his father. As a result, the client was subjected to repeated situations which were similar to in vivo exposure. Freud alluded to intense sessions over a long period of time, so we could infer that the client had much time to habituate within severe, repeated in vivo exposure to his anxiety-provoking event. It is also important to consider what did not work for Freud until Lanzer confronted his anxiety-provoking situation within the transference. Interpretations and intellectual explanations of the dynamics that led to the client’s distressing obsessional thoughts had little impact on the client before he acted out his main problem during the therapy sessions.

Interpretations were much more effective after the crucial transference situations were played out with Lanzer, or after the turning point when the more severe in vivo exposure principle was employed. Some researchers (Gabbard, 2004; Wachtel, 2008) considered effective interpretations a type of exposure exercise. During the process of working through all of his obsessive thoughts and compulsions, Lanzer had to come face to face with the root causes of his anxiety. Lanzer’s case earned him the moniker of Rat Man due to the client’s obsessional thoughts related to a story of a rat torture told to him by another military officer. Freud’s interpretations of the rat story were replete with several interpretations of symbolic activities leading to the client’s obsessional thoughts, but one example explained the relation between interpretation and exposure particularly well. Lanzer had several obsessive thoughts related to
the story of rat torture. The German name for rats sounded very similar to the German name for money. The client referred to himself as “a rat currency” and when paying Freud his fee for therapy Lanzer stated, “so many florins so many rats” (Freud, 1909b, p. 213). Through a series of complicated associations, Freud’s interpretations related the idea of rats to money which translated to the client living according to his father’s standards and not his own. Lanzer’s symptoms were determined by a series of associations relating to his main conflict, or his symptoms were overdetermined. In addition, his symptoms provided an advantage, or secondary gain, of keeping him more honest and conscientious than many of his military colleagues. Freud’s interpretations found the relation between the client’s symptoms and his main conflict of emotional ambivalence toward his father. Through interpretation the client had to confront one piece of his anxiety-provoking situation. In sum, the Rat Man case provided a good example of many of the important factors of Freud’s theory of OCD and provided a good example of the main factors of his treatment method. Several aspects of his theory along with transference and interpretation have similarities to exposure therapy.

Psychoanalysis and Specific Phobia

Freud specifically updated his theory for phobias with the publication of *Inhibitions, Symptoms and Anxiety* (1926). He added his updated theory of anxiety and used the case of Little Hans as an example to explain his theoretical changes. Freud’s ideas regarding phobias and their classification changed throughout his career. Strachey (1974b) noted it was “not hard to detect some uncertainty” in how Freud chose to define and classify phobias (p. 83). Freud (1909) made this point clear in his discussion section for the case history of Little Hans, writing, “In the classificatory system of the neurosis no definite position has hitherto been assigned to ‘Phobias’” (p. 115). In fact, Freud even suggested the name of “anxiety neurosis” as a replacement for
phobia due to the significance of anxiety and fear for the disorder (p. 115). In the following passage Freud described his reasons for changing the name of phobias:

It finds its justification in the similarity between the psychological structures of these phobias and that of hysteria – a similarity which is complete except upon a single point. That point, however, is a decisive one and well adapted for purposes of differentiation. For in anxiety-hysteria the libido which has been liberated from the pathogenic material by repression is not converted (that is, diverted from the mental sphere into a somatic innervation), but is set free in the shape of anxiety. (p. 115)

Freud believed that phobias and hysteria had very similar etiologies and that phobic disorders were commonly mixed with both hysteria and obsessions (Strachey, 1974b). Accordingly, the reader may notice that Figure 3 outlining phobias had some similarities with Figures 1 and 2. The most important difference with phobias for Freud was that repressed emotion resulted in more anxiety, or a phobia. He used the loosely defined phrase “set free” because he thought the repressed emotion could result in any number of symptom combinations, including one specific phobia, agoraphobia, several phobias, or a combination of a phobia with another disorder.

Figure 3: Freud’s Theory of Specific Phobias

As was the case with OCD, Freud had a particular type of trauma in mind to start the process which caused a phobia. He claimed it was possible that phobias had assorted etiologies, but he only described oedipal problems in detail. The important factor to consider with Freud’s
theory of an oedipal conflict was that the person was reacting to a real life danger, rather than to an internal conflict. The person within the oedipal situation could feel pure aggression for his father, but most likely had an ambivalent reaction due to loving his caretaker and wanting the caretaker out of the way during different intervals. The real life danger situation produced anxiety as a signal for danger and an autonomic reaction. The result was that repression occurred as a natural reaction to protect the person within the dangerous oedipal conflict. At this point, Freud was more ambivalent with phobias than PTSD or OCD. He had a particular type of defense or set of defenses in mind which created the other disorders, but with phobias he was open to different combinations. It was possible for a person to employ a reaction formation, repression, or a combination of both defenses to help keep aggressive feelings out of awareness.

After defenses were employed, ideas and affect were separated. Pathogenic ideas related to the Oedipus complex were not completely out of awareness with phobias. Affect eventually became displaced to another external object instead of the client’s father. This object wound up producing fear in place of the client feeling fear toward his father. Before the phobic object became established there was a building process in which the person felt a sense of anxiety without fully realizing the problem. Freud (1915b) explained the initial sense of anxiety as follows:

In anxiety hysteria a first phase of the process is frequently overlooked, and may perhaps be in fact missed out; on careful observation, however, it can be clearly discerned. It consists in anxiety appearing without the subject knowing what he is afraid of. (p. 182)

This is an example of Freud’s nuanced theory of anxiety when repression was not completely effective and the person did not feel well and remained unclear about what created the problems. The original fear became transposed, so the new external object became a symbolic replacement.
for the feared caretaker within the Oedipus complex. Freud summed up the phobic process as follows (1915b):

The whole construction which is set up in an analogous way in the other neuroses, is termed a phobia. The flight from a conscious cathexis of the substitutive idea is manifested in the avoidances, renunciations and prohibitions by which we recognize anxiety-hysteria. (p. 184)

Freud made it clear that phobias were very similar to other anxiety disorders and that the process was an attempt at flight from a danger, or an autonomic nervous system response to danger. As a result of the new external object becoming a symbol of anxiety, a set of avoidances were created. Freud noted what he considered an important aspect of avoidance of the symbolic object as follows:

One essential characteristic of anxiety-hysterias is very easily pointed out. An anxiety-hysteria tends to develop more and more into a ‘phobia’. In the end the patient may have got rid of all his anxiety, but only at the price of subjecting himself to all kinds of inhibitions and restrictions. (p. 116)

Freud did not believe this was a static process. One simple phobia would most likely continue to grow into additional phobias or at least additional restrictions. For example, a person with a phobia of snakes can begin by merely avoiding snakes to avoid anxiety. Freud thought a person would most likely generate more phobias and inhibitions, possibly of different animals, or a person could become more intensely inhibited by developing agoraphobia.

Little Hans Case

A case history would help explicate what Freud thought was clear and unclear about specific phobias. The case of Little Hans provided an example to compare with exposure therapy, but the procedures and record of the case also provided some challenges for determining the important factors of therapeutic action. The client was a five year old boy who had developed a fear of horses. The treatment lasted a relatively short period for an analysis, approximately four
months. Freud was the consultant for the treatment, but the actual treatment was conducted by Little Hans’ father and recorded through letters to Freud from the father. The client’s father was a follower of Freud and part of his inner circle that met together one night each week. Through these meetings and correspondence the father was able to obtain enough consultation to carry out Freud’s treatment methods (Blum, 2007). The fact that someone other than Freud conducted the treatment and the lack of a specific record of procedures created some challenges for discerning therapeutic action, but there was still value in reviewing the case for understanding Freud’s method for treating phobias. In addition, Freud used the Little Hans case as an example to explain the revisions to his final theory of anxiety in *Inhibitions, Symptoms and Anxiety* (1926).

In the case of Little Hans, Freud was very clear in his belief that Little Hans was in the throes of the Oedipus complex and the danger of that situation created his phobia. He wrote, “The anxiety felt in animal phobias is, therefore, an affective reaction on the part of the ego to danger; and the danger which is being signaled in this way is the danger of castration” (p. 54). Emotions were the most important part for creating symptoms for phobias and other neuroses. Little Hans’ phobia was created by his normal autonomic reaction to any realistic danger. The Oedipus complex contained all the necessary factors of the birth trauma, danger, and the loss of a valuable object. The conflict of his feelings of aggression toward his caretaker along with the danger this situation created was something too difficult for an infant to assimilate. Due to the realistic danger confronted by Little Hans, anxiety signaled the danger and Little Hans repressed all the dangers associated with the Oedipus complex. Freud (1926) compared the case of Little Hans to the Wolf Man case and called it “somewhat less complicated” (p. 28). It was less complicated because the only defense of Little Hans which Freud could discern was repression. Through the forces of repression, Freud explained that Little Hans found some relief from the
conflicts and dangers of the Oedipus complex: “The process of repression had attacked almost all the components of his Oedipus complex – both his hostile and his tender impulses towards his father and his tender impulses towards his mother” (p. 29). Freud (1909) described the treatment for Little Hans as one of the “cases of simple anxiety-hysteria” because the child did not use other defenses such as reaction formations or regressions, and there were no conversion symptoms (p. 116).

According to Freud’s final conceptualization, Little Hans employed repression to avoid danger and the repressed fear led to his phobic symptoms. Anxiety was an autonomic response and the intense emotions created by the danger Little Hans faced had to be channeled somehow after repression. Freud (1926) explained the situation as follows: “This anxiety differs in no respect from the realistic anxiety which the ego normally feels in situations of danger, except that its content remains unconscious and only becomes conscious in the form of a distortion” (p. 54). This distortion was the means by which emotions related to the dangerous event remained out of awareness. Freud noted that the distortion also caused the disorder, writing, “What made it a neurosis was one thing alone: the replacement of his father by a horse” (p. 25). Little Hans mentally replaced his father with a horse, and the fear of castration was transformed to the distorted version of a fear of being bitten by a horse. The fears related to horses were symbolic representations of the original realistic fear Little Hans was forced to confront. Freud described the advantages of creating the phobia as follows:

In the first place it avoids a conflict due to ambivalence (for the father was a loved object, too) and in the second place it enables the ego to cease generating anxiety. For the anxiety belonging to a phobia is conditional; it only emerges when the object of it is perceived – and rightly so, since it is only then that the danger-situation is present. (p. 53)

The secondary gain Little Hans received from his phobia was more time and attention from his mother. As stated, a primary feature of Freud’s theory was that phobias were not a static process
but were inclined to expand. Accordingly, Little Hans began with a fear of horses but this phobia expanded to a fear of carts, buses, and carts being loaded. Little Hans had the undefined sense of anxiety and dread which Freud believed accompanied an anxiety disorder. He frequently had bad dreams, consistently reacted strongly to other people crying, and feared being alone at night. Freud did not believe he developed agoraphobia because he could leave home with his parents on many occasions, but he refused to leave home or was reluctant on many other occasions. In short, Little Hans’ young life was filled with many restrictions and a prevalent sense of unknown anxieties and specific fears.

This was the condition of Little Hans at the start of his treatment. The setting of Little Hans’ treatment was especially relevant to this study and important to consider for any study of this case. As stated, Freud did not provide the treatment, but only consulted as Little Hans’ father provided the treatment. The treatment services were not provided within a traditional consulting room or an area established for play therapy; it was a naturalistic setting within the family home and in front of their home in which the traffic of that period occurred. At that time, horses were a main part of the transportation system. From reading Freud’s case history, we know that Little Hans’ case was the first time psychoanalysis was employed as the treatment method for a child. Little Hans’ father attempted to utilize the methods of psychoanalysis such as free association and interpretation. In the end, there was good evidence that Little Hans was cured of his phobia; moreover, there was good evidence that the treatment was a long-term success with the client going on to live a productive working life (Blum, 2007).

There were many other details known about the case, but their relevance to understanding the case history remained open for debate. The Little Hans case has captured the imagination of those interested in psychoanalysis and been an example of the influence of the Oedipus complex.
for creating psychological disorders (Lazarus, 1991; Ross, 2007; Wolpe & Rachman, 1960). Relatively recent evidence from the release of archived material has provided much more information about the case (Blum, 2007; Chused, 2006). This recent evidence reveals a family history that includes Little Hans’ mother suffering from severe pathology and Little Hans’ witnessing or experiencing trauma (Stuart, 2007). The methodological problems of the case history have been well documented by Freud’s critics. For example, Wolpe and Rachman noted their belief that “phobias are conditioned anxiety (fear) responses” and believed they could find some evidence in the case history of Little Hans to support their perspective (p. 10). However, the authors stopped short of advocating an alternative version due to a lack of evidence from the case history. Wolpe and Rachman went on to note that the methods of treatment and reporting do not allow for evidence of any other conclusions for therapeutic action:

The main facts of the case of Little Hans are presented and it is shown that Freud’s claim of "a more direct and less roundabout proof" of certain of his theories is not justified by the evidence presented. No confirmation by direct observation is obtained for any psychoanalytic theorem, though psychoanalysts have believed the contrary for 50 years. The demonstrations claimed are really interpretations that are treated as facts. This is a common practice and should be checked, for it has been a great encumbrance to the development of a science of psychiatry. (p.11)

Contemporary psychoanalytic researchers have noted Freud’s selective reporting of facts for the case, and the fact that Freud preferred creating a polemic for his theoretical views rather than collecting data according to scientific principles (Ross, 2007; Stuart, 2007). I can find no fault with these conclusions. As a result, the wisest course for me to follow was the example set by Wolpe and Rachman in using only the known facts of the case without attempting to settle on conclusions confirming theoretical ideas or endorsing particular therapeutic actions.

What was known about the case was that Freud combined treatment methods. Little Hans’ father attempted many of the known interventions of psychoanalysis, including free
association, using transference, providing information, and interpretation. Freud’s description of the case and the father’s reports emphasized analytic interventions. In addition, Little Hans was purposely taken in front of the family residence and also into the street adjacent to their residence to confront horses, his anxiety-provoking stimulus. It was not known how frequently or how many times Little Hans was put in this situation. One could read the case history and find examples similar to a productive hierarchical approach to gradual exposure, but one could also find other examples that could have negatively reinforced the phobia. Was Freud’s purpose to directly treat Little Hans by exposing him to his anxiety provoking stimulus? Was Freud using the exposure situation merely to generate more information from free association? There is no evidence in Freud’s writings to draw a conclusion either way. There was definitely not enough information to determine how long the exposure exercises lasted and if the client would have had the opportunity to habituate. It was also difficult to discern if the client’s father followed a typical course of therapy for psychoanalysis, such as working through defenses for a period before making interpretations. There was no place within a scientific study for conclusions drawn from the Little Hans case. The only significant information to be gained for this study was the fact that Freud (1918) was not speaking metaphorically when he stated that a person needs “to go into the street and to struggle” to cure a phobia (p. 166). He was speaking literally and he clearly promoted a combined treatment with interventions from psychoanalysis and in vivo exposure.

**Integrative Literature**

In this section, I reviewed literature comparing psychoanalytic and exposure therapy approaches. I utilized the Psychinfo database because it was a popular and well respected tool to search for psychological literature. The main search keywords used were “exposure therapy,”
“psychoanalysis,” and “psychoanalytic.” A search using “exposure therapy” resulted in 3,320 items. “Psychoanalysis” as a keyword resulted in 38,305 items, and “psychoanalytic” as a keyword resulted in 65,083 items. A Psychinfo search which merged the keywords of “exposure therapy” and “psychoanalytic” resulted in 14 items. Of these 14 items, two were used in the comparative literature section of this study. A Psychinfo search which merged the keywords of “exposure therapy” and “psychoanalysis” resulted in nine items. Of these nine items, only one was used in the comparative literature section of this study. For inclusion criteria, any piece of literature was included to the study which compared exposure therapy and any psychodynamic therapy, not just psychoanalysis. The comparison could have included any aspect of theory or treatment. In addition, any integrative effort for exposure therapy and any psychodynamic therapy was considered a comparison and included in the study. The main reason for excluding most of the material discovered through the database search was that it did not discuss the topics of this study. For example, several of the articles discussed systematic desensitization, hypnosis, or some other interventions which were not covered within this study. The remaining comparative literature used in this study were found through a variety of research methods, including searching the reference section of existing literature and from information provided by subject matter experts.

Studies concerning systematic desensitization and flooding were not part of the inclusion criteria. Despite the fact that each of these treatment methods utilized a form of exposure, both of these approaches had critical differences with exposure therapy and psychoanalysis. Systematic desensitization treatment employed relaxation training before the client was exposed to an anxiety provoking stimuli. In contrast, exposure therapy and psychoanalysis both had critical treatment guidelines for a client to fully experience his or her feelings associated with an
anxiety provoking stimuli. Flooding did not include a hierarchical approach to exposure and started the treatment with a client being exposed to their most anxiety provoking stimuli. Exposure therapy utilized a gradual hierarchical approach in which a client started exposure exercises with something low on their hierarchy, or something comparatively less anxiety provoking. An important aspect of psychoanalysis was the concept of defenses and the need to work through a network of associations before the main anxiety producing stimuli could be uncovered. Accordingly, the psychoanalyst had no choice but to employ a gradual hierarchical approach. Due to these major differences, studies concerning either flooding or systematic desensitization were not included in this study.

French (1933) produced one of the earliest comparisons between the theoretical foundations of psychoanalysis and learning theory. His research compared Pavlov’s theoretical work with Freud’s theoretical findings. As the reader will recall, Pavlov’s classical conditioning theory was the basis of Mowrer’s first factor and a critical aspect of the foundational theories of exposure therapy. French began by acknowledging there were “fundamental differences” between the two theories, but then delineated his ideas for many similarities between the two theories (p. 1166). The author initiated his comparative analysis by quickly summarizing Pavlov’s most famous experiment of pairing a dog’s food with the sound of a bell and producing a conditioned stimulus. At this fundamental juncture of explaining how Pavlov demonstrated creating a conditional stimulus, French believed there were obvious similarities to psychoanalysis that needed little explanation. He concluded that there were obvious theoretical parallels within psychoanalysis for a conditioned stimulus with the terse summary, stating, “That the calling up of one reaction or mental process by another with which it has become associated, is essentially the same phenomenon as Pavlov’s conditioned reflex, is of course generally
recognized and needs no further comment” (p. 1168). The reader was left to agree or disagree
with this conclusion; the author believed it was too obvious to explain in a detailed manner.

French (1933) proceeded with discussing what he believed were less obvious theoretical
concepts which Pavlov’s work and psychoanalysis had in common. An example from French’s
work clarified how the two theories were related. The author compared Freud’s concept of
repression to Pavlov’s theory of internal and external inhibition. To explain external inhibition it
was helpful to return to Pavlov’s classic experiment, when a dog had been conditioned to salivate
at the sound of a bell, the situation changed so that a strange person entered the room when the
bell sounded. The result was the dog ceasing to salivate for a period because of what Pavlov
termed external inhibition. Similarly, internal inhibition would be demonstrated by the
conditioned stimulus of the bell repeatedly sounding without the dog receiving food. The result
would eventually be that the dog would stop salivating at the sound of the bell. French compared
external inhibition to the oedipal situation in which the male child desired his mother but feared
his father. The child eventually ceased to desire his mother due to fearing his father, or
experienced external inhibition of a basic drive. Internal inhibition within Freud’s theory would
be even more fundamental. It could be any situation in which a drive was repeatedly not
satisfied. In that particular situation, the person’s drive instinct became internally inhibited,
according to French. The author provided several more examples of relating the theories of the
two disciplines. His point was that each theory could be used to explain human experience and
that the basic concepts were actually very similar. The language and setting of each theory was
the main difference. One discipline utilized experimental situations to explain human experience,
whereas the other discipline utilized the complicated dynamics of development and societal life
to explain human experience. French compared individual concepts of each theory to make his
argument. He did not compare more general themes of each theory or attempt to develop an integrated theory. As a result, French’s work was not useful for creating an integrated theory or for attempting new clinical interventions. French’s work was mainly useful as an exercise to demonstrate how basic concepts of learning theory and psychoanalysis were similar.

Mowrer (1939) may have developed the most useful theoretical comparison of psychoanalysis and behavior therapy. The reader may recall Mowrer (1947) established the foundational theory for exposure therapy, so it may not be a surprise that he was the researcher who could accurately compare the two disciplines. In his 1939 article, Mowrer recasted the existing theories of anxiety into stimulus-response terms and provided his ideas for the problematic situation of human beings apparently behaving irrationally, or not following known principles of human behavior. To accomplish these tasks, Mowrer explained his idea that all anxiety was learned. He refuted the existing ideas of that time that anxiety or fear was a phylogenetic phenomenon (James, 1950) or that it was a reflexive reaction to experience (Watson, 1928). For a pure learning theory of anxiety, Mowrer turned to Freud’s revised theories, as documented in the following passage:

Freud seems to have seen the problem in this light from the outset and accordingly posited that all anxiety (fear) reactions are probably learned; his hypothesis, when recast in stimulus-response terminology, runs as follows. A so-called ‘traumatic’ (‘painful’) stimulus (arising either from external injury, of whatever kind, or from severe organic need) impinges upon the organism and produces a more or less violent defence (striving) reaction. Furthermore, such a stimulus-response sequence is usually preceded or accompanied by originally ‘indifferent’ stimuli which, however, after one or more temporally contiguous associations with the traumatic stimulus, begin to be perceived as ‘danger signals,’ i.e., acquire the capacity to elicit an ‘anxiety’ reaction. (p. 554-555).

Mowrer clearly viewed Freud’s revised theory as compatible with his own perspective for a learning theory of anxiety. Next, Mowrer easily explained some of Freud’s revised anxiety theory with behavioral terminology. A traumatic event was a stimulus that produced a strong
reaction. Classical conditioning takes place from the associations that are present during the stimulus-response sequence. Thus, Mowrer utilizes Freud’s theory to explain how anxiety was learned through classical conditioning.

Mowrer (1939) continued to utilize Freud’s revised theory of anxiety to explain more characteristics of anxiety. He supported Freud’s view that anxiety can be described as an increased state of tension in which the person remains alert in case action would be needed to reduce anxiety or danger. Mowrer reformulated Freud’s ideas concerning anxiety as a motivating force in stimulus-response terms. The state of tension of anxiety was obviously uncomfortable according to Mowrer and Freud (1926). This created a motivating force to escape to dangerous situations and avoid them by decreasing any opportunity to encounter the danger in the future. Mowrer summarized the above aspects of Freud’s revised theory as follows: “In short, anxiety (fear) is the conditioned form of the pain reaction, which has the highly useful function of motivating and reinforcing behavior that tends to avoid or prevent the recurrence of the pain-producing (unconditioned) stimulus” (p.555). Mowrer’s ideas are clearly influenced by Freud’s revised theory; however, Mowrer manages to distance himself from Freud as shown in the following passage which was used to explain the adaptive nature of Freud’s anxiety theory: “In the mentalistic terminology that he characteristically employs, Freud has formulated this view of anxiety formation and its adaptational significance” (p. 555). Mowrer simultaneously relies on Freud’s theory to explain the nature of anxiety and distances himself from Freud with the derisive comment of mentalistic terminology, implying Freud’s terminology was less than scientific and unavailable for empirical validation.

Despite some criticism of Freud, Mowrer (1939) provided a favorable estimate of psychoanalysis when compared to classical conditioning. Mowrer noted that both Pavlov and
Freud accounted for the importance of anticipatory reactions to dangers in the environment, “As early as 1903, Pavlov expressed a point of view that bears a striking resemblance to the position taken by Freud in this connection” (p. 556). The author explained that Pavlov employed classical conditioning to account for animals recognizing signals of danger and Freud emphasized that anxiety functioned as a signal. Mowrer continued by contrasting the two disciplines. He rejected Pavlov’s conditioning theory because of the limits placed on developing adaptive behavior. Mowrer refuted Pavlov’s idea that the only reactions that could be learned were the reactions closely associated with some type of stimulation. In contrast, Mowrer favored the expansive perspective of Freudian theory as exemplified in the following statement:

According to the conception of anxiety proposed by Freud, on the other hand, a danger signal may come to produce any of an infinite variety of reactions that are wholly unlike the reaction that occurs to the actual trauma of which the signal is premonitory. (p. 557)

Mowrer emphasized the conceptualization of anxiety as a state of tension and readiness that could motivate a variety of responses to reduced anxiety. Furthermore, the author explicitly expressed his agreement with Freud in that anxiety was an organizing force for human motivation and behavior. Mowrer stated, “Anxiety is thus to be regarded as a motivating and reinforcing (fixating) agent, similar to hunger, thirst, sex, temperature deviations, and the many other forms of discomfort that harass living organisms” (p. 558). Following this view of anxiety as a basic aspect of human functioning, Mowrer noted his agreement with Freud in that anxiety was a main force for creating psychopathology and neurotic symptoms. Mowrer used Freud’s concept of anxiety as a learned signal to determine that anxiety was “basically anticipatory in nature” (p. 563). Anything that can reduce this signal of anxiety can be reinforcing. It is adaptive but also creates irrational behavior. Mowrer provided the example of someone overreacting to a signal of danger. Additionally, the author noted that anxiety was the force behind an assortment
of other irrational human behaviors such as superstitions, magic, or any action meant to relieve the tension associated with a dreaded future event, even if the action actually has little effect on determining real future events. In sum, Mowrer skillfully reformulated Freudian theory into behavioral terms and developed a theory explaining the reasons human beings behave irrationally. Mowrer discussed his view that a behavioral version for explaining irrational behavior had “the advantage of being open to objective investigation” (p. 564).

Dollard and Miller (1950) created a foundation of research for integrating behavior therapy and psychoanalysis. However, their work went beyond integrating different approaches to therapy. The authors integrated ideas from Freudian psychoanalysis, behavior therapists, and modern social science. Dollard and Miller had the lofty goal of “the creation of a psychological base for a general science of human nature” (p. 3). A small set of their broad research was relevant to this study. The authors were not content with describing human behavior in terms of scientific principles; they also conceptualized personality and internal experiences in terms of principles from natural science. In addition, Dollard and Miller described therapy as a learning process, writing, “Psychotherapy establishes a set of conditions by which habits may be unlearned and non-neurotic habits learned” (p. 8). The authors translated theoretical concepts of psychoanalysis in terms of learning theory. Some examples were the pleasure principle being conceptualized as reinforcement, repression as the inhibition of cue-producing responses, and fear as a learned drive. Dollard and Miller seemed to create a new model for therapy because they created new terminology as part of describing psychoanalysis in behavioral terms. In fact, the authors’ goal was not to describe a new approach but to use experiential terms to describe the etiology of psychological disorders and how people change. As part of this process,
As with psychoanalysis, Dollard and Miller (1950) believed that neurotic disorders resulted in painful symptoms and painful internal experiences. The authors viewed most neurotic disorders in the same manner as many psychoanalysts. The neurotic disorders that brought people to therapy were complex, long-term problems resulting from internal conflict. Dollard and Miller described their view as follows:

Suffering so intense as that shown by neurotics must have powerful causes, and it does. The neurotic is miserable because he is in conflict. As a usual thing two or more strong drives are operating in him and producing incompatible responses. (p. 13)

The authors espoused a similar view to Freud in that repression has a major influence in creating psychological disorders. Dollard and Miller noted that a person suffering from a neurosis knew their pain but were unaware of what created the problem and were usually unable to explain his or her situation. The authors believed that the forces of repression caused the lack of awareness of the problem and were what prevented the neurotic from solving their problem. For Dollard and Miller, the main problem was anxiety creating repression, which then could lead to a neurotic disorder. As a result, a main concern for the authors was reducing anxiety.

Dollard and Miller’s (1950) ideas for anxiety reduction in therapy were the most relevant topics for this study. It was important to note the fact that the authors conceptualized Freud’s revised version of psychoanalysis as an anxiety reduction process, as evidenced by the statement, “The therapeutic situation which Freud hit upon after considerable trial and error [Freud, 1924, Vol. 1, pp. 253-254] is arranged so that anxiety can be steadily weakened by extinction” (p. 241). A psychoanalyst would start by creating an atmosphere in which the client felt comfortable discussing personal matters and continuing with free association. The therapeutic setting was
important to the authors as they described how the patient’s statements were received by the therapist in the following passage:

His statements are received by the therapist with an even warm attention. The therapist is warm and friendly. He is willing, so far as he can, to look at matters from the patient’s side and make the best case for the patient’s view of things. (p. 243)

Within this setting, the client gradually learned they would not be treated negative, or punished, for discussing personal matters they found anxiety provoking to think about or verbalize. Dollard and Miller described the effect of this therapeutic setting by writing, “These permissive circumstances are genuinely new, and they have their great effect. The fears evoked by free communication are gradually extinguished through lack of punishment” (p. 244). As a result, the therapeutic setting with psychoanalysis, characterized by free association and an accepting therapist, became a series of anxiety reducing interventions for Dollard and Miller.

This process could also be viewed as a series of short exposure exercises as the client became exposed to their own anxiety provoking thoughts and behaviors which were kept out of awareness through repression. Additional exposure and anxiety reduction was created by what the authors referred to as labeling. Dollard and Miller (1950) described the process as follows:

Only after extensive study of the patient’s life can the areas of repression be clearly identified. The surprising fact emerges that the competing drives which afflict the neurotic person are not labeled. He has no language to describe the conflicting forces within him.

Without language and adequate labeling the higher mental processes cannot function. When these processes are knocked out by repression, the person cannot guide himself by mental means to a resolution of his conflict. (p. 15)

The therapist labeled, or described with words, the client’s repressed thoughts and conflicts. For the authors, this description with words allowed repressed material to fully enter awareness; in other words, it exposed the client to repressed thoughts and conflicts. In psychoanalysis, the therapist used labeling with interpretation as the person free associated to reduce defenses.
Through labeling with an interpretation, a client in psychoanalysis was exposed to his or her main conflicts causing neurotic problems. An example from Dollard and Miller’s work helped clarify this point. The authors described an important conflict for a client as follows: “Mrs. A. repressed her hostility toward her mother-in-law, just as she had repressed her hostility toward her mother in childhood. This repression prevented her from recognizing it and from reacting appropriately to the social affronts” (p.296). The forces of repression did not allow the client to label and become aware of her problem. The authors continued with this example with a description of the impact of labeling:

After Mrs. A was able to express resentment of the insults she had endured from her mother-in-law (when she found that the therapist encouraged her and did not take her to task for being angry) her anxiety about saying and thinking hostile thoughts was greatly reduced. She was able to discover that her mother-in-law was jealous of her. She was able to label her anger (make it conscious) and to recognize the social cue (mother-in-law) who evoked it. (p.297)

For Dollard and Miller (1950), the therapeutic process inherent in psychoanalysis reduced the client’s anxiety and labeling reduced anxiety by exposing the client to an internal conflict which was repressed. For the authors, interpretation was an important intervention which created the anxiety reducing process of psychoanalysis. Dollard and Miller believed that interpretations reduced anxiety and inhibition, writing, “Interpretations may have a number of different functions which are not mutually exclusive. An interpretation often implies permission or nonpunishment” (p. 397). In the following passage the authors also described interpretations as a means to label some material which reduces anxiety through exposure to repressed material:

Another function of an interpretation is to label a drive, emotion, or type of behavior. It should be noted that a connection can be formed between the cues of the drive or emotion and the response of the label only when they are both present simultaneously. (p. 397)

Dollard and Miller concurred with Freud in that a person needs to be emotionally aroused by the anxiety provoking cue in order for the interpretation to be effective. According to Dollard and
Miller’s conceptualization of therapy, after a person’s conflicts were exposed and anxiety was reduced, a client could employ his or her higher mental processes to effectively find solutions to problems. The authors again concurred with Freud that the final stage of therapy needed a real world aspect in which the client confronts their problems and makes changes in a real life setting. The authors specifically credited Freud with identifying this need for a “real-world aspect” for therapy (p. 331). Dollard and Miller described the final phase of therapy as follows: “In this second phase, the patient must directly confront the distortions of his current life produced by neurotic inhibition. The past has helped to create his problems but only in the present can it be solved” (p.331). Interestingly, Dollard and Miller viewed this need for real-life exposure to anxiety provoking situations as part of Freud’s early theory found within the last chapter of *Studies on Hysteria*, which Freud wrote without the assistance of Breuer.

Dollard and Miller’s (1950) main goal was to outline a base of knowledge that could be utilized to improve the description and study of human nature. To help reach their goal, the authors were able to describe psychoanalysis in terms of experimental psychology. In turn, Dollard and Miller identified many similarities between behavior therapy and psychoanalysis. The main task of therapy was anxiety reduction, and the authors were able to identify the anxiety reduction techniques routinely used in psychoanalysis. It was beyond the scope of this study to adopt or reject the terminology of Dollard and Miller or accept or judge how well they advanced toward reaching their main goal. More important to the aims of this study was Dollard and Miller’s assertion that the application of psychoanalysis helped people with complex neurotic problems because it was an effective anxiety reducing process utilizing the exposure principle.

Feather and Rhoads (1973) proposed a much more theoretical approach which was focused on developing a new form of behavior therapy. The authors began by noting there was
an unfortunate tendency to accentuate the differences between a behavioral approach and a
psychoanalytic approach to therapy. Their goal in describing the similarities between the
foundational theories of behavior therapy and psychoanalytic therapy was to develop a new form
of behavior therapy. The authors believed that there were “hidden similarities” between the two
approaches and their intention was to bring these hidden likenesses to light (p. 136). They
identified two main foundational theories of behavior therapy: operant conditioning with a
systematic application of rewards and punishments, and Pavlovian conditioning with the
explanatory concepts of conditioning.

Feather and Rhoads (1973) focused on phobias to provide clinical examples of theory and
technique. The authors used the theoretical concepts of behavior therapy to explain the etiology
of phobias. They started with the accidental conditioning concept, which was the process in
which mental stimuli presented during the original anxiety provoking event became conditioned
as the phobic object. Accidental conditioning required classical conditioning and a generalization
of the original conditioned anxiety response. This combination of classical conditioning and a
generalization of the conditioned anxiety response were critical to their rationale for proposing a
new form of behavior therapy. After explaining the main theoretical concepts of behavior
therapy and accounting for the etiology of phobias, the authors continued their concise analysis
by turning to the theoretical concepts of psychoanalytic therapy used to explain phobias. They
identified internal conflicts created by natural impulses, repression, and displacement as the main
concepts of psychoanalytic theory used to explain the etiology of phobias.

Following their outline of the most relevant theories of each approach for creating
phobias, Feather and Rhoads (1973) compared the theories to discuss the hidden similarities they
believed existed between the two seemingly oppositional approaches to therapy. The authors
emphasized the similarities between the Pavlovian concept of conditioning with the Freudian ideas of associations and repression. This similarity was considered by Feather and Rhoads as one of the more obvious parallels between the different approaches. A less obvious parallel the researchers described was the similarity between the inhibition concept of Pavlovian theory and Freud’s concept of repression. Feather and Rhoads summarized the similarities by stating, “Both interfere with the occurrence of a response, and both mechanisms entail the assumptions that absent reactions remain available if inhibition or repression is removed” (p. 147).

After identifying the hidden similarities of the different theories, Feather and Roads (1973) discussed their rationale for a psychodynamic behavior therapy. The authors pointed out that the cause of most phobias was not readily apparent because an internal conflict was related to the phobia. This type of phobia would be exemplified by “a woman develops a fear of driving immediately after a vivid fantasy of leaving her husband and driving to another town to meet a lover” (p. 149). Next, Feather and Rhoads proceeded to link this concept of internal conflicts causing phobias to a larger theoretical concept. The authors described how the accidental conditioning of the original conditioned anxiety response occurred without the need for repression. Behavior theorists emphasized physically similar objects to the original anxiety provoking stimuli as what normally became generalized. For example, Feather and Rhoads described how a person who was in a car accident can become afraid of all cars, not just the car they were driving at the time of the accident. According to the authors, this was an example of what behavioral theorists would call primary generalization. However, all other generalizations related to internal processes rather than environmental stimuli. The authors noted that psychoanalytic theorists employed the idea of displacement to describe how internal conflicts transformed to phobic reactions. As a result, Feather and Rhoads determined, “Generalization
and displacement then may be viewed as identical processes” (p. 149). The existing similarities and need to treat difficult to understand phobias not created by primary generalization were sufficient reason for Feather and Rhoads to propose a new behavioral treatment method.

Feather, Rhoads, and Durham (1972) continued their discussion of developing a psychodynamic behavior therapy in a second article which described the clinical aspects of their approach. Their approach consisted of the following steps: (a) two to five sessions for interviewing clients about their symptoms history, (b) one to two sessions for training in muscle relaxation and practicing daily at home, (c) establishment of a hierarchy of feared impulses related to the phobia with corresponding fantasies of each impulse, (d) imagination of these fantasies from lowest to highest on the hierarchy while the client was relaxed, (e) direct confrontation of the client’s feared situation in a hierarchical fashion. The authors noted they were not attempting to employ most of the main techniques of psychoanalysis, such as developing insight or providing interpretations. Similarly, other behavioral techniques such as assertiveness training were not used to augment the systematic desensitization.

The authors provided four vignettes with successful outcomes of former clients to outline the applied version of their ideas for a new therapy approach (Feather, Rhoads, & Durham, 1972). The cases involved two clients diagnosed with obsessions and compulsions and two diagnosed with phobias. The length of treatment varied from 8 sessions to 40 sessions in accordance with the authors’ guideline of having no set limit but ending the treatment after symptoms were alleviated. The imagery employed by the researchers mainly involved the clients deliberately acting out the feared impulse of their conflict. One example from a case history clarified the proposed treatment method. That particular client developed a fear of driving his automobile after becoming angry towards his mother while driving her to the hospital a short
period before her death. According to the authors, the client developed a phobia of driving due to his imagining running over pedestrians. This client was instructed to imagine deliberately driving over pedestrians repeatedly after he practiced the muscle relaxation technique. Within two weeks of employing this form of systematic desensitization, the client was able to freely drive to any part of the city in which he lived. The therapists never bothered to develop insight between a possible link between the client’s angry reaction toward his mother and his driving phobia. The authors concluded that desensitization in this case was successful for two reasons. The first step was resolution of the client’s conflict. The conflict was resolved by providing evidence to the client that the intensity associated with his impulses or inhibitions had been reduced. Next, the client was assisted in realizing the difference between fantasizing about his impulses and the reality of actually carrying out the impulses. The authors believed that the therapeutic action was mainly the result of the imagery exercises in which the client fantasized about carrying out his feared drive impulse. When considering the effects of relaxation training, the authors were more equivocal, reporting that relaxation could either have provided an optimal forum for eliciting conflicts or contributed little or nothing to the desensitization technique. Rhoads and Feather (1974) returned with another short article that provided another four cases demonstrating their ideas for a new treatment method, but this brief article contained no theoretical insights and provided no new treatment techniques beyond their previous work.

The strength of this series of articles was that the authors provided some intriguing results and theoretical arguments. Specifically, they articulated forceful and concise arguments for some similarities between behavioral and psychodynamic theories. Their discussion of the similarities of conditioning and generalization of symptoms for generating phobias compared to psychoanalysis was particularly interesting. It seemed difficult to argue with the accuracy of
most of their conclusions; however, their arguments were nonetheless not developed to the extent that one might hope. Freud and most other prominent theorists of psychoanalytic theory were not quoted. In addition, references of the complete psychoanalytic theories that the authors compared with behavior therapy were not provided. Feather and Rhoads provided a list of similarities, but did not provide a detailed explanation of their ideas on a more integrative level. It seemed that with the level of detail within their research, Feather and Rhoads would have been better served with claiming to have found some theoretical similarities of diverse theories, as opposed to claiming to have discovered a new treatment method.

As part of promoting his own integrative approach to therapy, Wachtel (1997) contributed interesting comparisons between behavior therapy and psychoanalytic therapy. Wachtel’s cyclical psychodynamic approach had two foundational principles: (a) an active approach to therapy was more ethical and more effective than a passive approach, and (b) personality was a process starting early in maturational development and continued through adulthood. His own cyclical psychodynamic approach built upon the work of Dollard and Miller (1950), classic psychoanalysis, and the work of many other psychoanalytic and behavior therapy theorists. Wachtel believed that psychoanalytic models and behavior therapy were the most influential sources for clinical practice guidelines and theoretical concepts. Wachtel was a great admirer of the work of Dollard and Miller and credits them with several key concepts that were at the core of his cyclical psychodynamic approach, including the complexity of personality, the emphasis on anxiety, and the integration of behavioral and psychoanalytic theory. In general, he appreciated Dollard and Miller’s attempt to describe psychoanalytic concepts using behavioral terms.
Wachtel (1997) built upon Dollard and Miller’s (1950) work by integrating behavior
therapy and a psychodynamic approach to establish his own approach. For example, Wachtel
believed that Freud’s revised theory was basically a learning model for anxiety. He explained,
“Psychoanalytic therapy also is a learning experience, and the psychoanalytic theory of neurosis
– especially since Freud’s revised view of anxiety [Freud, 1926a] – can readily be shown to be a
learning model” (p. 7). As a result, Wachtel built upon Dollard and Miller’s work and Freud’s
revised theory in order to promote the reduction of anxiety as the central therapeutic process for
psychoanalytic therapy and his cyclical psychodynamic approach. Due to the importance of
anxiety reduction, the author stressed exposure techniques:

Increasingly, however, it has become to be recognized that one of the central reasons, if
not the central reason, that repetitive exposure to conflicted material is necessary is to
enable inappropriate anxiety to diminish. Insight into what is desired but disavowed may
still be sought, but the gradual unlearning of reactions of anxiety has been recognized as
critical. (p. 91)

For developing his approach to therapy, Wachtel gave priority to exposure as central to
therapeutic action as opposed to insight. He believed this emphasis on exposure corresponded to
Freud’s revised theory and Dollard and Miller’s work. Freud conceptualized a working through
phase of treatment with his technical papers, especially with his essay Remembering, Repeating,
and Working Through (1914b). Wachtel provided a valuable contribution to the psychological
literature by conceptualizing the working through phase of treatment as a series of exposure
techniques:

Extinction of anxiety requires repeated exposure to the anxiety-provoking cues without
the anticipated harmful reaction. The working through process can thus be seen as a
series of extinction trials. By talking over and over again about the wishes and fantasies
he fears, the patient is exposing himself to the anxiety-provoking cues, which are largely
reinclinations. This repeated exposure enables the anxiety response to these cues to
gradually be extinguished. (p. 92)
Wachtel described the importance of repetition, which was an important aspect of the working through phase, as a critical factor for extinction of anxiety provoking cues. The author believed in the traditional concept of transference needing to intensify to gain the positive effects from psychoanalytic therapy, which was one important reason for exposure or other behavioral techniques to occur during the working through phase. During the working through phase, defenses had already been reduced, which Wachtel regarded as a situation in therapy in which successful exposure would become more likely. As a result, the author considered this final phase of therapy as the most promising setting to apply exposure techniques.

Wachtel (1993) worked to refine psychoanalytic techniques in order to facilitate effective exposure. As part of his work developing cyclical psychodynamics, he reformulated many traditional psychoanalytic techniques and forms of therapeutic communication. With regards to exposure, the author believed that interpretation was the most effective technique for the psychoanalytic therapist, writing, “In psychodynamically oriented therapies, a primary means by which the patient is exposed to previously avoided experiences is through interpretations” (p. 42). Wachtel mainly considered exposure to internal anxiety provoking experiences during psychoanalytic therapy. For exposure to just one external stimulus, he believed behavior therapy was an effective approach on its own. For internal experience, Wachtel described how interpretations could create exposure as follows:

> Interpretations facilitate exposure to these forbidden inner experiences in a number of ways. To begin with, by naming the implicit thought or inclination, the interpretation brings it into sharper focus and thus contributes to its entering the patient’s experience more directly. (p. 42)

Wachtel adopted the concept of labeling from Dollard and Miller (1950) for utilizing interpretations which created effective exposure therapy. Naming defended against and anxiety provoking material through interpretation allowed the client to direct their attention toward
warded off experiences and allowed he or she to further discuss these experiences. Wachtel stated, “Interpretations also facilitate exposure, and contribute to the overcoming of anxiety, by rendering the “unspeakable” spoken about” (p. 42). An interpretation of ideational content in the working through phase could facilitate exposure by eliciting the person’s feared thoughts. After a person focused his or her attention and discussed the internal experience he or she had been avoiding, the client could experience, or become exposed to, the anxiety provoking material in session. An example from the following passage of Wachtel’s work helped clarify this point: “That is, when the therapist says ‘it sounds like you were angry at Bob,’ that comment not only clarifies what the patient was feeling but also contributes to the patient’s experiencing the anger a bit” (p. 43). Wachtel advocated for the same principle as Freud (1914b) in his technical papers, which was for the client to experience his or her anxiety provoking inner experience in therapy. As a result, Wachtel continued to advocate for an in vivo type of exposure during psychoanalytic therapy.

In most cases, Wachtel (1997) described exposure as a complex process. For the author, personality development and maintenance was a continual process which continued into routine adult life. Accordingly, exposure was most effective at reducing anxiety when a person was exposed to the entire complex set of cues which created and maintained anxiety. Wachtel explained this important concept as follows:

At times, reduction in anxiety, or some other aspect of the therapeutic situation, enables the patient to verbalize about inclinations that he was previously too scared to acknowledge. Whether further change will follow upon this depends importantly on whether he merely emits words or whether he produces the whole complex of anxiety-provoking cues – words together with autonomic and other physiological reactions, muscular inclinations to act in certain ways, and cognitive representations of intentionality. That is, in many instances, the inhibitory anxiety is primarily attached to the whole configuration of cues, and exposure to merely the verbal component will do little to further the patient’s freeing from neurotic constrictions. (p. 93)
Wachtel advocated for the necessity of releasing emotion, but his version of exposure was more complex than the cathartic method. A person needed to be exposed to many associations, physical reactions, and ideational content to make significant progress in therapy. With his 1997 publication of *Psychoanalysis, Behavior Therapy, and the Relational World*, he described traditional psychoanalysis as the best forum for exposure therapy because of his conceptualization of the working through phase as an ideal situation for repeated exposure to anxiety provoking stimuli.

With the publication of *Relational Theory and the Practice of Psychotherapy* in 2008, Wachtel altered his theory of cyclical psychodynamics to incorporate recent theoretical and clinical developments of relational psychoanalytic therapies. Utilizing the new theoretical concepts of enactments, intersubjectivity, and unformulated experience of relational psychoanalytic theory, the author advanced his concept for a complex type of exposure therapy. The relevant aspect of these relational concepts for this study was the emphasis on the client acting out his or her relational patterns with others in the therapy session. A main difference was that the client was not purely acting out an old pattern; instead, the client was also influenced and reacting to the therapist. The therapist could not help but join the relational event, or the client’s enactment, and became influenced by the client too.

Hirsch (1998) defined an enactment in psychotherapy as follows: “That is, the analyst may unwittingly actualize the patient’s transference and, together with the patient, live out intrapsychic configurations” (p. 78). This short definition had many subtle components with widespread ramifications for Wachtel’s approach and relational psychoanalytic clinicians. According to several theorists of the relational movement of psychoanalytic theory (Aron 2003; Gerson 1996; Jacobs, 1986; Mitchell, 2005), a therapist would have little choice but to be
influenced by his or her own personality and the personalities of his or her clients. This new view of therapy had the therapist and client both arriving with their personalities intact to each session and being influenced by the other person. Each person, including the therapist, had an internalized view of other people, and this internalized pattern for perceiving others manifested in therapy. As the client interacted with the therapist, certain aspects of the therapist’s patterns of relating to others were activated. As a result, the client influenced the therapist. This same scenario applied to the client. From a relational analyst’s perspective, the therapy environment had a sense of mutuality in which both therapist and client influenced one another. This was referred to as an intersubjective setting by relational psychoanalytic clinicians and was part of Wachtel’s (2008) two-person model. Stern’s (1983) concept of unformulated experience was an important part of Wachtel’s revised approach to therapy. According to Stern, the client or therapist was normally not aware of engaging in enactments. The enactments represented internalized modes of experiencing the self and others. Quite often the enactments were current versions of previous traumatic experiences or problems that occurred during development. These previous experiences were either too traumatic to be fully conceptualized and described linguistically, or else occurred too early in development to be constructed into a meaningful narrative. Thus, these traumatic or problematic experiences represented an unformulated experience for Stern, or an experience which had not been available for mental processing. The therapist would eventually be drawn into an individual client’s enactments over the course of treatment.

This setting became the optimal environment for Wachtel (2008) and his revised conceptualization of exposure therapy. The author wrote, “But I wish here to complement these perspectives with an emphasis on the utility of an expanded, two-person or intersubjective
version of the exposure paradigm” (p. 210). Wachtel adopted Dollard and Miller’s (1950) perspective that most people entered therapy to alleviate complex interpersonal problems which were developed from such internal experiences as fears, conflicting motivations, or unacceptable desires. The author described his revised conceptualization of exposure therapy as follows:

That is, instead of the patient needing to accumulate exposure to something outside of the therapeutic relationship (high bridges, small spaces, pigeons, dogs, etc.) he must accumulate exposures to the kinds of relational experiences he has fearfully avoided. Central to those experiences are the patient’s own warded-off thoughts, feelings, and longings as they arise in interactions with key others. Those psychological events must be mobilized and experienced in the transaction for the patient to be exposed to the real sources of his anxiety, with the consequent possibility of overcoming that anxiety. (p. 208)

The two-person process of relational psychoanalytic therapy added a new dimension to exposure therapy as the client and therapist impacted one another while the client enacted his or her current relational patterns with the therapist. This new setting and two-person exposure were the main updates to Wachtel’s cyclical psychodynamic approach to therapy that was most relevant for this study.

Wachtel (1997) sought similarities between Dollard and Miller’s work and the revised theories of Freudian psychoanalysis in order to develop his cyclical psychodynamic approach. The author maintained that Freud’s final version of psychoanalysis had anxiety supplanting repression as the new cornerstone of the theory. With anxiety reduction as a main clinical goal, Wachtel promoted exposure techniques as critical interventions. His ideas for cyclical psychodynamic therapy integrated psychoanalytic therapy and behavior therapy with alterations to both approaches, but maintained what he believed were the important aspects of each approach. Wachtel’s work delivered much needed ideas for an integrational approach to therapy. Moreover, his theoretical descriptions provided important information about the commonalities of seemingly disparate theoretical orientations. Nonetheless, Wachtel’s work pertaining to
integrating exposure therapy and psychoanalytic therapy had some inconsistencies within his monographs. For example, interpretations of defenses and content would increase the likelihood of exposure throughout therapy, not just during the last working through phase, and Wachtel does not discuss these situations. The author produced some vague arguments within his research. For example, he promoted a new type of exposure therapy within the two-person therapeutic situation of relational psychoanalytic therapy, but he did not outline how he would maintain or alter specific mechanisms like habituation and extinction, which facilitate effective outcomes when utilizing exposure therapy. Wachtel’s work seemed to be an excellent platform for more research of integrational methods. I concurred with Stultz (2006) that the failure of Wachtel’s ideas to generate new integrational discussion or research was unfortunate.

Stultz (2006) provided one of the few examples of integrating exposure therapy and psychoanalytic therapy for treating trauma. The author began with a clear rationale for integrating the two approaches to therapy followed by concise explanations of the main interventions of both approaches to therapy. The rest of the article was replete with realistic clinical examples describing practical methods of combining the two treatment methods. For example, the author described four clear examples of how to utilize psychoanalytic techniques to overcome the client’s resistance to exposure therapy. Stultz provided two clinical vignettes along with several examples of how exposure therapy could improve psychoanalytic interventions, including working with transference, constructing narratives of past events, and building insight. The realistic clinical examples outlined by Stultz created a practical list of possibilities for combing both approaches; the clinical examples were clearly the strength of the article.

The weakness of the research was some vague structure for integrating the two approaches. Stultz (2006) mentioned integrating an eight week exposure therapy protocol into
current approaches for psychoanalytic therapy. However, she also discussed using psychoanalytic technique to prepare the client for treatment and handling resistance without making it clear how a therapist would still complete the exposure therapy portion of the treatment in the proposed eight weeks. In addition, the author did not outline a clear segment of psychoanalytic treatment to begin the exposure therapy or address the possible impact on existing psychoanalytic treatment. It was interesting to note that Stultz delineated between “single blow traumas” and “complex” PTSD, and that she addressed only the former group in her theory. Her rationale for this limitation was her belief that a flaw of existing research was that exposure theorists had not adequately addressed treating complex PTSD (p. 482-483).

Unfortunately, she did not outline her thought process for coming to this conclusion. Despite some lack of specifics, Stultz provided several clear examples of integrating exposure therapy with psychoanalytic therapy which instilled a sense of possibility and pragmatism to the difficult task of integrating two different approaches to psychotherapy.

Massad and Hulsey’s (2006) research was a recent attempt to integrate exposure therapy and psychoanalytic therapy in a limited manner by augmenting standard exposure therapy with free association. The research of the authors focused on what they believed was a common problem with exposure therapy, a phenomenon they termed as renewal. Massad and Hulsey stated, “Renewal has been defined as the recovery of responding following extinction” (419). The authors continued to describe the renewal problem and exposure therapy as follows:

Patients who develop PTSD may extinguish the original fear response to certain conditioned stimuli in therapy only to have it return (i.e. renew) in other contexts that more closely resemble those present during the original trauma. This is a critical limitation of exposure or extinction treatments. (p. 419)

According to the authors, clients who primarily processed their traumatic experiences through sensory cues associated with the environment were particularly susceptible to renewal. Massad
and Hulsey discussed the idea that such a nonconscious cognitive process could have a role in producing PTSD symptoms. The authors reported that one result of this perceptual processing style was a tendency to deemphasize the meaning associated with traumatic events. Another consequence of emphasizing perceptual processing was an increased likelihood of developing the automatic physiological symptoms associated with PTSD, including hyperarousal, hypervigilance, and reexperiencing trauma. The authors believed the clients diagnosed with PTSD with this set of characteristics were less likely to maintain a positive outcome with exposure therapy on a long-term basis.

Massad and Hulsey (2006) proposed several ideas for improving outcomes of exposure therapy with this particular subset of clients diagnosed with PTSD. They proposed increasing the number of exposure trials, inserting a long-standing safe object (e.g., family member, friend, pet), or the use of conditioned inhibition. The latter proposal referred to using the cues present during exposure therapy sessions outside of therapy to assist with the generalization of extinction. Massad and Hulsey also suggested integrating free association into an initial semi-structured interview. The authors explained their reasoning for the use of free association in the following passage:

Furthermore, we think that a structured patient inquiry designed to establish trauma details will be fruitfully augmented by free association. Free association increases the likelihood that the web of associated memories linked to the trauma in the patient’s experiences will be more fully rendered. (p. 426)

The addition of free association was another means to assist with uncovering the maximum amount of the client’s associations with past traumas. For Massad and Hulsey, this increased uncovering of associations had the potential of eventually improving the outcome of exposure therapy, especially with the difficult subset of clients defined by the authors. Massad and Hulsey acknowledged that utilizing free association with exposure therapy would require some
“refinement” of technique, but they believed it would be worth the effort for therapists employing exposure therapy.

Inserting a period of free association into the initial interview before utilizing exposure therapy appeared to be a reasonable idea. The only risks seemed to be logistical concerns about the length of treatment and the training effort required for therapists to learn a new technique. If Massad and Hulsey (2006) were correct in their ideas about renewal with clients who process trauma via sensory cues which remain unconscious, free association had the potential of increasing the effectiveness of exposure therapy. As a result, in regards to integrating free association within the initial interview for exposure therapy, I would have to concur with Massad and Hulsey in that, “the benefits would seem to outweigh the costs” (p. 427).

Some auxiliary evidence in support of integrating exposure therapy and psychoanalytic therapy had been provided by authors who briefly noted how the two therapy approaches had been integrated in the past. For example, Gabbard (2004) divided psychoanalytic interventions into primary interventions which develop insight and work within the therapeutic relationship and secondary strategies, one such secondary strategy was exposure (p. 88). Gabbard stated, “Many interventions in psychoanalytic therapy actually rely heavily on exposure” (p. 94). Gabbard continued the topic of exposure as a secondary intervention by describing an example of how exposure could be used with a client suffering from depression in the following passage: “For some patients, it may be that no amount of analysis of defense will overcome the natural tendency to avoid what is threatening. Without active confrontation of the feared situation, no progress may be made” (p. 94). Unfortunately, Gabbard did not continue this discussion much further, but the fact that a prominent author included exposure as common intervention of
psychoanalytic therapy was some evidence of the increased acceptance of exposure therapy with psychoanalytic researchers.
RESULTS

The major theoretical and clinical components of exposure therapy were outlined in Table 1 and Table 2. These outlines were compared to corresponding theoretical and clinical components of psychoanalysis which were discussed in this study. These results were summarized in the following Tables. The theoretical foundations of exposure therapy began with Mowrer’s (1947) two-factor theory. As a result, the most obvious point to begin the examination of results from the preceding literature review was with Mowrer’s (1939) own research in which he translated Freud’s revised theory of anxiety to behavioral terms. Mowrer easily described the classical conditioning and operant conditioning components of Freud’s revised theory of anxiety along with describing Freud’s anxiety theory as a conditioned reaction to pain in order to avoid a future reoccurrence of the painful stimulus. Mowrer viewed Freud’s revised anxiety theory as a learning theory. Levis and Brewer (2001) assisted with connecting Mowrer’s and Freud’s research:

In other words, Freud posited that all anxiety (fear) reactions were probably learned, such that the anxiety is the conditioned form of the pain reaction, which according to Mowrer (1939) “has the highly useful function of motivating and reinforcing behaviors that tend to avoid or prevent the recurrence of the pain-producing (unconditioned) stimulus” (p.555). However, Freud’s conceptualization proposed that a danger signal may come to elicit an infinite variety of reactions that may be completely unlike the reaction that occurs to the actual trauma being signaled (response substitution). He further assumed that the initial response to the danger signal is not, as Pavlov would hold, a complete overt reflexive behavioral reaction, but rather a covert, internal state of tension and increased preparedness for action – a state of anxiety. (p. 564)

According to Levis and Brewer, Freud developed a learning theory of anxiety which Mowrer adopted. In addition, Levis and Brewer noted that Mowrer preferred the flexibility of Freud’s theory in which danger signals or anxiety had the ability to elicit many different reactions
unrelated to a past trauma. Levis and Brewer continued with their comparison of Mowrer and Freud:

As such, Freud reasoned that human symptoms of psychopathology were essentially learned avoidance behaviors enacted by the patient to remove danger signals linked to the patient’s unconscious memory, aversive cues eliciting symptom behavior were considered to be generalized cues associated with earlier traumatic learning situations. Recognizing the importance of Freud’s contributions regarding symptom elicitations and maintenance, Mowrer (1939, 1947) set out to resolve these paradoxes by combining into a single theory the principles associated with Pavlov’s classical conditioning and Thorndike’s (1898) law of effect learning. (p. 564)

Levis and Brewer concurred with Mowrer in that Freud’s revised anxiety theory could be described as a learning theory. Moreover, Levis and Brewer believed that the impetus for Mowrer’s work was accounting for Freudian concepts of learning not yet established within behavior theory at that time. Mowrer (1947) did not credit Freud for developing the concepts of his two-factor theory, so this last point from Levis and Brewer remained up for debate. Nevertheless, Mowrer’s research provided the foundational theory of exposure therapy, and he clearly demonstrated Freud’s revised anxiety theory was similar to learning theory with classical and operant conditioning components. As a result, Mowrer’s (1939) research could be considered a credible source for concluding that at minimum Freud’s revised anxiety theory contained classical and operant conditioning components. French (1933) found it self-evident that Freud’s theory was compatible with classical conditioning. Feather and Rhoads (1973) researched the etiology of phobias and found similarities between psychoanalysis classical conditioning for creating phobic responses. In addition, the authors described the similarities between classical conditioning and the Freudian concepts for associations and repressions. These results from a literature review seemed to provide significant evidence for the classical and operant conditioning components having strong corollaries within psychoanalysis. These conclusions are summarized in Table 3.
The next two items in Table 3 corresponded to Mowrer’s (1947) two-factor theory. The two factors were cues associated with a trauma increasing over time and the person’s efforts to avoid these cues would also increase over time. Similar concepts within psychoanalysis could be found by starting with Freud’s roots in associational psychology and the cathartic method. Then, continuing to Freud’s development of the concept of repression which was used throughout his career. As discussed, Freud was influenced by the associational psychology concept that one new idea or sensory perception could trigger the activation of a host of other thoughts stored in
memory (Hearnshaw, 1987; Makari, 2008; Olsen & Koppe, 1988). This associational concept established the foundation for Freud’s ideas on repression that corresponded closely to Mowrer’s ideas about how cues increase over time. Freud began writing about the tendency for cues associated with a traumatic event expanding with his work for *Studies on Hysteria* (1895).

Freud’s first complex conceptualization which corresponds to Mowrer’s first factor described a “nucleus” of traumatic memories surrounded by a large amount of other memories which kept the traumatic memories out of awareness (p. 26). The most complete descriptions of Freud’s theories that directly corresponded with each of Mowrer’s two factors were found within the essay *Repression*. Freud’s conceptualizations of primal repression and after pressure corresponded nearly identically to Mowrer’s two factors. Levis and Brewer (2001) alluded to Freud’s revised anxiety theory as a foundation for Mowrer’s development of his two-factor theory; however, Mowrer did not describe Freud as a major influence, so Mowrer’s testimony in support of a similarity with psychoanalysis was left out of Table 3. It was less important to debate whether Freud’s ideas influenced Mowrer than to understand that matching ideas for Mowrer’s two-factor theory were found within Freud’s ideas for repression.

Rosqvist’s (2005) critical factors for successful exposure therapy found in Table 4 further the process of comparing psychoanalysis and exposure therapy and assisted in contrasting the two disciplines. Rosqvist noted the importance of the difficult process of accessing autonomic memories sustained within a nonconscious substrate. It was well known that Freud focused much of his research on nonconscious experiences and this study detailed some of these ideas found within the essay *Repression*. More specifically, Freud’s ideas for nonconscious autonomic memories created by anxiety as a danger signal were discussed. These ideas could be found within *Inhibitions, Symptoms and Anxiety* (1926), and this work most closely matched the
specific nonconscious autonomic memories discussed by Rosqvist. Freud described how anxiety as a signal of danger initiated a flight reaction from danger, which contained a biological aspect. Repeated exposure, not just exposure to what was feared or avoided, was a critical factor for Rosqvist. As discussed, the concept of exposure and psychoanalysis began with Breuer and Freud’s research within *Studies on Hysteria* (1895). While still employing the cathartic method, Freud emphasized the long process of overcoming the nucleus of traumatic memories and the memories surrounding the nucleus. This process entailed repeated imaginal exposure of trauma related associations until exposure to the actual traumatic memories could take place. In addition, Freud emphasized taking time to employ the cathartic method after the main trauma memories were exposed. As a result, Freud emphasized repeated exposure, as opposed to a single cathartic event, from the beginning of his work developing psychoanalysis with *Studies on Hysteria*.

Through the concepts of transference, interpretation, and working through, Freud continued to develop theory and treatment that contained the principle of repeated exposure. These ideas for repeated exposure were scattered throughout Freud’s technical papers and other works he focused on treatment methods; especially relevant were *Remembering, Repeating and Working Through* (1914b) and *The Dynamics of Transference* (1912a). Wachtel (1997, 2008) noted exposure taking place through interpretation in general, but he emphasized repeated exposure during the working through phase of traditional psychoanalysis.
### Table 4

**Comparison of the Theoretical Foundations of Exposure Therapy and Psychoanalysis**

**Treatment Factors**

<table>
<thead>
<tr>
<th>Rosqvist’s critical factors</th>
<th>Especially Relevant Literature</th>
</tr>
</thead>
<tbody>
<tr>
<td>Access information from nonconscious autonomic memories</td>
<td><em>Inhibitions, Symptoms and Anxiety,</em> <em>Repression</em></td>
</tr>
<tr>
<td>In vivo preferred, imaginal also effective</td>
<td>Technical papers, case studies, Wachtel (1997, 2008)</td>
</tr>
<tr>
<td>Four critical factors</td>
<td></td>
</tr>
<tr>
<td>Duration</td>
<td>No direct comparison</td>
</tr>
<tr>
<td>Severity</td>
<td><em>Studies on Hysteria,</em> Case Studies, <em>Repression,</em> technical papers, <em>Inhibitions,</em> <em>Symptoms and Anxiety</em></td>
</tr>
<tr>
<td>Latency</td>
<td>No direct comparison</td>
</tr>
</tbody>
</table>
Rosqvist’s (2005) next factor listed in Table 4 was the added effectiveness possible with in vivo exposure as opposed to imaginal exposure. Freud clearly established his preference for an in vivo situation with the shift from the cathartic method to a transference based treatment. Freud explained transference and his treatment method in several publications, but the essay *The Dynamics of Transference* (1912a) was an especially relevant example. Two of the case studies reviewed within this study provided examples of the in vivo exposure within psychoanalysis. As discussed, The Rat Man acted out his conflicts and problematic relationship patterns during the therapy sessions, and Little Hans was taken in front of his house and to the street where he confronted his phobic response to horses. In addition, psychoanalysts gained much meaning from Freud’s pithy statements, so I would be remiss without reminding the reader of Freud’s (1919) warning that the cure for a phobic client necessitated the client “go out into the street and struggle” (p. 166), or that Freud (1912a) warned future therapists that it was “impossible to destroy anyone *in absentia or in effigie*” (p. 108). These statements provided additional evidence of Freud’s preference for an in vivo exposure situation in the form of a phobic client moving outside of the consulting room to confront their phobic object directly and for in vivo exposure through transference and interpretation. Several years ago Wachtel (1997) described the benefits gained from traditional psychoanalysis for creating exposure to internal experiences, and more recently Wachtel (2008) described the beneficial aspects of relational psychoanalytic treatment for creating in vivo exposure through enactments.

In Table 4, Rosqvist’s (2005) four critical factors for exposure therapy to result in a positive treatment outcome were listed. Severity was one of the critical factors that closely matched ideas for therapeutic action within psychoanalysis. It referred to a person needing to be
exposed to the items rated highest on their fear hierarchy, or the situations they feared most. Freud’s cases clearly exemplified this severity principle: in the Rat Man case Lanzer had to experience exposure through transference to alleviate his developmental problem concerning his father, Elisabeth Von R. had to experience exposure through the cathartic method to alleviate her moral transgression, and at least part of Little Hans’ treatment entailed experiencing exposure to the horses which scared him. The severity principle was clearly a part of the major literature of psychoanalysis reviewed within this study, including *Studies on Hysteria* (1895), *Repression* (1915a), Freud’s technical papers, Freud’s case studies, and *Inhibitions, Symptoms and Anxiety* (1926). In addition, with the techniques of free association, working with defenses, a client would need to work through many associations and items lower on their fear hierarchy before becoming aware of their most feared situation.

The rest of Rosqvist’s (2005) critical factors seemed to have important similarities and important differences with techniques of psychoanalysis. The factor for frequency provided a good example to demonstrate the main differences between psychoanalysis and exposure therapy. As stated, a client would be repeatedly exposed to his or her feared situations as part of treatment with psychoanalysis. As a result, when broadly considering the principle of frequency, psychoanalysis could be referred to as satisfying this principle. As Rosqvist explained, the principle of frequency was satisfied systematically with exposure therapy through designed exposure exercises during session and most likely having the client perform exposure exercises between sessions (p. 47). Psychoanalysis does not involve such a systematic approach incorporating structured sessions with designed exercises. Similarly, sufficient duration of exposure could be determined by a 50% reduction in subjective units of distress during an exposure exercise (Rosqvist, p. 47). There was not a comparable systematic measure of duration
within psychoanalysis. Latency simply meant starting an exposure exercise promptly without hesitation so not to reinforce the avoidance of fear during an actual session. Again, there did not seem to be a clear corollary within psychoanalysis for this systematic technique. The timing of interventions was important for a psychoanalyst. For example, for an interpretation to be effective, an analyst needed to perform this intervention while the client acted out his or her problem in therapy; however, there were other factors for the analyst to consider with this complicated treatment method, including if a sufficient therapeutic relationship had been established and if defenses had been reduced enough for a client to benefit from the interpretation (Gabbard, 2004; Olsen & Koppe, 1988). In sum, there were comparable goals and techniques that matched most of Rosqvist’s important exposure therapy factors for treatment when considering general concepts. In contrast, there were no matching techniques within psychoanalysis for the systematic procedures involved in exposure therapy, including procedures necessary to ensure the frequency, duration, and latency which Rosqvist viewed as critical for effective exposure therapy.

The important factors for Foa and Kozak’s (1986) emotional processing theory were listed next in Table 5. As part of their emotional processing model, Foa and Kozak developed their ideas for how fear was processed in memory. Their theory contained the idea that all emotions were created through information in memory and the concept of a fear structure. As the reader will recall, a fear structure was a set of information about the feared stimulus, responses, and meaning of the situation. The information within a fear structure was mainly unconscious according to Foa and Kozak. As listed in Table 5, anxiety represented information stored in memory according to Foa and Kozak. The researchers believed this information creating fear or anxiety was mainly unconscious, but could be altered through conscious thought processes. The
fear structure was basically a memory of fear to access all the unconscious information related to the fear, and Foa and Kozak believed that a person’s actual fearful emotions needed to be activated during treatment. The final item for Foa and Kozak’s model listed in Table 5 was repeated exposure, which the authors considered an effective means to activate emotions and alter information in memory creating anxiety. Foa and Kozak developed their emotional processing theory to explain the effectiveness of exposure therapy, and they believed that exposure was an important element in psychodynamic therapies (p. 20). Not surprisingly, their theory was highly compatible with the theories underlying psychoanalysis. Freud’s signal anxiety could be viewed as a form of information about a dangerous situation. Of course, Freud was concerned with unconscious information and accessing this unconscious information in order to alter it, or develop new insight. As repeatedly stated in this study, activating emotions was a significant aspect of psychoanalysis since Freud’s early work with the cathartic method. Some of Freud’s major works were listed in Table 5 that were clearly compatible with the emotional processing theory. In addition, I believe it would be difficult to find strong challenges within any of Freud’s theories to any major ideas of Foa and Kozak’s emotional processing theory. Emotional processing theory was compatible with avoidance learning, so it was completely compatible with Freud’s revised theory of anxiety and Mowrer’s two-factor theory.
Table 5

Comparison of the Theoretical Foundations of Exposure Therapy and Psychoanalysis

*Foa and Kozak*

<table>
<thead>
<tr>
<th>Foa and Kozak’s Model</th>
<th>Especially Relevant Literature</th>
</tr>
</thead>
<tbody>
<tr>
<td>Emotion created by information in memory</td>
<td><em>Studies on Hysteria, Repression</em>, revised anxiety theory</td>
</tr>
<tr>
<td>Anxiety represents information in memory</td>
<td>Revised anxiety theory</td>
</tr>
<tr>
<td>Activating emotions is critical treatment factor</td>
<td><em>Studies on Hysteria, Repression</em>, technical papers, etc.</td>
</tr>
<tr>
<td>Complications for Foa and Kozak</td>
<td></td>
</tr>
<tr>
<td>Avoidance</td>
<td><em>Studies on Hysteria, Interpretation of Dreams, Repression</em>, revised anxiety theory, etc.</td>
</tr>
<tr>
<td>Some people do not readily habituate</td>
<td><em>Studies on Hysteria, Interpretation of Dreams, Repression</em>, revised anxiety theory, etc.</td>
</tr>
<tr>
<td>No direct comparison</td>
<td>Emphasis on Defenses</td>
</tr>
<tr>
<td>Cognitive restructuring may be needed</td>
<td><em>Studies on Hysteria</em>, revised, theory, etc.</td>
</tr>
</tbody>
</table>
The treatment complications for Foa and Kozak (1986) listed in Table 5 provided more opportunities to discuss similarities and differences between exposure therapy and psychoanalysis. A person’s natural avoidance to what was feared could be viewed as an obvious complication for any treatment approach, including psychoanalysis and exposure therapy. Within Studies on Hysteria (1895), Freud discussed changing treatment techniques from hypnosis to pressure to the client’s forehead and insistence to assist with dealing with a person’s natural avoidance of recalling past traumas. Several publications that provided sufficient support for the importance Freud afforded avoidance and other defenses complicating treatment, but one could find many more within Freud’s publications. Likewise, Freud’s work defining and developing treatment techniques to deal with defenses supported Foa and Kozak’s idea that some people do not readily habituate to a feared stimulus. In fact, Freud’s research listed in Table 5 and his emphasis on defenses suggested that most people do not readily habituate. When considering avoidance and the ability to habituate, general theoretical aspects of exposure therapy were not discordant with the theory of psychoanalysis; however, the emphasis within theory devoted to these topics were much different with psychoanalysis. Freud’s ideas for repression and other defenses were a major part of his theories underlying psychoanalysis, and these ideas did not have close corollaries within the theories underlying exposure therapy, as displayed in Table 5.

The final treatment complication which was listed in Table 5 was the issue of whether adding cognitive restructuring would improve treatment outcomes. Recent research was summarized earlier to conclude that there was some disagreement on this topic (Bryant et al., 2003; Foa et al., 2005; Marks et al., 1998; Paunovic & Ost, 2001). This issue represented a clear demarcation between exposure therapy and psychoanalysis. As discussed earlier, from Freud’s first work developing psychoanalysis to his final guidelines for treatment, exposure alone was
never considered as a sufficient treatment to cure anxiety disorders (Makari, 2008). Understanding and insight were always considered important parts of treatment from early conceptualizations of psychoanalysis to Freud’s final revisions (Breuer & Freud, 1895; Freud 1938).

In contrast to the ideas concerning defenses and cognitive restructuring, the need to activate emotions had clear theoretical and clinical convergence between exposure therapy and psychoanalysis. The failure to activate emotions was previously discussed as the most common treatment factor cited within behavior therapy literature which caused treatment failure, and this item was listed in Table 6. Breuer and Freud (1895) emphasized the need to fully activate emotions during cathartic treatment and Freud maintained this principle throughout his career. Again, a short list of publications in which Freud specifically discussed this issue was provided in Table 6, but the astute reader could find a long list of instances in which Freud (1909) discussed “strangulated affects” found in hysteria and the required generation of strong affect which was “the decisive factor both for the onset of illness and for recovery” (p. 15).

<table>
<thead>
<tr>
<th>Table 6</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Comparison of the Theoretical Foundations of Exposure Therapy and Psychoanalysis</strong></td>
</tr>
<tr>
<td><strong>Therapy Failure</strong></td>
</tr>
<tr>
<td>Consensus for exposure therapy failure</td>
</tr>
<tr>
<td><strong>Consensus on reason exposure therapy fails</strong></td>
</tr>
<tr>
<td>Failure to activate emotions associated with trauma</td>
</tr>
</tbody>
</table>
The results for the systematic outline of Freud’s theories of psychoanalysis and the foundational theories of exposure therapy combined with a literature review yielded other similarities between the two disciplines. Both approaches appeared to work toward reversing the process which created the client’s disorder, or reversing the process of avoidance by having the client repeatedly confront what he or she had been avoiding. Each approach relied on the exposure principle to produce positive treatment outcomes. Psychoanalysis was a complicated theory with its own esoteric terms, so it was more difficult to understand how the exposure principle was applied throughout treatment. To clarify how the exposure principle was applied in psychoanalysis, the theory of select anxiety disorders was outlined in more neutral language and explained in a linear manner. This linear explanation combined with a literature review explained how psychoanalysis contained a series of exposures on the way to producing a positive treatment outcome for select anxiety disorders. Dollard and Miller (1950) viewed psychoanalysis as an anxiety reduction process, and the linear explanation of Freud’s theories also revealed an anxiety reduction process. During psychoanalysis, a client was confronted with, or exposed to, how much of his or her life had been structured to avoid conflicts and fears. The Rat Man case provided a convenient example to discuss psychoanalysis as typically containing a series of exposures. Prior to Lanzer, the client of the Rat Man case, becoming aware of his main conflict through transference and interpretation, the exposure principle was employed many times during his treatment. Lanzer’s defenses and symptoms established a series of situations he needed to confront before he could confront his main conflict. Each one of his obsessions and compulsions had a purpose, and he obtained some benefit from these symptoms. Lanzer had to be exposed to each one of these issues before therapeutic gain could be obtained from exposure to his main conflicts. For example, it was explained that Lanzer employed the reaction formation defense,
i.e., he aligned his motivations and behaviors to match those of his father. Lanzer joined the military, gambled, and was strictly scrupulous with paying his debts just as his father was in his life and just as his father desired. Through free association, transference, and interpretation, Lanzer was exposed to the benefits of adhering to his father’s desires and what desires of his own he relinquished as a result of his reaction formation. In essence, Lanzer went through a series of exposures before being exposed to his core conflict creating his disorder. The pivotal point in treatment when Lanzer was exposed to his core conflict and expressed strong emotion toward Freud, was a more obvious example of the principle of exposure and similar to the cathartic method. The series of exposures demonstrated through a linear outline of Freud’s theory and treatment were less obvious, but still added to the therapeutic action of psychoanalysis.
DISCUSSION

The research conducted as part of this study did not reveal much literature integrating exposure therapy and psychoanalysis. A separation between the two disciplines seemed odd given the fact that their theoretical foundations and basic treatment interventions had much in common; however, a systematic analysis of each approach has unveiled many of their hidden similarities. The foundational theories of each approach had much in common if one used Freud’s revised theory for the comparison. Freud’s last major theoretical revisions found within Inhibitions, Symptoms and Anxiety not only encompassed Mower’s two-factory theory, these revisions turned psychoanalysis into a parallel of learning theory. Freud’s theory for the etiology of anxiety disorders could be readily translated into learning theory terminology. It was hard to envision how ignoring or denying the similarities of the two approaches had benefitted psychological thought. Anxiety disorders were prevalent problems within our society for which we had not yet found a cure, so any artificial separation between two theoretical approaches with even some similarities would only slow our progress in creating improved treatment outcomes.

Speaking in general terms, the exposure within exposure therapy referred to a person confronting a feared stimulus, and this broad perspective was where exposure therapy and psychoanalysis had the most in common for the treatment of anxiety disorders. There was a lot of exposure within psychoanalysis. The goal of psychoanalysis was for a person to confront a feared memory or internal experience. Freud’s fundamental rule of therapy was for the client to engage in free association, which had the purpose of loosening associations to allow exposure to take place. Transference was the ubiquitous phenomenon of the client acting out their
maladaptive patterns of relatedness during the therapy session. When an interpretation from the therapist had been accurate and fully accepted, the client became exposed to their current maladaptive pattern during the therapy session. Transference continued throughout the treatment episode and interpretation was a common intervention for the psychoanalyst. As a result, this form of exposure was a common phenomenon within psychoanalysis. After an analsand had been exposed to his or her main trauma or developmental problem through transference and interpretation, another series of exposures would most likely take place as part of the working through process. These common occurrences of exposure were discussed as part of the linear discussion of psychoanalysis, but there appeared to be another aspect of exposure for the psychoanalyst; exposure seemed to underlie the training and work of the psychoanalyst. McWilliams (2004) described a psychoanalyst as someone who had obtained an “unflinching self-awareness in a personal analysis and who bore the responsibility for fostering the same achievement in the patient” (p. 2). My broad translation of McWilliams’ description into behavioral terms was that a psychoanalyst was someone who had been exposed to the internal experiences and memories which they were avoiding, so that they could better create the same type of exposure therapy with their clients. When viewed from this perspective, a significant portion of the analyst’s job was to expose the client to what they have been avoiding.

The first version of psychoanalysis utilizing the cathartic method provided the most obvious similarities with exposure therapy. During treatment with the cathartic method, a client described previous events with strong emotion, which readily compared to imaginal exposure. If this was the foundation for developing exposure therapy referred to by some researchers (Barlow 2002; Foa & Kozak, 1986), exposure therapy had progressed a great deal from its original inspiration. Exposure therapy had a theoretical foundation, structured treatment procedures, and
specific factors of treatment to facilitate habituation and extinction of anxiety provoking stimuli. Researchers of exposure therapy created a large amount of empirical support for exposure therapy as an efficacious and effective treatment of anxiety disorders. As discussed, a main goal of psychoanalysis from its original form to Freud’s final revisions was to bring unconscious material to conscious awareness. A main goal of treatment was for the client to confront their past, because this exposure to the past would alleviate painful symptoms and lead to permanent change. The main goal of psychoanalysis had a strong exposure component. Dream analysis, working with transference, and interpretation were all common techniques for the psychoanalyst to help a client confront their past. It seemed only reasonable that psychoanalysts would receive some assistance with bringing unconscious material to consciousness by utilizing some of the empirically supported techniques of exposure therapy. It was hard for this researcher to imagine that incorporating an understanding of habituation and extinction along with critical treatment factors of exposure therapy would not benefit the psychoanalyst in their efforts to have the client confront their unconscious memories. Gabbard (2004) had proposed that exposure had been a secondary intervention within psychoanalytic therapy. Even as something less than a primary intervention for change, it was conceivable that incorporating important treatment factors of exposure therapy would assist in obtaining positive treatment outcomes for psychoanalytic therapists. Moreover, it was difficult to envision how a hard separation of the two disciplines, without thorough research for integrating techniques, was benefitting the psychoanalyst.

This same argument could be made for the clinician utilizing exposure therapy. Choy et al. (2007) produced an extensive review of specific phobia treatments and concluded that exposure therapy was the most empirically supported treatment. Through the use of a meta-analysis of treatments for OCD, Abramowitz (1998) concluded that exposure therapy with
response prevention was the treatment of choice for OCD. Abramowitz reported that approximately half the clients diagnosed with OCD and experiencing exposure therapy with response prevention treatment demonstrated a reliable change. The point of reminding the reader of these research findings was that exposure therapy may be the most empirically supported treatment for certain anxiety disorders, but there was still much room for improvement.

Increasing the support for empirical research for all types of psychodynamic researchers and clinicians could be a crucial factor for integrational efforts. The recent trends for psychodynamic researchers reported by Shedler (2010) concerning increasing empirical research and changing attitudes toward empirical research in general had provided some hope for extending the influence of psychodynamic theory and technique. In fact, more empirical support for any psychodynamic therapy could be the best hope for generating future research comparing exposure therapy with any psychodynamic therapy. Empirical support would garner more interest and credibility for those researchers not already associated with psychodynamic therapies. In addition, further empirical research for psychodynamic therapies would make it more difficult for clinicians and researchers with different theoretical orientations to ignore psychodynamic theories and techniques. Acceptance of the importance of empirical research in general could also make it more difficult for psychodynamic clinicians to ignore empirically supported treatments.

Researchers such as Choy et al. (2007) had noted the common problems of significant numbers of dropouts and those that decline to participate in exposure therapy. Psychoanalytic theory and technique could help with these persistent problems for clinicians utilizing exposure therapy. Psychoanalytic clinicians had specialized in working with resistant clients and defenses for over 100 years; it seemed only logical that their theory and technique would somehow help
alleviate the problem of dropouts and those rejecting treatment for clinicians utilizing exposure therapy. The long-term psychoanalytic therapies contained many theoretical concepts and techniques not accounted for within exposure therapy. The theory and techniques for working with defenses, transference, and the symbolism within phobic symptoms were just a few examples. Massad and Hulsey’s (2006) incorporated free association to augment exposure therapy, and there seemed to be many more opportunities for similar efforts of utilizing individual techniques of psychoanalytic therapies with exposure therapy.

The strengths of this study seemed to be approaching the vexed question of how a behavior therapy such as exposure therapy could have much in common with a psychoanalytic therapy and in devising a linear procedure for comparing the two approaches. The actual similarities of each approach seemed readily apparent after psychoanalysis was outlined in a linear manner. The weakness of this study was not having a novel approach to altering the cultural forces in the field of psychology that maintained a strict separation from some theoretical orientations. With this strict separation of psychoanalytic therapy and behavior therapy remaining, it was unlikely that the information of this study would generate much new research to improve treatment outcomes in the future.

Judging from the existing empirical support for exposure therapy and the great impact of Freud’s theoretical research, the therapeutic action provided through exposure seemed to be an important factor in the treatment of certain anxiety disorders. Many aspects of exposure therapy and psychoanalysis seemed separated within the psychological literature; the principle of exposure was just one. Segregating the two diverse disciplines relying on the same treatment factor did not seem beneficial for the advancement of the treatment of PTSD, OCD, or specific phobias.
After a thorough comparison of exposure therapy and psychoanalysis, it seemed to me that there was much more than different theories and techniques keeping the two approaches from integrating. There was something within the culture and institutions of psychology that fostered a competitiveness and suspiciousness of different theoretical orientations than one’s own. The two disciplines had many similarities, and clinicians from each approach had much to learn from one another. The dichotomy between the two disciplines was more of an artificial imposition born of prevailing attitudes and culture rather than theoretical or clinical differences.
SUMMARY

This study provided a thorough comparison between the theories underlying both psychoanalysis and exposure therapy for treating certain anxiety disorders. In addition, the basic clinical applications of each approach were discussed in order to clarify the similarities of each approach. The anxiety disorders considered in this study were PTSD, OCD, and Specific Phobia. The rationale for using exposure therapy as a standard to compare with psychoanalysis was developed through a concise overview of empirical studies supporting exposure therapy as an efficacious and effective treatment for certain anxiety disorders.

The comparison was developed through a literature review. A review of the foundational theories of exposure therapy was provided along with a summary of the most important theoretical factors in order to facilitate a comparison with the theories of psychoanalysis. Freud’s early theories and his final revisions regarding the designated set of anxiety disorders were outlined in a linear manner to create a format in which psychoanalysis could be effectively compared to exposure therapy. The most important theoretical factors of exposure therapy were then compared with theoretical concepts from psychoanalysis.

It appeared that the more fundamental and broad the theoretical concept, the more similar the two approaches became. The results of the comparison indicated that the two disciplines had several important theoretical factors in common and also shared the critical factors of therapeutic action. The most important concepts of learning theory underlying exposure therapy were proven compatible with Freud’s revised theory of anxiety. The principle of exposure and repeated exposure was demonstrated to be an important factor for therapeutic action for psychoanalysis.
Since the two approaches to therapy were applying some of the same theory and techniques, logical research questions would be to consider the most effective treatment setting to apply exposure techniques, and determining when exposure was appropriate for a long-term treatment, and when it was appropriate for a short-term setting. It was possible to consider that after the two approaches were compared utilizing outcome research one approach would completely supplant the other, but I believed this was highly doubtful. It seemed more likely that clinicians of both disciplines would have much to learn from one another.

The two theoretical orientations diverged as the examination of clinical application became more specific. For example, psychoanalysis did not have a corollary for the structured application of exposure exercises found within exposure therapy. This was an obvious topic for future research due to the fact Stultz (2006) had attempted to integrate the structured exposure interventions into psychodynamic therapy and emphasized that future research was needed to clarify the effectiveness of this initial attempt at integration. Applying structured exposure therapy techniques within a psychoanalytic approach to therapy could speed up the process of habituation and extinction for some anxious clients. Adding several weeks of exposure therapy to a long-term psychoanalytic treatment episode would have the benefit of taking advantage of both methods without developing a new integrated approach. Some potential problems with this type of integration would be lengthening an already long-term treatment approach and disturbing the transference relationship within psychoanalytic therapy. Integrating exposure therapy within a psychoanalytic therapy could speed up the entire therapy process and reduce the risk of lengthening treatment. A serious attempt at integrating the exposure therapy within psychoanalytic therapy could lead to new integrational treatment approaches. Future research
could determine if the benefits of adding exposure therapy to psychoanalytic treatment would be worth the risks.

Exposure therapy did not have the flexibility of psychoanalytic therapies to apply the most effective intervention to whatever changes occurred between or during therapy sessions. In addition, exposure therapy did not have a corollary for the theoretical and clinical emphasis that psychoanalytic therapies place on defenses despite the fact that avoidance had been identified as a complicating factor of exposure therapy (Foa & Kozak, 1996). Clients dropping out of exposure therapy and declining treatment were identified as important factors which had limited the rate of effectiveness of exposure therapy (Choy et al., 2007; Stanley & Turner, 1995; Ost, 1989). Foa and Kozak identified that some clients did not habituate as well as others during treatment and a failure to activate emotions reduced treatment effectiveness. In sum, the main problems reducing the effectiveness of exposure therapy would be the following: avoidance, dropping out of treatment, declining treatment, lack of habituation, and a failure to activate emotions during exposure exercises. It was possible to classify all of these problems as active resistance and active use of defenses on the part of the client. Working with resistance and defenses was an important part of psychoanalysis and many psychoanalytic therapies. As a result, the possibility of adding enough flexibility within exposure therapy for working with defenses would be an option for future research.

This option for adding interventions to work with resistance and defenses within exposure therapy could take many forms. Within traditional psychoanalysis, working with defenses was embedded within the long-term process of therapy. An abbreviated form of working with defenses could be an adjunct to exposure therapy. For example, interventions for the clients natural avoidance could be added at the vulnerable points of exposure therapy, the
initial period when client’s decline therapy and when client’s drop out of therapy. A more expansive perspective would be adding working with defenses throughout exposure therapy as a person’s natural tendency to avoid anxiety provoking stimuli manifests. This latter option could even expand to a creative idea for a new form of treatment. Integrating working with defenses and exposure therapy in some form had the potential to counteract clients dropping out and declining treatment.

The work by Massad and Hulsey (2006) provided the most accessible model to begin integrating exposure therapy and psychoanalytic therapy. The authors integrated only one discreet technique from psychoanalytic therapy, free association, into exposure therapy. There were many opportunities to continue this approach, including incorporating the concepts of secondary gain and symbolic nature of symptoms into exposure therapy. This limited integration could be implemented in straightforward interventions. For example, a client and clinician who had a discussion regarding the costs and benefits of retaining a symptom such as repeated hand washing would have incorporated secondary gain. A therapist who utilized exposure techniques to assist a client in confronting internal conflicts discovered during an initial interview would be another example. There could be many more options for this type of integration of a discreet treatment technique.

The two approaches clearly diverged on the issue of exposure therapy as a sufficient stand-alone treatment to cure anxiety disorders. Further research examining the different treatment settings in which exposure methods were applied and future integration of the two treatment approaches could help resolve this difference.
Any preliminary proposal for more research on integration to me seemed much preferred compared to the separation of all behavior therapies and psychoanalytic therapies that had taken place for many years. Even many of the authors quoted within this study, who have focused their efforts on integration, had commented on the inimical division between the two disciplines (Dollard & Miller, 1950; French, 1933; Stultz, 2006; Wachtel, 1997, 2008). This division between the two disciplines seemed harmful to the seemingly logical integration of exposure therapy and psychoanalytic therapy and to the general progress of psychological thought. My systematic comparison of the foundational theories and basic clinical methods of each approach could lend some much needed support to the notion of integrating the two disciplines.

Comparing the seemingly different approaches to therapy was an attempt to reveal the most important theoretical concepts explaining anxiety problems and the most important aspects of therapeutic action for select anxiety disorders. Freud’s revised anxiety theory centering on signal anxiety and Mowrer’s two-factor theory were shown to be very similar. The exposure principle was shown to be an important treatment factor for each approach. These hidden similarities of seemingly divergent disciplines provided evidence for the most important factors of theory and treatment for a set of anxiety disorders. Generating new research regarding integrating the two disciplines had already been proven to be a difficult task. The clarification of similarities between the two approaches provided within this study hopefully assisted in reducing some of the barriers for generating new research for integrational ideas to improve theory and treatment for anxiety disorders.
REFERENCES


Levis, D. J., & Brewer, K. E. (2001). The neurotic paradox: Attempts by two-factor fear theory and alternative avoidance models to resolve the issues associated with sustained avoidance responding in extinction. In R. W. Mowrer & S. B. Klein (Eds.),


