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Editorial

Acting and reflecting in behavioural psychotherapy

Presumably, behaviour therapy attracts behaviourally-oriented therapists with proneness to action and decision making. Problems of patients are frequently tackled by directly inducing changes in motor, cognitive or emotional behaviour. "Symptom"-behaviours are regarded as obstacles that should be removed quickly; deficits of behaviour trigger skills training programs; frozen, stereotyped behaviour patterns in individuals or systems are to be broken up by communication techniques.

Most of us indulge in such actions with the strong impression of reinforcement by success.

Upon reflection of our actions what risks are we likely to encounter?

1. We may deprive ourselves of the chance to analyze compensatory or protective individual or interactional functions of "symptoms", thus trying to remove them before the patient is "ready" (Hand 1981*b*). It seems easy to derive, that increased checking can be an adequate response to depression or certain organic diseases of the brain, as it may help to reduce mistakes due to impaired functioning of memory. But there seem to be much more subtle protective functions of "symptoms", especially in social systems. (I don't mean this as a rule—but even the exception should be explored.)

2. We may not recognize our own "blind spots" with regard to moral, socio-economic and political "norms", affecting our goal-setting in therapy.

(a) Previous treatment programs to suppress existing sexual responses (and to establish "better" ones) in male homosexuals may frequently have been applied according to moral norms of social pressure groups rather than to the needs of individual patients. Treatment programs for other sexual "disorders" even created those "disorders" by trying to impose norms of psycho-professionals on the general population.

(b) Standard treatment packages with the main aim of getting alcoholics "dry" are to a great extent guided by the norms of Alcoholics Anonymous. Their relevance for the individual "alcoholic" in behaviour therapy practice has still not been assessed. How could they help those "alcoholic" patients who appear confused by the cultural double-bind: "You drink?—Jolly good fellow, let's have another drink"—"You are a drinker?—Poor chap, stay dry or you will die. Cheers."

A similar example regarding obsessive–compulsive behaviour: most of the achievers (ourselves included) in industrial societies are conditioned to

function in an obsessive–compulsive pattern, as this makes them productive, predictive and controllable. Some of our obsessive–compulsive patients seem to be the "accidents" of this huge cultural conditioning paradigm—trying to save their souls by shocking their environment with excessive or "absurd" variations of the required "sane" obsessions or compulsions. How difficult for the behaviour therapist to protect himself and his patient from premature, inadequate goal-setting in treatment.

(c) At the European and International Behaviour Therapy Congress in 1981 it was claimed that unemployment can be overcome by training job-seeking skills. No mention of socio-economic or political aspects of unemployment. No questioning whether such programs might not just create "winners" who push out the "losers", who originally held the jobs. Did the authors really want to imply: the higher job seeking skills in a nation, the lower the unemployment rate? As so often at recent congresses, no time left for discussion.

These examples may appear to be exceptions. Yet, in more subtle ways we are frequently exposed to the risk of making similar mistakes resulting from a "high action/low reflection"-ratio. It might help to get our actions more safely based upon reflection, if in 1982 this journal could attract papers concerned with the following topics:

1. Individual and interactional functional analysis of "symptom"- and "problem"-behaviour and its impact on goal setting for treatment.

2. Strategies for unfolding hidden motivational problems in patients and therapists (Hand, 1981*a*). "It has been erroneously assumed that voluntarily entering psychological treatment is prima facie evidence of a desire to change" (Kanfer and Grimm, 1980).

3. Contextual analysis of the socio-cultural, economic and political framework of treatment. This includes reflection upon the norms of our patients and ourselves in these areas.

All this, it is hoped, can be done with the methodology of experimental psychology, as long as we remain open to the observation of real events and ready to question established concepts. In fact — whatever the resulting changes in clinical practice — behaviour therapy would thus remain its true self.

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