THE THEORY AND PRACTICE OF PSYCHOTHERAPY WITH SPECIFIC DISORDERS

Psychotherapy with Patients with Anxiety Reactions

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Table of Contents

REFERENCES

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Anyone who wants to make a living from the treatment of nervous patients must clearly be able to do something to help them.

Sigmund Freud

Anxiety is our primary topic here. Phobia, one of the many ingenious ways man has found to relieve his feelings of anxiety, will be referred to from time to time in this chapter because anxious people act phobic too when the opportunity presents itself, but usually they do not look that far ahead. True phobics should be categorized with the obsessionals, who can smell anxiety a mile away and take evasive action; so I will leave them properly to be dealt with in the appropriate other chapters.

Very few psychotherapists have not experienced the reality of feeling anxious themselves. The vast majority of our patients spend a fair amount of their time feeling just that way. Thus, it is not surprising that we have placed "feeling anxious" at the heart of our psychopathologies and the relief of such feelings as at least one measure of our therapeutic successes. We probably should call it the management of anxiety rather than its treatment, because to be without anxiety altogether is to be hit by a car or to find that one has become "unexpectedly" pregnant. Like food, we have to have it, but anxiety is really only helpful in moderation. Our problem then is to keep it within reasonable bounds while maintaining its signal function, so that we can draw

upon experience to set an appropriate criterion for our performance. (*Note:* Some of this thinking was done with the support of the U. S. Army Medical Research and Development Command, 1966-67, Behavioral procedures in psychiatric practice, DA-49-193-MD-2638, and 1967-68 Metaphorical Communication—Its uses and changes when psychotic patients receive psychotherapy, DA-MD-49-193-67-G9240.)

For the sake of making a few points I have invented an evolutionary story we can share.

It might be fair to say that signal or expectant anxiety has been with man from the day he developed a bit of forebrain and some capacity for a bit of foresight. Perhaps an equally enlarged sub cortex adds an increment of foreboding. Somehow I suspect that in the evolution of man, this heightened capacity to sense impending danger and respond to it flexibly has provided the basis not only for our survival but for our extraordinary development of secondary process thinking as a way of coping with our pervasive uneasiness about what is going to happen next. Both morbid and simply expectant anxiety then can be described as a response sequence set in motion by a present stimulus. We have one fundamental criterion to judge its morbidity—that is, if its signal elicits a response sequence quite out of keeping with the average expectable response of such an environmental event. Here we can account for a variety of idiosyncratic behaviors, including the category of

"acting anxious," when anxiety so far overshoots its signal function that it preempts the stage and thus leaves no room for corrective search and response sequences, by inferring that they all are responses to a peculiarity of the individual's foresight.

From the standpoint of safety, primitive man found it imperative, if not certainly convenient (and I think desirable), to live in groups, as do many of our relatives in other primate groups to this day. Then, as now, the preservation of the group was crucial. For this purpose one of the group's important functions is to control prediction to encourage and constrain the individual's own predictions such that they fall within the limits of what is good for the group. This avoids the risk of idiosyncratic predictions which when acted upon hazards the group as a whole. This group function has a developmental consequence in view of our long period of dependency in childhood; thus the family group must be considered the primary transmitter of a child's reasonable expectancies or what Jerome Frank calls the child's "assumptive world."

As the group became larger than a single family unit, some method for achieving consonance may have needed to be devised among families which still took into account individual survival. This may well have been the beginning of the development of the role of priest or shaman. His task was to structure those predictions for the individual that could come in conflict

either with a prudent man's definition of reality or with the good of the larger group. The evidence that myths in the oral tradition have evolved in every preliterate society strongly suggests that they developed in consonance with man's ethology and are as characteristic of social man as is the development of language. Such myths might best be considered not as tales spun on a long winter's evening but as analogs for predictive behavior using language as a mnemonic device.

Myths' subjects are birth, death, life transition—all anxiety foci. We have no reason to think that myth-making decreased in the literate societies but rather that literacy simply increased our mnemonic capacity—that is, our capacity to store and retrieve information. This development of longer and more complex mythically sanctioned behavioral sequences serves as convenient guiding referents for prediction, "templates" to interpret and prescribe action which could be achieved by rational prediction but would not be as convenient and orderly if they did.

Myth functions to sanction "packages" of socially significant time and effort which are not to be questioned; for example, anxious rites of passage like our residency training, mixtures of ritual and education which are to be taken for granted. This is for the benefit of the group, but, as you may well imagine, it also relieved the burden of choice for the individual on these larger issues, just as a daily routine permits us to get up and go to work

without the agonies of existential choice. Thus, perhaps the age of faith, which bridges the unseen and unknown, was born and lasted a million years.

Now we are told that the age of faith has given way to the age of anxiety. Our myths worn thin, we shiver in the cold fight, not of reality necessarily but of uncertainty. Some say we are now free of the myths that controlled us, and now we can see the face of reality. I share Levi-Strauss' idea that mythic thought is an essential component of mental life. The notion then (that we are without myths at all) may be the most damaging myth of all, especially if it provides no assumptions on which to proceed! It seems unlikely that self-evident good has changed. We still value health over (physical) illness; wisdom over ignorance (although the defense of innocence has its faddish moments); hope over despair; love over hate; productivity over indolence. But how to achieve them seems to call for some new or reaffirmation of some old behavioral sequences.

All of our present-day shaman are not on Madison Avenue cueing us from our television sets. A fair number of them are called psychotherapists. They come from a variety of the helping professions, including medicine, the clergy, clinical psychology, sociology and so on. Diverse though the academic backgrounds may be (psychodynamic or behavioral psychology), a common set of assumptions creates strong similarities in theory and technique. This common set of assumptions includes the notions that we are all more alike

than we are different; that differences exist on a continuum along which the patient may be induced to move; that, with a half-hearted sort of determinism, we hope that by bringing into awareness the past assumptions controlling our present behavior, we may achieve some degree of freedom of choice. Underlying all is a strong bias in favor of verbal interaction as the vehicle for treatment.

Far from being a handicap, this diversity of backgrounds can bring to the psychotherapist's training a wide variety of behaviors that add richness to the metaphor of whatever theoretical system with which he is identifying his work. We might feel sorry for the impoverishment of the hypothetical student trained in only one discipline, having read in only one discipline, who encounters a patient or a series of patients who do not fit his system.

Relatively few of our customers come to us because they represent any real and present threat to the group. Their trouble with the group is that what seems to work for others fails them or they fail at it. In fact, in contrast to our ancestors, they may have little or no sense of authentic group membership. Our society is so mobile today that group membership is no longer conferred and retained automatically as in one's family and community of origin. It must be defined, identified as to what is congenial and convenient; indeed frequently it must be intentionally sought out as part of our growing up. With all its hazards, this greater possibility of developing individual potential and

choice of groups is where our civilization is at. Our patients have all, to a greater or lesser degree, failed at both group membership and individuation. Even though we treat them as individuals we must recognize the need for their entry into an authentic and congenial group as one of the goals of treatment. This is not to be confused with group therapy which has its own special advantages and economies for some patients and may be very inappropriate for others. We cannot digress at this point to consider the timing in therapy of optimum group or therapeutic community experience for our patients. If we are to adequately canvas our resources for treatment, however, we must consider what training is better done in a group and what is done better with the therapist alone, while also acting as a representative of the healthier group toward which the patient is moving. Our uneconomic use of individual therapy is not in all cases a bad choice dictated by theory. Our theory itself is a response to our greater individualization in comparison to the average Sea-Dayak of rural Sarawak where group therapy has been the mode of treatment for centuries.

Most of our patients come self-referred because in the ordinary course of events, they find their lives difficult to live. Their needs are not different from those of others, but their success in getting their needs met leaves something to be desired. For many of them, the avoidance of anxiety has become such a major undertaking that the pursuit of pleasure seems to be irrelevant. Harry Stack Sullivan pointed out in his *Conceptions of Modern*

Psychiatry, just how much of our daily activities are security operations—that is, the avoidance of anxiety rather than the active pursuit of pleasure. Pleasure itself is hard to define in positive terms. Reduction of tension in a need system is not very far removed from the reduction of anxiety. Put positively, it might come out that pleasure is simply the affect accompanying performing well under favorable conditions.

I wish to discuss those portmanteau terms, psychoanalytic psychotherapy and behavior therapy—both of which theoretically center upon relief of anxiety—from the standpoint of their complementarities rather than their differences. It is my view that there is no real contradiction in the theoretical polarities with which we are being presented. It is more a matter of what is covert in one system while being overt in the other.[1] It puzzles me why we strive for such purity of doctrine when it is the combination that works. Certainly the combination includes not only the relief of anxiety, which is a negative concept, but the training of new behaviors which can be performed well and the identification of favorable circumstances in which the patient can experience pleasure. Why not assume, rather than having two competing ideologies, each may have a different piece of the picture, neither complete nor irrelevant. Psychotherapists have abundant knowledge of the doctor's and patient's mental states and the vicissitudes of a therapeutic relationship but a narrow range of acknowledged techniques. Behavioral psychologists have an impressive array of techniques for observing and

modifying behavior—verbal, overt (motor) and visceral—but a curious lack of interest in the relationship other than viewing the therapist as a potential reinforcer of desired responses. We may be able to describe what they are doing in a way that heightens their effectiveness, just as they may be able to help us look at what we are actually doing in the treatment session. A final common pathway of theory and technique strikes me as logical, if not inevitable.

We analysts must admit that we have tended to refine and complicate our theory, possibly beyond its utility in doing psychotherapy. This behavior need be viewed neither as essential nor as perverse and capricious. It might be profitably viewed as part of man's pattern-making or myth-making propensity, an ethological sink-hole into which we tend to slip, much as the Breland's raccoons tended to slip into food-washing behavior at the expense of persisting in a more useful behavior sequence when the program of training ran too close to their innate food-washing sequence.

We have tended to ritualize our method. In our efforts to heighten our effectiveness or deepen our analyses, we have lengthened the period of dependency in treatment until it approaches the length of the original period of dependency in childhood. At the same time, we have been recommending such treatment for increasing numbers of patients in spite of Freud's endorsement of a wide variety of simpler psychotherapeutic measures which

he would not hesitate to use in appropriate circumstances. Horrified as we may be at treating a patient without the polite effort of making his acquaintance, as in Peter Lang's "automated desensitization procedure," we need to become more alert to the likelihood that a fair number of patients are probably waiting for some face-saving way of dropping a symptom. In our fascination with the unfolding of the patient's mental life, we may have tended to rely on the mysterious workings of his unconscious, perhaps even at the expense of good clinical observation and a responsive technique. It is for all these reasons that I suggest we broaden our view.

B. F. Skinner has been foremost in the efforts to establish a language and method of behavioral analysis which is based upon observable data generated from the close study of the individual over a relatively long and open-ended period of time. Rather than statistically comparing end results, he emphasizes clarifying the point-to-point relationships between the behavior of the experimenter and the behavior of the individual under study, with the assumption that out of such scrutiny some useful generalizations can be made. His method has been used in the operational study of a variety of transactions, including education, various forms of psychotherapy, as well as drug effects on the intact organism. This analytical approach is not to be confused with a system of behavior therapy based upon the discovery that a nod of the head means yes. Nor is it be equated with Eysenck's "learning theory" or Wolpe's "conditioning theory." They have their own language of

intervening variables, drawn in the main from the laboratory of Pavlov with the behavior considered as reactive to controlling stimuli, in contrast to the Skinnerian concept of behavior governed by its consequences.

It has become a convention in the numerous articles and summaries to refer to behavior therapy in general as “direct,” as opposed to the “indirect” method of psychoanalysis. “Indirect” seems to be used in the sense of seeking to remove the underlying cause, rather than addressing one’s attention to the presenting complaint. From my point of view Wolpe’s use of fantasy as a vehicle for reciprocal inhibition can hardly be described as more direct than analyzing a dream or a slip of the tongue, unless we consider it more direct to be inhibiting the report of a maladaptive response rather than eliminating a conflict by interpretation. In any event, both approaches use verbal exchanges in a therapist’s office in an attempt to influence the patient’s behavior outside the office, and they are both, in that sense, indirect. It seems rather that “direct” would imply addressing oneself to the symptomatic behavior *in situ* and modifying it, as has been done in some research settings with children; however, these authors present themselves as investigators rather than as behavior therapists. It would appear then that “behavior therapy,” as it is commonly defined, is not, in that total sense, direct, but rather follows the procedural method of Wolpe’s “systematic desensitization” method.[2] When we contemplate the dynamics of the curative effect of a technique such as systematic desensitization, all protestations to the contrary, it would seem

highly improbable that the transferences (the individual's unconscious carry-over of specific inappropriate learned patterns of response) which insinuate themselves into all relationships should not be present in the behavioral therapist's office. Indeed, Eysenck and Rachman's book on therapy introduces as parameters all the devices of conventional psychotherapy which leaves their definition of "behavior therapy" as a form of psychotherapy with the essential element of systematic desensitization, just as psychoanalytic psychotherapy may be defined as a form of psychotherapy with the essential element of interpretation (including interpretation of the transference as contrasted to psychoanalysis which focuses on the analysis of the transference neurosis).

Is interpretation the necessary, if not sufficient, ingredient of psychoanalytic psychotherapy? Given a technique which rests upon the fundamental notion of interpretation rather than relaxation as the therapeutic tool, what can we do to demonstrate a significant relationship between interpretation and behavioral change in the patient during the process of analysis itself, as well as subsequent to it? What is characteristic of a mutative interpretation? Is it "direct" or "indirect"? We have been taught that it includes three elements: (a) consideration of the transference, (b) consideration of the current life situation and (c) consideration of the patient's past experience. We have also been taught that when timely it works, and when it works, we can state only that there is a higher degree of

congruence between the patient’s witting and unwitting behaviors, that the move has been toward a higher degree of appropriateness in the here and now.

The interpretation itself may well be dependent on a careful scrutiny of the patient’s statements about past behavior and experiences with others to define the nuance of the behavior currently under study. Many authors express a critical concern with the historical truth of such interpretation. This correctness or truth of the interpretation is, however, actually validated not by extra-analytic attempts at historical research but by its consequences in modifying the patient’s behavior—either interrupting ongoing behavior or instating new behavior. What is often lost sight of is that the nature of preliminary interpretations and working through is such that whatever truth is established is tautological truth. Thus the question of validity is more properly addressed to the behavioral change rather than the ultimate historical truth of the concept used in bringing it about. Recognizing this aspect of interpretation is important in another sense, in that we tend to be mysterious about it rather than curious. Interpretation is directive at least in the sense of cognitive focusing. We select, we have something in mind, even if we profess unawareness we specify what new behaviors may be engaged in and what behaviors are prohibited. This adaptational aspect of interpretation is often ignored because our theory suggests that new, appropriate behaviors simply appear once the unconscious conflict has been brought into

awareness. This is also a weakness of Wolpe's theoretical position, with his emphasis on removing the maladaptive response rather than on the teaching of appropriate responses.

We are led then to ask how do we choose our way of engaging this common misery? If we consider "feeling anxious" to be an epiphenomenon of certain performances, then our technique can be at least as varied as the performances themselves. For example, the evolution of Freud's thinking about anxiety suggested three very different therapeutic strategies. In 1895, his definition of anxiety neurosis was that of actual neurosis. That is, in response to a present stimulus, there is an inadequate discharge of sexual excitation that remains in the body, seeking alternate somatic routes of discharge. Common sense observation indicates that incomplete drive behaviors produce an altered psychophysiological state.[3]

In 1917, Freud's lecture 25 of the *General Introduction to Psychoanalysis* is entitled "Anxiety." Here, he defined three categories of anxiety: reality or expectant anxiety, bound or phobic, and free-floating anxiety. The latter two are defined as reactions to internal danger—namely, id impulses which threaten discharge.

In 1936, when he wrote *The Problem of Anxiety,* his view had again changed somewhat. His position here, which is derived from the analyses of

Little Hans and the Wolf Man, is that morbid anxiety is an affect of the ego rather than arising in the id and secondly, that anxiety precedes repression rather than following it. Freud notes that in all of the psychoneuroses there is one motivating force behind the ego's troubles. This one force is anxiety, which Freud describes as castration anxiety, derived from a situation which is perceived as a danger far out of proportion to what we might define as a rational expectancy. All symptoms, inhibitions and defenses are means which the ego uses to ward off this anxiety; that is to say, the symptoms, the inhibitions and the defenses are behaviors—behaviors which are developed to avoid anxiety reactions to a situation which is perceived as threatening. If these behaviors are not developed effectively (or, as we said earlier, in moderation), anxiety becomes predominant in psychic functioning and paralyzes effective behavior.

The three therapeutic strategies to meet Freud's definitions of anxiety might be as follows. With regard to the actual neuroses, it would appear that by advice and guidance one might put an end to the abuse and allow its place to be taken by normal sexual activity. In the 1917 theory, anxiety is a response to repression. Therefore, it would seem that the appropriate way to alleviate anxiety would be by therapeutic catharsis or loosening of the repressed energies. In the 1926 theory, morbid anxiety is a signal-like expectant or reality anxiety; however, it is a response to a misperception. Therefore, it would seem that the appropriate mode of alleviating such

anxiety is to develop more adequate perception. Now, if our goal were to develop a unitary theory, we would have to choose which formulation is preferable. However, if we consider anxiety to be an affect accompanying certain performances, we are free to retain all three, using one or another strategy as the patient's performance indicates. We might take courage from

Freud, who wanted a unitary theory as much as any of us and yet said in his 1926 paper:

> It might still be true, therefore, that in repression anxiety is produced from the libidinal cathexis of the instinctual impulses. But how can we reconcile this conclusion with our other conclusion that the anxiety felt in phobias is an ego anxiety and arises in the ego, and that it does not proceed out of repression but, on the contrary, sets repression in motion? There seems to be a contradiction here which is not at all a simple matter to solve. It will not be easy to reduce the two sources of anxiety to a single one. We might attempt to do so by supposing that, when coitus is disturbed or sexual excitation interrupted or abstinence enforced, the ego scents certain dangers to which it reacts with anxiety. But this takes us nowhere. On the other hand, our analysis of the phobias seems to admit of no correction. Non liquet. [It is not clear.]

It is this lack of clarity of which Freud complains that we should actually welcome, because it dispels any notion that the presence of anxiety dictates any single treatment strategy and throws us back directly to the observation that anxiety is an affect accompanying certain performances, because the patient's performance, not his anxiety, is the interface at which we meet. It is also important for us psychoanalysts to recognize that understanding the

dynamics of a performance is not identical with the treatment of choice.

Robert White, in his monograph “Ego and Reality in Psychoanalytic Theory,” laid much of the groundwork for a sound rapprochement between psychoanalytic ego psychology and the behavioral psychologists with his emphasis on competence and the need for the development of a general theory of action. He points out that classical psychoanalytic theory and method, so superbly adapted to uncovering unconscious processes, is very limited in helping us learn about reality and how to be effectively active in it. If this is so, we have several alternatives. We can confine ourselves to the psychoanalysis of a very select group of patients, for whom simpler measures fail in other people’s hands, or we can see what other methods and theories there are which may have something to contribute to our own repertoire. Assuming that we are all willing to give sound advice to the actual neurotic, help him relax if need be, present an opportunity for catharsis when appropriate, what more can be said about the treatment of anxiety as an affect of the ego? Because I am inclined to agree with White that what the ego is concerned with is competence, I also see the ego as primarily a control device concerned with the appropriate staging and phasing of behaviors. Our assumption is that even seemingly erratic behavior is in fact consequential, often at a level below awareness, and that the elucidation of its consequences is our major vehicle for treatment (making the unconscious conscious). For this reason I am confident that behavior analysis along Skinnerian lines can

be helpful to us (Goldiamond and Dyrud, 1966). Such an approach in no way precludes our investigation of the roots and multi-level relationships of a symptom, it simply gives greater precision to our descriptions.

At any event, when we turn to the study of the functional relations of the human organism with his environment, if we are not to credit ESP, we must devise some language of observables in which to make our observations and validations. Our criteria must be defined in terms that can be specified and observed. For this reason I like Joseph Brady's description of anxiety: "If we draw two lines on a graph, the upper one called expectations and the lower one called performance, the distance between them may be called a measure of anxiety." Phobia then may be described as staying off the graph. Simple as this may seem, the model gives us two handles on the problem of anxiety: we can treat it by either raising the performance or lowering the expectations. A good psychotherapist of any school very likely reduces anxiety initially by the latter method. His warmth and acceptance suspends contingencies for the time being and permits the patient to experiment with raising his performance level, along with an almost imperceptible rise in expectations. All of our emphasis on trust and understanding as a basis for successful psychotherapy may well relate to this necessity of overriding the patient's initial criterion, which is, at the moment, too high and substituting for it responses which support uncertain and inadequate moves in the right direction. If this fails to happen, the patient has only the choice of bitter

disillusionment or chronic attachment to the therapist, because nothing outside the sessions improves.

Any effort I know of to improve performance of alienated people without this ingredient of trust or social reinforcement, to put it minimally, has failed to persist.[4]

It is true that punishment can knock out an aberrant behavior when one is dealing with an acute disruption of an otherwise fairly adequate repertoire of behaviors. One of the problems with it is that it not only suppresses the target behavior, but it tends to suppress behavior across the board, and if the patient is not emitting a wide range of behaviors to begin with you might find you have very little left to work with. It is also true that the prospect of punishment must be maintained indefinitely unless a different behavior is developed which better achieves the goal of the aberrant behavior. Ayllon and Azrin's schizophrenics on their token economy ward showed perfect A-B-A reversals because their behavior was rigorously linked to the token economy, without the phasing in of social reinforcement. Such rigor was essential to test the model, and later work has demonstrated the success of phasing in social reinforcement as a way of maintaining the new performance level in the community.

In the office, we may not need behavioral gimmicks like a token

economy, but we do need a good start. Don’t we all start out with a few simple techniques first without violating any of our theoretical principles? For instance, the initial history-taking takes the form of helping the patient identify his up till then private and subjective misery as something the doctor feels competent to help him with. Wolpe finds phobias; psychoanalysts find a broader history of maladaptation. In either case it is critical that doctor and patient together feel successful in identifying something they can work on. If the patient has some capacity for trust, the work can focus quickly on his specific behavioral deficit and the more we know about techniques for discrimination training, relaxation training or just plain sound advice, the faster he will be relieved of his need for treatment.

> A 45-year-old physician came in with an intense concern over his “cardiac symptomatology,” palpitation and shortness of breath, although he assured me there were no physical findings to support a diagnosis of heart disease. As he sat leaning forward in his chair in a mixture of eagerness and embarrassment telling his story, I was impressed by the fact that he was holding his breath. I suggested that he lean back, drop his shoulders and exhale. As he did so he began to cry. With some encouragement to let himself feel the emotion he sobbed for a time, then reported that the tightness in his chest was gone. Reviewing some of the fleeting thoughts he had had while crying, he reported that it seemed so sad that his condition might lead to his leaving his wife and newly adopted son alone in this world. He left feeling much better.
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> During the next two visits his sadness turned to fury over the little intruder’s presence, and his wife’s insistence on adoption when after many years she had failed to become pregnant. As he turned these thoughts over in his mind he recalled the birth of a younger brother and some of his feelings at that time. Throughout this period of review the fury eased and a

> warmth and regard for both the baby and mother were evidenced. We stopped by mutual agreement.
>
> This fleeting encounter of three visits seems profane in our day of long-term treatment, but it was over eight years ago and the family has grown and prospered. He was ready to trust another person to help him discriminate past from present, perhaps ready for confession and absolution, in any event he was relieved of his distress.

There are many patients for whom such a trusting relationship needs to be developed and examined before they can profit from their new performance level by becoming part of a congenial social group. I think what we actually do first in developing a relationship of trust needs to be spelled out a bit, to clear up the possible misconception that some therapists simply have it and others do not. Whitehorn and Betts' type A and type B therapists, rather than being immutable diagnoses, may have more to do with our inchoate theories of technique rather than with innate limitations of the therapists. Their type A therapist was three times as successful as their type B therapist in eliciting improvement in schizophrenic patients. The two groups were indistinguishable in their results with depressive and neurotic patients.

If we assume, as they did, that the schizophrenic patients had a greater problem with trusting another person, we can learn from their data some of what we have to teach. The type A therapists were more interested in the patient's personality than in his psychopathology. They were actively involved in their relationship with the patient rather than applying treatment

to him. Their treatment goals were defined in positive terms of personality growth, often quite specific, rather than in terms of eliminating symptomatology. In other words they were located toward the evocative end of the therapeutic spectrum, whereas the type B therapists were located toward the directive end. I wish to emphasize the notion of a single spectrum of psychotherapeutic approaches with classical psychoanalysis at the evocative pole and behavior modification at the directive pole. Assuming some sort of a normal distribution curve between trust and distrust in our patient population, we might then assume that the vast majority of our therapeutic efforts should be an optimum mixture of directive and evocative techniques. Ian Stevenson's description of such an approach is very much to the point here.

When expectant trust is high, it may not be too critical what technique is used; directive techniques may be the fastest. When trust is deficient, directive therapies falter and evocative therapies take a longer time. In such a case the therapist is strongly drawn toward polarizing his technique—to become more purely directive or purely evocative in order to strengthen his own conviction and thus maintain his own behavior. I am of the opinion that usually this is an unfortunate security operation on the part of the therapist. Our task is to build that deficient trust by a patient and diligent attention to the patient's need for the kind of emotional arousal that emerges from discovering with the therapist that in some small ways he can be successful.

> Some years ago I saw an alcoholic, childless woman who was entering the menopause. Her marriage was crumbling and her mother was dying of cancer. Scanning the field to find something to work on, I found that in her general apathy there was a small peak of unhappiness over her mother's unwillingness to eat that was hastening the elderly lady's death.
>
> Following Arthur Bachrach's prescription for anorexia nervosa, I suggested in her daily visits to the hospital, which were greatly prized by her mother, that she go at mealtime and stay only as long as her mother continued to eat. The experiment was successful. Not that the mother recovered, because in spite of the weight gain she died, but the daughter felt effective and also felt that she had been helped. This was the beginning of her opening up with me to examine many other ways of being more effective, and over a period of several years she was. Later on in treatment she described that early episode as one of being "recognized" by me as a really decent and capable person in spite of all appearances.

I am not concerned here with the charismatic healer's magic touch, but rather with a relationship of trust growing out of and responding to the alienated patient's need to be "known"—known in the sense of being permitted to be with the therapist more than the bearer of a familiar symptom complex. Once I had glibly written to a nonpsychiatric friend, Arthur Stratton, that therapy works because we are more alike than we are different. He wrote back, "yes, but aren't you always surprised by the people once they have done their best, or worst, to strip themselves bare for your help, aid or succor? They are the more mysterious for standing revealed, not mother-naked, but as bare as bare can be. Which is to say, with their hair on, clothed in scars." This is true in my experience. The new beginning of which Michael Balint speaks is based upon mutual acceptance of this core of

mystery in each participant. That is how trust is born in those who lack it. Much of our work with alienated patients from the very beginning must be toward removing obstacles from the path to this sort of intimacy.

Here history-taking transcends the statistical sheet to become part of the process of the patient's making himself known to another. In addition to factual recall, it calls for organizing one's inner experience into an intelligible communicable thought which requires an interaction with the therapist about what is consensually valid—meaning, not on the therapist's terms in a didactic sense but in terms of what they together can comprehend. In spite or rather because of the terrible personal and unique character of such an interchange, the therapist must remain clear as to his role of change-agent and representative of the prospect that the patient can find his way into meaningful community of his own. This process tends to gravitate toward the puzzling or distressing aspects of experience, which are seen to form fairly characteristic repetitive patterns as diverse as anxiety attacks, stomach distress or a temper tantrum. In most instances, these aspects of experience have a quality of inevitability for the patient, stemming from the lack of alternatives within the patient's awareness, a lack enduring over a period of time sufficient to permit question and answer alike to drop out of awareness. In the process of becoming "known," some of these troublesome behavior-controlling patterns become conscious and explicit. Then the repetition comes in as these patterns are tested verbally in many ways. Being "known"

gives strength to leave a shared question open until a new and more adequate answer develops. In the hands of a tyro, psychoanalytic theory or behavior theory may interfere when the therapist introduces a new system of causality rather than helping the patient transcend his need for a pat answer. This type of "working through" is the crux of therapy—that is, giving the support to prevent premature closure. The person who has been "analyzed" but unimproved has often simply learned a new set of answers by repetition of these same answers. The one who does not move in therapy may be dealing with a therapist who tries one answer and if the question comes up again, he tries a different answer; thus, the point of reference is lost and the patient is deprived of even the doubtful good of learning a new set of answers.

I have taken this rambling approach to our subject because I must admit to being rather bored with the mind-body dichotomy, which is represented by the humanist versus mechanist, psychotherapist versus behaviorist of today. All very reminiscent of the nature-nurture controversies of the 1930's which still flicker on from time to time. I say this because we have enough data at hand now to know that one cannot really be comfortable in either camp.

Behavior analysis can be of significant help to us in the opening moves of therapy which have more to do with ease than with intimacy, reliability and regularity of response rather than subtlety. We must also recognize that a fair number of patients can make it on their own from there. For those whose

loneliness is more established, however, a return to the “old self” is a goal I question. In this respect I agree with Ronald Laing that the patient’s symptomatology may be a creative attempt to enrich his barren life, but one that miscarries. In that sense, he cannot go back through the same door he entered without a real sense of failure. For these people there is that need to be known rather than understood with all its reductive implications. They need openness rather than closure. Perhaps technicians can help the easy ones, but the others require our broadest training and our best effort.

The patient who both requires and profits from this experience has reached the point of needing fewer simple cause-and-effect explanations and has some capacity to five with unsolved problems until sufficient relevant data is in to come to a conclusion. This is not a solitary strength but a confidence forged in a prototypical relationship with the therapist which generalizes to the patient’s interpersonal environment. His foresight has become both prudent and reasonably benign; he will have begun to find his authentic group.

In summary then, the anxious patient may need advice and direction to reduce the ambiguity of cues which make it difficult for him to proceed. He may need to be helped to relax to reduce the psychophysiological concomitants of his anxiety. He may need discrimination training to identify the stimuli as well as his inappropriate responses to them, whether called

interpretation or something else. Verbal psychotherapy is important to discrimination training as well as in labeling of inchoate experiences. However, a large part of psychotherapy, though unrecognized, is simply a sharpening up of the patient's expressive behavior. He must learn to discerningly trust himself and the other person, but not all within awareness. Awareness is simply never large enough to take care of all the responding required, and for this we have no vocabulary at all.

Notes

1 Fiedler's study of the behavior of beginners and experts during psychotherapy, with three very different theoretical orientations, demonstrated that there was a high correlation among the behaviors of the different experts as there was among the beginners but essentially no correlation between beginner and expert holding the same theoretical views. This supports my impression that as we develop more skill in our healing craft, we are brought closer to the actual myths we and our patients live by, needing the secondary elaborations less in our practice while still persisting in them in our fraternal activities.

2 Definition of systematic desensitization: Neuroses are persistent, unadaptive learned habits of reaction that have been learned under conditions of anxiety and can be unlearned by presenting stimuli for the neurotic response under conditions of deep relaxation. This is done in a systematic sequence beginning with the least anxiety-provoking stimulus, mastering it and proceeding to the next in its hierarchy.

3 When I was a boy on the farm, it was the practice to bring in a cheap stallion to "warm up" an expensive mare so that she would be receptive to the expensive stallion and not kick him. At the auspicious moment, we would lead the cheap stallion away and bring in the valuable one. Out behind the bam the loser would stand and sweat and shiver, pupils dilated—having to all appearances a full-blown anxiety attack.

4 Lang's subjects, who responded well to automated desensitization procedures, happened to be university students selected as paid subjects from a nonalienated, or at least non-help

seeking group, so we may assume that their capacity for trust was higher at tire outset.

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