Psychotherapy Guidebook

Implosive Therapy

Lowell H. Storms

Implosive Therapy

Lowell H. Storms

e-Book 2016 International Psychotherapy Institute

From *The Psychotherapy Guidebook* edited by Richie Herink and Paul R. Herink

Table of Contents

Implosive Therapy

Lowell H. Storms

DEFINITION

Implosive Therapy is a form of desensitization, which means that it involves repeated exposure to anxiety-provoking stimuli. These stimuli are usually presented in the form of visual imagery guided by the therapist's vivid descriptions. A continuous series of such images lasting fifty minutes or more is presented, with the imagery becoming more and more frightening and more catastrophic. The subject is encouraged to feel as much anxiety and fear as possible. This contrasts with Systematic Desensitization, which involves short presentations of mild images that are terminated when the subject reports anxiety. A very similar approach called "Flooding" was developed independently in England. Flooding involves not only imagery, but sometimes exposure to real life or in vivo fear-producing stimuli. Occasionally Implosive Therapy may also involve in vivo exposure to stimuli.

Implosive Therapy is more likely (than Flooding) to include material inferred from the patient's "dynamic" conflicts.

HISTORY

Pioneered in the 1950s by Thomas Stampfl. the first published description of Implosive Therapy appeared in 1964. In 1966 a series of promising published reports of empirical studies on the effectiveness of Implosive Therapy began appearing. A few years later reports from England on the successful use of flooding began to be published. Active investigation of the technique is still under way.

TECHNIQUE

The rationale for Implosive Therapy involves extinction of conditioned fear and anxiety. Fear is learned by the pairing of previously neutral stimuli with painful events. Neurotic symptoms develop as ways of avoiding the conditioned fear-producing stimuli or related stimuli. In order to extinguish the fear, it is necessary to circumvent the avoidance behavior and persuade the person to face the fear-inspiring stimuli repeatedly. This is where Implosive Therapy comes in.

Implosive Therapy begins with two, and perhaps more, evaluative interviews with the patient. The first interview includes history taking and general exploration of the patient's fears and other major complaints. What the patient is afraid of, the situations that elicit the fears, when they began, and how they have affected his life are discussed. I find it helpful to give a fear survey schedule, an MMPI (Minnesota Multiphasic Personality Inventory),

and perhaps a life-history questionnaire before the second interview. In the second interview there is further investigation to obtain as much detailed information about the patient's fears as is possible. Inferences are made about these fears from what the therapist knows about the patient's history and his modes of adapting to life situations.

A story is then developed using the data at hand and the therapist's imagination. The story consists of a series of scenes to be described by the therapist in vivid imagery as the patient visualizes the sequence of events. The story generally begins with imagery related to the relatively mild and more peripheral fears and then becomes progressively more disastrous, catastrophic, and gruesome. In contrast to Systematic Desensitization, Implosive Therapy builds up to the most frightening material as rapidly as the patient can tolerate it.

To accustom the patient to visualization, a pleasant or neutral scene is described and the patient is asked to visualize it with his eyes closed. During this practice and from time to time during the story itself it is important to check how well the patient is visualizing. The patient is asked whether he is seeing it clearly and also how he is feeling. Rather than relaxing, the patient is encouraged to experience as much fear and anxiety as possible, including suggestions of rapid heartbeat, sweating palms, etc.

The story — which may contain such gruesome elements such as the patient being brutally beaten and murdered, being immersed in feces, or being condemned by the eye of God — must continue for forty-five minutes to an hour. Research evidence suggests that shorter stories are less effective. Although it is not standard procedure, I add a relaxation exercise taking about ten minutes at the end of the story. This reduces the residual tension and helps heighten the contrast between the frightening fantasies and the safety of the office.

The same story is visualized repeatedly until the patient is bored with it and reports no more fear. Sometimes the most gruesome scenes are not included in the first presentations of the story but are added later. Early portions of the story that no longer elicit anxiety may also be dropped.

An audiotape of the story can be made to be listened to by the patient once or twice a day at home. While there is some evidence that audiotapes are not as effective as implosion in the office, playing a tape at home may speed up treatment for cooperative patients who visualize the scenes clearly.

Sometimes a patient will experience increased fear after the first session of Implosive Therapy. For this reason it is helpful to schedule the first two sessions in quick succession, preferably on successive days. Research suggests that five sessions or more are necessary to get results; Stampfl

suggests ten to fifteen sessions for most cases.

APPLICATIONS

There is no evidence to support the opinion of some writers that Implosive Therapy is unsafe. In a few cases, patients have had an increase in their fears after their first session of implosion, but the patients returned for further treatment and showed notable improvement. It appears that if a patient does the extensive and vivid visualization repeatedly for at least forty minutes per session and at least five sessions, he is likely to improve.

While more research is needed on the indications for appropriate use of Implosive Therapy, some kinds of patients appear to be especially likely to benefit from it. People with agoraphobia (fear of leaving home) apparently benefit more from Implosive Therapy than from Systematic Desensitization. Such patients characteristically have multiple fears, and other patients with multiple fears also seem to benefit. Obsessive patients, who do poorly in insight-oriented psychotherapy, are frequently helped by implosion. Hospitalized depressed, anxious patients showed greater improvement with Implosive Therapy than standard hospital treatment or a free association desensitization technique. A five-year follow-up showed this improvement was also maintained better. Another indication for the use of Implosive Therapy appears to be when fears are attached to a person's impulses or

fantasies. For example, many patients are afraid of their own anger, and implosive imagery involving expressions of anger can be helpful.

In general, I believe that in vivo desensitization, especially with modeling, is the treatment of choice where it is possible. For simple, specific phobias, systematic desensitization may be more reliably effective than implosion. However, neither in vivo desensitization nor systematic desensitization have much to offer for the kinds of cases we have described above.