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Integrative Treatment of Symptomatic Disorders

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Symptomatic disorders such as substance abuse, eating disorders, depression, and anxiety states can cause significant life impairment in patients. The author proposed that an optimally responsive, analytically oriented treatment for an individual with symptomatic distress may involve the use of active symptom-focused techniques. Reduction of symptomatic problems strengthens the self and facilitates deeper levels of self-exploration and therapeutic involvement. Techniques originating in behavioral and cognitive–behavioral orientations may be implemented in an analytically informed treatment and adapted accordingly. Current psychoanalytic models such as self psychology and some other relational approaches that emphasize the importance of empathic appreciation of a patient's perspective and optimal responsiveness to the individual can encompass such an integrative approach.

Patients come to psychoanalytic treatment troubled with an array of distressing issues. Many of these involve chronic difficulties in achieving satisfying relationships or life goals due to characterological disturbances. These entrenched patterns of impaired functioning seem particularly well suited to psychoanalysis or long-term psychoanalytic psychotherapy.

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However, numerous patients also enter treatment distressed about symptomatic disorders that would be diagnosed on Axis I of the *Diagnostic and Statistical Manual of Mental Disorders (DSM–IV,* American Psychiatric Association, 1994), such as eating disorders, substance abuse, anxiety disorders, sexual dysfunction, and depression. These symptoms may appear alone or in conjunction with characterological problems.

The classical psychoanalytic stance toward symptoms has been to conceptualize them as compromise formations resulting from the interplay of reprehended drives, ego defenses, and superego prohibitions (e.g., Freud, 1916–1917/1964). Traditional theory has thus viewed symptoms as manifestations of underlying conflicts and has proposed that they will resolve as the dynamic unconscious forces propelling them are brought to awareness in analysis or psychotherapy. Furthermore, the symptom was thought to occupy such a central place in the psychic economy that attempting to remove a symptom prematurely was believed to result only in the substitution of another symptom.

Adherents of psychoanalytic relational theories such as self psychology and intersubjectivity have proposed minimizing or eliminating aspects of Freudian metapsychology and focusing on affect rather than drive (e.g., Mitchell, 1988; Stolorow & Atwood, 1992; Stolorow, Brandchaft, & Atwood, 1987). However, relational theorists have generally not turned their focus toward specific symptoms and their amelioration, resulting in few analytically oriented writings on particular symptomatic disorders.

In contrast, literature from behavioral and cognitive–behavioral perspectives primarily addresses specific symptomatic disorders and often describes empirical studies measuring the efficacy of one treatment technique versus another. The analytically oriented clinician might be inclined to dismiss this body of work as overly narrow, mechanistically technique-oriented, and naive about the tenacious nature of psychopathology. In many respects these criticisms are justified; with a few exceptions (e.g., Beck & Emery, 1985; Linehan, 1993), behavioral and cognitive–behavioral authors have attended little to the relational dimensions of their work and certainly take an "objectivist" rather than an intersubjective stance (Stolorow & Atwood, 1992). Nonetheless, I believe that techniques originating from these perspectives have much to offer distressed patients. My intent in this article is to suggest that such techniques may be incorporated into a psychoanalytic treatment. My orientation is primarily self psychological, although I believe that these active techniques would be compatible with a range of psychoanalytic relational approaches (as delineated by Mitchell, 1988).

However, psychoanalytic clinicians may feel quite uncomfortable with this prospect. Frank (1992) commented on the traditional psychoanalytic opprobrium toward the use of such active techniques, noting that action in psychoanalysis has been associated with resistance and acting out and that the relationship between action and intrapsychic processes has been relatively neglected in psychoanalytic study. Similarly, Bader (1994) noted a tendency in psychoanalysts to focus too narrowly on process goals, such as insight, within the psychoanalytic situation, with a de-emphasis on therapeutic change and symptom relief. He stated that analysts often seem more comfortable with understanding the dynamics of a case rather than helping the patient get better in his or her outside life. Bader suggested that a variety of factors in the history of psychoanalysis have resulted in a subtle valorizing of intraanalytic processes over therapeutic aims, noting that for a number of theorists, understanding and exploration constitute the analytic task, with symptom relief a relatively unimportant by-product. Bader cautioned that a theory that encourages an exclusive focus on the analytic interaction may result in a process that is overly theory-driven and insufficiently responsive to the patient's actual difficulties.

Rationale for a Symptom Focus

There are several reasons that interventions designed to affect specific symptoms may be indicated. Some symptomatic disorders place patients in actual physical jeopardy. Anorexia nervosa has been estimated to have a mortality rate ranging close to 10% (Sibley & Blinder, 1988). Bulimia nervosa can also be life threatening, with such consequences as cardiac arrest resulting from electrolyte imbalances (Johnson & Connors, 1987). Substance abuse can be quite dangerous as well, particularly at severe levels or when toxic drugs such as inhalants are used. Compulsive unsafe sexual behavior can have fatal consequences.

The impairment caused by some symptoms may mean that psychotherapy is not a real possibility until the symptoms abate. The malnourished anorexic whose cognitive functions are impaired by starvation is in no position to achieve insight into her unconscious motivation. Neither is the alcoholic who is always either inebriated or beginning to experience withdrawal, or the bulimic who is binge-eating and purging multiple times a day. Patients who are feeling terrorized by panic attacks or flashbacks related to traumatic experiences likewise cannot be fully present in a therapeutic relationship. In such cases symptom reduction is required

before the patient can be cognitively and affectively ready to engage in psychological exploration.

The patient's level of distress about the symptom might also warrant a specific symptom focus. Some symptoms are so ego-dystonic, anxiety-provoking, or eroding of self-esteem that their rapid amelioration is desperately sought. The classical tradition—with its emphasis on abstinence rather than gratification, renunciation of infantile wishes, and removal of resistances to uncovering unconscious conflicts—may lead clinicians to take an unnecessarily harsh stance toward symptom relief. Distress resulting from troublesome symptoms is often not useful for personal or therapeutic development and may promote rigid and risk-avoidant behavior. There is a difference between a patient's stating, "I can't stand to feel this angry at my parents," versus "I can't stand to go on having panic attacks every day." The former requires empathy for the patient's painful struggle to tolerate disturbing but vital affects; the latter may warrant something more immediate.

The most empathic and attuned therapist response to a patient in great symptomatic distress is to try to do something about the symptom quickly, if this seems at all possible. Clinicians from different perspectives tend to agree that active crisis intervention is necessary when a patient is suicidal. Here it is obvious that unless the therapist manages the situation and secures the patient's safety, severe consequences could result. Distressing symptoms are not necessarily life threatening, but they may be so pressing that patients will not remain in psychotherapy or be able to engage in a therapeutic relationship unless they are attended to relatively early in the treatment. The immediacy with which a clinician intervenes when a patient is suicidal, regardless of the clinician's views concerning underlying causality, might be appropriate in less extreme situations as well.

Patients with problematic symptoms, particularly those involving substance abuse or eating disorders, have often been relegated to treatment in inpatient programs. This will continue to be necessary at times: for example, when brief detoxification from substances is indicated or when an eating disordered patient is at great physical risk. However, in an era of such concern about health care costs, formerly ubiquitous practices such as a 3- or 4-week hospital stay for alcoholism are rare. Because outpatient treatment over a longer period is far less costly than hospitalization, clinicians will probably have to manage many situations involving symptomatic disorders without resorting to inpatient care.

Symptom Formation and Function

A proposal for active intervention with symptomatic behavior raises issues concerning the function of symptoms. My self psychological conceptualization focuses on affect and self states ranging from relative cohesion to fragmentation. Symptoms are best understood using a biopsychosocial and relational perspective, in which temperamental predispositions and genetic vulnerabilities, selfobject failures including trauma and neglect, and cultural factors such as gender roles and prevailing social values combine in an additive fashion to produce psychopathology (Connors, 1994). Symptoms are manifestations of a vulnerable self in an interpersonal milieu that has failed, perhaps both on a familial and a societal level, to provide needed functions. Psychological conflict and structural deficits are both central in the genesis of symptomatic disorders.

Symptoms develop as individuals attempt to titrate psychological pain that otherwise seems unbearable and to manage seemingly insoluble intra- and interpersonal dilemmas. I have proposed four particular pathways to symptom formation (Connors, 1994). The first consists of a self-state of impending fragmentation that is then warded off through involvement with a substance or activity, as in addictive disorders. The second denotes a state of fragmentation without a behavioral means of restitution, seen in anxiety disorders. The third involves the use of a symptom as a compromise formation between conflicting impulses as a result of psychological trauma, seen in dissociative and somatoform disorders. In the final pathway outlined, symptoms such as depressive states and work inhibitions result from an internalized conflict between maintaining needed relational ties and pursuing self-strivings.

It is my experience that symptom substitution is more than a remote possibility only in the first category of symptomatic disorders: addictive behaviors that serve to regulate affect in a fragmentation-prone self. Occasionally patients may relinquish one addiction only to take up another. However, the most common manifestation of fragile self-cohesion will be the recalcitrance of the original symptom rather than its disappearance and replacement with another. Further, some patients will be able to reduce their dependence on a destructive addiction and substitute behaviors that may still be rigidly adhered to but are less harmful, such as daily self-help group attendance or exercise. In symptomatic disorders other than addictions, the symptom may be a manifestation of vulnerability to fragmentation or internal conflict but does not function to regulate mood in the same fashion. Symptoms of anxiety, dissociation, or depression–

inhibition involve affect, cognitions, and sometimes avoidance of activities, rather than the acting out seen in addictions. In such situations symptom substitution is unlikely.

An Integrative Treatment Model

In earlier works (Connors, 1992; Johnson & Connors, 1987; Johnson, Connors, & Tobin, 1987) my colleagues and I described how the integration of psychoanalytic psychotherapy and active techniques of symptom management not only facilitated the control of problematic symptoms (specifically, bulimia nervosa) but also furthered the analysis of the transference. We proposed that all events in therapy, including the introduction of behavioral or cognitive–behavioral techniques, can be discussed with the patient regarding her or his ongoing experience of the therapist and the treatment. We suggested not only that therapists who proffer such behavior-change suggestions must be committed to understanding and analyzing patients' reactions, but that all therapists and analysts offer (implicitly or explicitly) suggestions to patients for proceeding together in a manner that they hope will be helpful, including free association, meeting a certain number of times per week, and so forth.

Similarly, Frank (1990, 1992, 1993), in a series of articles on more generally integrating behavioral–cognitive techniques and object-relations-based psychotherapy, noted that in a two-person psychology where it is clear that the analyst's or therapist's influence is always present, such techniques can be implemented "analytically"—that is, in a fashion that promotes understanding and consciousness. He further suggested that behavior change can facilitate structural change and that insight and adaptive behavior form a dialectic in which behavior change may lead to increased insight, and vice versa.

My specific focus in this article is exploring the possibility of including active techniques in a treatment guided by principles of self psychology. Treatment from a self psychological perspective involves engaging in an empathic relationship that permits the reemergence of thwarted developmental strivings, interpretation of environmental failures in the provision of selfobject functions, and a focus on strengthening the self (Kohut, 1977, 1984; Wolf, 1988). The concept of the selfobject is central in self psychology, referring to the intrapsychic function served by others whose responsiveness assists one's experience of a cohesive self (Kohut, 1977; Wolf, 1988). Particular selfobject needs have been identified as developmental necessities, including needs for mirroring (feeling

truly seen and affirmed), idealizing (being calmed and soothed through connection with a more competent other), and twinship (feeling similar to another rather than isolated and singular). These needs are thought to continue throughout life, although they mature in form.

Some self psychological authors have been careful to stress that the clinician's role is that of interpreter of past selfobject failures and their impact, rather than as a provider of selfobject functions who can compensate for past deficits (e.g., Wolf, 1988). Certainly it is important to note that adult patients are not children who can be "reparented." However, accepting the limitations of what a therapeutic experience can provide does not mean eschewing all notions of provision of selfobject functions by clinicians. For instance, empathic listening and understanding may provide for patients' mirroring needs quite powerfully, and a therapist's calm voice when a patient is upset may promote idealization. Stolorow and Atwood (1992) suggested that the therapist may serve a self-delineating selfobject function for patients in need of attuned help with identity and differentiation that was not available in their families. If thwarted developmental needs are remobilized in treatment, as self psychology suggests, it may be useful to consider what might constitute optimal responsiveness to them (Bacal, 1985; Lindon, 1994) without erring in the direction of believing that all patient demands can or should be met. An analytically informed treatment that also offers patients specific help with disturbing symptoms provides a unique combination of an attuned and transformative relational experience coupled with special expertise.

Myriad selfobject functions are served by the provision of active help with symptoms, most notably idealization. Patients feel calmed and soothed by the fact that their therapist possesses sufficient competence, knowledge, and experience to help them with their particular problems. It can be intensely relieving for patients to begin discussing their symptoms (so often kept secret because of shame and embarrassment) with a therapist who has enough expertise to ask the right questions and eventually offer a few suggestions. Patients frequently feel overwhelmed and somewhat fragmented about dealing with distressing symptoms; their self-cohesion can be improved considerably by feeling attached to an idealizable therapist who knows just what to do. Many if not most patients lacked attuned and competent parental care when they had a problem because of parents who were fragile, preoccupied, or limited in one fashion or another due to their own psychopathology and stressors. A therapist who provides useful help with a specific problem in the context

of a warm relationship, like the good-enough parent who bandages the scraped knee, is doing no small thing.

Mirroring functions are served as well in the offering of symptom management. Patients may feel that the therapist really understands and is attuned to their unique dilemmas. Twinship needs may be met as patients come to understand that other people with problems similar to theirs have been helped. This is not to suggest that the therapist regale patients with tales of former patients who are now "success stories," but rather that the therapist communicate that in his or her experience, as well as in the literature, symptoms similar to theirs can improve. Meeting of such twinship needs inspires hope and a sense that one is part of the human community of people with troubles rather than an isolated and singular sufferer. This selfobject function is probably responsible for much of the success of self-help groups for people with specific problems. Finally, patients' efficacy needs (Wolf, 1988) may be met as they perceive that they are having sufficient impact on the therapist that he or she offers an individualized plan designed to respond to their particular concerns.

Offering patients active help with managing disturbing symptoms thus could provide in some measure for important selfobject needs that may become more prominent in the safety of a treatment relationship. Optimal responsiveness (Bacal, 1985) to a particular patient's struggles might require more activity and more structure than many psychoanalytically inclined therapists typically offer. It may be only through such activity that the patient will experience the therapist as a usable object (Winnicott, 1965). The various selfobject functions served by the provision of such help enable patients to be somewhat more trusting in the therapeutic relationship and less fearful that retraumatization will result from deeper involvement with the therapist. In a milieu of increased safety and confidence and decreased preoccupation with life-impairing symptoms, disavowed affects and wishes can more readily be mobilized.

Moreover, providing help with symptom management is often an effective and efficient intervention in regard to strengthening the self. When individuals are attempting to solve dilemmas that have too high a difficulty level, they become hopeless and frustrated; this is often the case with symptomatic problems. Aiding a patient in achieving mastery over and relief from a significant problem inspires hope and releases energy to work on other issues. People confronted with problems that they are capable of solving with concerted application and appropriate help experience a sense of efficacy at doing so. Patients who have achieved some degree of symptom remission through using active techniques seem to

have enhanced self-esteem, greater vitality, and a more harmonious self-experience, all indicative of improved self-cohesion.

A psychoanalytic treatment that includes active help with symptomatic problems may or may not be brief. Use of such active techniques may be particularly important in brief treatments where symptom reduction is feasible given the time limits but characterological change and in-depth exploration are not. However, active techniques should be considered in longer term therapy as well. Patients will differ in their experience of treatment goals in such treatments. Some patients whose symptoms have improved will be content with what they achieve in a treatment lasting several months to a year. Others will wish to pursue much more prolonged and deeper self-exploration and in fact may be significantly more capable of doing so when less troubled by symptoms. Many patients will experience curiosity about themselves and their development of particular difficulties only after some symptom remission, and will then engage in a long-term therapeutic process.

Techniques of Symptom Management

It is beyond the scope of this article to describe in detail the many behavioral and cognitive–behavioral techniques currently available; useful descriptions can be found in such resources as Goldfried and Davison (1976) and Lazarus (1981). Some techniques such as systematic desensitization can be quite time-consuming and are less easily integrated into a psychoanalytic treatment. The techniques that I have found most useful are self-monitoring, relaxation training, assertiveness training, and cognitive restructuring.

Self-monitoring consists of keeping records of problematic behaviors in order to understand clearly how often such behaviors occur and what the antecedent events tend to be. Patients would thus keep charts or make journal entries detailing their symptom episodes, and patient and therapist can then collaborate on understanding the interpersonal situations, difficult affects, and so forth that tend to precede such problems. The technique is useful for expanding a patient's awareness of behavior that may be somewhat disavowed or dissociated. Patients are often surprised and relieved to see that their behavior can be understood within a context of internal and external events, as they often experience symptomatic behavior as mysterious and senseless. An increased sense of mastery and control may result. At times, self-monitoring alone is relatively effective in reducing symptomatic behavior. It is particularly applicable for record-

ing discrete symptomatic episodes such as panic attacks or bulimic episodes, but it may also be useful as a chronicle of shifting mood states for anxious or depressed patients.

Relaxation training is useful with chronic anxiety and related problems such as insomnia. It consists of verbally guiding the patient through a series of suggestions to relax various muscle groups (see Goldfried & Davison, 1976, for several different relaxation inductions). The exercise focuses on teaching patients to experience the difference between muscular tension and relaxation and gradually to induce deep relaxation. If a patient is interested in pursuing this after I describe the technique, I will take him or her through the progression once in session and then make an audiotape that the patient can practice with at home. After the initial session, little therapy time needs to be spent on the technique except perhaps problem-solving about any difficulties the patient may be experiencing in using the tape.

Cognitive restructuring (e.g., Beck & Emery, 1985) focuses on ways in which people process information and suggests corrections in habitual cognitive "errors" such as personalization or dichotomous thinking. Frank (1993) considered such techniques incompatible with a psychoanalytic approach because it is difficult to reconcile such correction with a view that the patient's way of construing events is plausible. In contrast, I propose that such techniques can be implemented in a fashion that is respectful of a patient's subjectivity by emphasizing the genesis of problematic perspectives on self and other in early interactions with caregivers. The therapist can comment that a patient learned to think in a certain way about her- or himself and others because of particular parental responses but that she or he may wish to reconsider the situation, including the effects of holding certain beliefs, from an adult perspective. Patients often find it useful to track their ingrained methods of information processing and interrupt the conclusions drawn by reminding themselves of alternative conceptualizations. Depression and anxiety symptoms may improve as a result. There are numerous similarities between the concept of cognitive schemas and ideas about internalizations of past experiences originating in various psychoanalytic perspectives, including various concepts of object relations, "internal working models" (Bowlby, 1973), and "organizing principles" (Stolorow & Atwood, 1992), which may facilitate analytic clinicians' comfort with this paradigm.

Assertiveness training (e.g., Alberti & Emmons, 1974) has become part of the self-help lexicon, but nevertheless many patients require therapeutic aid with verbally expressing their wishes in relationships in a

manner that is assertive rather than passive or aggressive. The technique involves therapist and patient discussing problematic interpersonal situations in which the patient wishes to speak up about perceived mistreatment or the like but is fearful of negative consequences or feels unentitled to her or his point of view. The therapist encourages appropriate communication, and together therapist and patient discuss optimal ways of verbalizing the patient's wishes and dealing with possible responses. Depressed patients who fear that self-assertion will result in abandonment or retaliation and hence are taken advantage of in relationships may particularly benefit from these interventions.

In implementing these techniques, the therapist must be artful, attuned, and warm, rather than mechanistic or overly technical. The focus may weave back and forth between explanation of the method, exploration of early determinants of the problem, and the current experience of the patient in the therapeutic relationship. Clinicians unfamiliar with symptom management techniques may imagine that their introduction and use must be abrupt and disruptive of the usual treatment, but it is often possible to achieve a relatively seamless integration of verbal exploration and symptom-focused techniques. The therapist begins by explaining a technique and its rationale, then asking whether the patient might be interested in working in such a way. If the patient declines, the therapist should be prepared to accept this for the time being, but there is much to explore in the patient's experience of the suggestion, fantasies of what working together in such a way might mean, fears of failure or change, and so forth.

More commonly, the patient will accede readily, and patient and therapist may then begin implementing a technique in an exploratory fashion, making sure to process the experience. Patients will bring their own unique organizing principles (Stolorow & Atwood, 1992) to this work as they do to all other interactions, so that reactions may range from gratitude and relief to fears of disappointing the therapist to resistance against perceived coercive demands. All should be discussed fully, and on this basis the therapist and patient together can decide the appropriate place, if any, of symptom-focused work in the current treatment.

Active Techniques and the Therapeutic Relationship

At times, use of active strategies for symptomatic distress can enable a focus on material that otherwise might be more obscure and more easily circumvented by a patient's characteristic defensive style. For instance, self-monitoring requires that the patient record and discuss symptomatic

episodes, a process potentially laden with shame and embarrassment. Patients sometimes attempt to titrate this humiliation by mentioning the symptoms in the initial interview and then filling session time with other material. Agreeing to collaborate on monitoring the problem provides access to aspects of the patient's world that might otherwise be too difficult to share and to the patient's feelings about disclosing such material to the clinician. Some patients will resist such revelation, "forgetting" to record material or to bring records to session. Inquiring about this avoidance may promote awareness and discussion of a patient's fears of exposure, rejection, vulnerability, and so forth. Obviously this interpersonal style would become apparent in various ways during the course of treatment, but processing the experience of self-monitoring may provide a useful, direct route to such issues in the transference.

Relaxation training is a helpful technique, but adding to the potency of this intervention is the impact of the patient's being given a tape of the therapist's soothing voice that he or she may listen to any time some calming is needed. Patients who lacked the sensitive parenting that facilitates the movement of dyadic regulation of affect and arousal to self-regulation (Sroufe, 1990) may benefit from a concrete representation of a regulating other during states of tension. Similar to Donnelly's (1980) suggestion that patients increase their self-calming abilities through imagining being in the therapist's presence ("the positive introject"), offering patients a relaxation tape can aid internalization of self-soothing via a relationship with an idealizable therapist. Patients who are quite vulnerable to fragmentation and may be at risk for severe tension states or self-destructive behavior might benefit from being given a tape, as demonstrated in some case material I discuss later.

Cognitive interventions offer therapeutic opportunities to combine attention to troubling symptoms with genetic interpretations, as therapist and patient explore together how the patient came to develop particular beliefs. The therapist can interpret failures of the early caregiving environment in responding to the selfobject needs of the developing child, furthering a self psychological treatment. Patients who gain some insight about the relationship between their life history and their depression or other symptoms will sometimes state that they are glad to understand this but that they want to know what they can do about it. Discussing the origin of problematic beliefs and offering some suggestions for implementing changes in them may provide a satisfying treatment experience. This combined approach may actually help patients tolerate more long-term treatment as they can observe incremental change.

Discussion of assertive techniques provides another opportunity to explore the impact of various sorts of responses on the patient—past, present, and in the therapeutic relationship—thus providing more useful material for an analytic treatment. Moreover, the therapist can demonstrate respect for the patient's wishes and validate that he or she should expect the same in other relationships. This process probably occurs in most analytically oriented treatments, but assertion training provides an opportunity for more focused attention and perhaps some education regarding these points. Female patients in particular may find it a novel idea to consider the legitimacy of their own wants and needs in relation to those of others, including the clinician, and may be able to become more disclosing about them in treatment following such discussions.

Analytic treatments have often erred in the direction of therapist underactivity and underinvolvement as experienced by the patient (Lindon, 1994). The iatrogenic effects of a treatment relationship that is not felt to be sufficiently active and helpful may be considerable. In such situations, it is difficult to ascertain what organizing principles the patient may be bringing to the relationship, as the deleterious impact of nonresponsiveness is the supraordinate factor in the treatment. In therapies where more active help is provided, not only are more patients likely to feel more satisfied with their treatment, but it also may be easier to observe patients' organizing principles in response to a less depriving experience.

It is gratifying for therapist and patient alike when this mode of collaboration feels congenial and results in positive changes. However, the ease of symptom remission in general is related to level of psychopathology. Patients whose overall disturbance is milder seem to be more amenable to active symptom management early in treatment. The increased self-cohesion that might be expected from a patient's having entered a positive therapeutic relationship can help less impaired patients mobilize to deal with conflicts, anxieties, and self-destructive habits relatively effectively. However, patients who have been more profoundly traumatized may be relying on at least some of their symptoms to help them maintain such limited self-cohesion as they possess, or the level of internalized conflict may be so profound that the rigid character structure must change before symptom amelioration is possible. Nonetheless, it may still be worthwhile to proffer symptom-focused techniques with more disturbed patients, as it is difficult to predict who will find them beneficial. Patients who are unable to use such techniques early in treatment may return to them as treatment progresses. The therapist should be aware that serious characterological psychopathology will affect the utility of these

interventions (as it does most others) and tailor expectations accordingly. As with other therapeutic endeavors, it is useful for the clinician to have a hopeful and curious attitude concerning the impact and to deal with any countertransference disappointment or frustration rather than blame the patient if little change occurs.

Timing is important, and active interventions should be offered on the basis of a therapeutic response to the patient's situation, not the wish of a frustrated therapist to do something. Frank (1992) cautioned against the therapist's implementation of active techniques on the basis of an inadequately understood countertransference reaction and suggested that the therapist should evaluate the idea of introducing active techniques for its possible countertransference meaning before deciding how to proceed.

It must be understood, however, that all therapeutic exchanges, including the use of active techniques, occur within a context of particular transference–countertransference configurations. Use of active techniques, as well as failure to use such measures, furthers particular transference and countertransference experiences. I believe that more positive transference and countertransference configurations may be promoted at times by use of active techniques (the converse, of course, is also true). I present some case material in which a transference and countertransference pattern that was becoming very difficult for patient and clinician alike was ameliorated by the introduction of a symptom-management strategy.

Sandy entered psychoanalytic psychotherapy with me reporting a history of severe depression that included one suicide attempt, a hospitalization, and several years of psychotherapy. She also reported severe anxiety, panic attacks, multiple physical problems, and difficulty functioning at her job. Eventually it became clear that she had an extensive history of sexual abuse and a dissociative disorder. Sandy's symptoms primarily corresponded to my third category of pathways to symptom formation; her terrible trauma history resulted in the use of dissociation to protect herself from unbearable knowledge and affects.

Sandy had to be hospitalized when her suicidal impulses could no longer be managed as an outpatient. In the hospital Sandy had continuous access to staff to help her handle panic states induced by emerging memories and rageful affects. She expressed great anxiety at the prospect of leaving the safety of the hospital and having to manage affects more independently. She also was experiencing much upset in her relationship with me, castigating herself for having become so dependent on me and fearing my rejection. I was very concerned about our posthospitalization relationship as well. For months prior to her inpatient stay, Sandy had been

calling me on a daily basis outside of our three sessions per week because she was panicked or suicidal. These calls often took place late at night and were quite disturbing and anxiety-provoking for me despite the help I was receiving from extensive consultation on her case. I felt it would be beneficial for both of us if she became more able to manage her self states without such frequent calls.

Late evening hours were the most distressing for Sandy, as she frequently was unable to sleep till early morning and would anxiously lie awake feeling isolated with her disturbing and tormenting thoughts. I proposed making her a relaxation tape that she could listen to at such times, and she expressed great enthusiasm. She responded well to the in-session relaxation exercise, but it was her use of the tape at home that proved very significant. She stated that the tape helped her feel that she was still connected to me even when I was not with her and that she felt calmer and less alone. This helped considerably with her insomnia and management of affects, and her profound fragmentation began to improve.

Sandy still called me outside of session, but less often, and the frequency of calls was less problematic for me. She also reported feeling much more comfortable in our relationship, with less worry about feeling desperate and being rejected. A theme throughout Sandy's life had been the development of a level of neediness and preoccupation with a friend or intimate that ultimately the other found intolerable, resulting in the termination of the relationship and Sandy's intense pain about yet another rejection. Listening to a relaxation tape enabled this distressed patient to use the therapy relationship while simultaneously maintaining some self-sufficiency, and this use of me by proxy at times was considerably easier for me than constant late night suicidal calls.

This technique did not obviate the importance of processing the larger issue of Sandy's having more needs for me than I could fulfill and the intense grief, rage, and shame that accompanied this for her; on the contrary, we included detailed discussions of the impact of using the tape and of actually calling me in our analysis of the current interaction. These exchanges also afforded numerous opportunities to explore genetic and life-history material concerning need and responsiveness in relationships; Sandy's tendency to "test" people, including me, with her behavior; and her expectation that she would always drive everyone away. I believe that the treatment at that time included extremely complex repetitive transference and countertransference processes but was also affected by a genuine skills deficit on Sandy's part concerning self-management of painful affects. This deficit could be partially remedied by the external assistance

of the tape in promoting relaxation. This enabled enough de-escalation of the intense transference wishes for round-the-clock care from me and equally intense anxiety and rage that such care would not be forthcoming so that they could be processed in a more manageable fashion. Sandy used the relaxation tape regularly for the next few years and ultimately found that she no longer required it. Treatment continued to a successful conclusion, with Sandy's occasionally making a reference to those "terrible times" in her life and how helpful it had been to know she could calm down through using the tape.

Concluding Comments

Current psychoanalytic relational perspectives such as self psychology that emphasize the importance of optimal responsiveness and empathic appreciation of a patient's perspective can encompass an integrative approach. Active techniques originating in behavioral and cognitive treatments may be used analytically and adapted accordingly. Stolorow and Atwood (1984) described psychoanalytic treatment as a method by which a patient acquires reflective knowledge of unconscious organizing and structuring activity. The active techniques I have described may facilitate this process by helping patients to focus on their internal states and interpersonal interactions.

Wachtel (1994) noted that this is an era in which psychotherapy integration is proceeding rapidly, but that the existence of "separate and bifurcated cultures" (p. 122) remains pervasive for psychoanalysis and behavioral therapy. This is regrettable, especially when current trends in relational psychoanalytic thought and the newer cognitive bent in behavioral theory imply more common ground than was formerly true. Ghent (1995) commented that in the psychoanalytic emphasis on helping patients achieve insight, psychoanalysts may overlook the "plurality of routes" (p. 486) by which psychic change occurs. A new relational experience that provides active help with symptomatic distress may generate internal and external changes that would not otherwise occur.

The ideas put forth herein are compatible with those of authors such as Gedo (1988) and Basch (1988), who discussed the need to remediate patients' skills deficiencies and restore competent coping, although my suggestions include the use of more formal techniques for doing so. This approach eschews piecemeal "eclecticism" and instead proposes that certain well-chosen techniques may be implemented analytically in a

fashion that furthers adaptive functioning, facilitates the therapeutic relationship, and strengthens the self.

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