THE TECHNIQUE OF PSYCHOTHERAPY

REEDUCATIVE THERAPY

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Reeducative Therapy

The relationship between patient and therapist in reeducative therapy has as its object the achievement of more extensive goals than in supportive therapy, namely, an actual remodeling of the patient's attitudes and behavior in line with more adaptive life integration. The therapist here attempts either (1) to influence the processes directly between the patient and his or her neurotic behavior, rewarding healthy responses, or (2) to release in the patient self-actualizing tendencies by utilizing the relationship as a corrective emotional experience. There is less emphasis on searching for causes than on promoting new and better forms of behavior. It is posited that individuals with help from a therapist have within themselves the ability to reorganize their values and behavioral patterns. Such approaches are more or less reeducative in nature and, therefore, may be designated as "reeducative therapy."

The objective in reeducative therapy, thus, is the modification of behavior directly through positive and negative reinforcers, and/or interpersonal relationships, with deliberate efforts at environmental readjustment, goal modification, liberation of existing creative potentialities, and, it is hoped, promotion of greater self-growth. No deliberate attempt is made to probe for unconscious conflict. Under these circumstances individuals may achieve sufficient command of their problems to enable them (1) to check acting-out tendencies, to rectify remediable environmental distortions, or to adjust to irremediable ones; (2) to organize life goals more rationally and to execute them in a facile manner; and (3) to consolidate some adaptive defenses and to alter others that are less adaptive. These are eminently worthwhile objectives, and, for reasons that will be considered later, are often as far as many patients can progress, even with the most intensive reconstructive approaches. Indeed, in many instances, reeducative therapy is the treatment of choice.

A fundamental assumption in reeducative therapy is that if one succeeds in altering a significant pattern in one's life, the restored sense of mastery will generalize over a broad spectrum of behavior. If substantial improvement is scored in one dimension of functioning, this may importantly influence other parameters of personality operation.

Reeducative therapy is conducted through (1) the implementation of a variety of techniques aimed

at reconditioning behavior or (2) an examination by the patient and the therapist of ways that the patient relates to people and to himself or herself. In the latter, manifestations of tension and anxiety are explored, and the patient is helped to recognize certain aspects of his or her behavior that are destructive to adjustment. The patient is then encouraged to experiment with new interpersonal attitudes and additionally stimulated to utilize his or her assets to best advantage so as to expand positive qualities within. While interview procedures are employed, little or no use is made of dream material, transference manifestations, and free association. Sometimes reconstructive changes occur as a consequence of reeducative therapy, although these are not specifically the objectives toward which treatment is directed.

The application of reeducative therapy requires specialized training that sensitizes the therapist both to aspects of behavior that require and will be amenable to alteration and to the recognition of gross interferences to the therapeutic process of transference and resistance. While personal psychoanalysis or personal reconstructive therapy for the therapist is helpful, it is not absolutely essential in executing this approach, provided the therapist does not have severe neurotic difficulties and can control countertransference if this begins to project itself harmfully into relationships with patients. Among reeducative therapeutic measures are "behavior therapy," therapeutic counseling, directive psychotherapy, casework therapy, "relationship therapy," "attitude therapy," distributive analysis and synthesis, interview psychotherapy, semantic therapy, reeducative group therapy, and certain philosophical approaches.

BEHAVIOR THERAPY

Behavior therapy continues to spread its influence over the entire field of human afflictions and disabilities. This is no fortuitous event since its methods have proven valuable in the hands of skilled practitioners. Books and articles on the subject and membership in behavior therapy organizations have increased in the past decade. To the traditional zone of behavioral distortions have been added internal mental processes and psycho-physiological ailments and habits. Maintaining the original dedication to the principles and findings of experimental psychology, behavior therapy has elaborated a plethora of techniques and a diversity of views that go far beyond learning theory and that are dedicated to the alleviation of all aspects of human suffering and the general enhancement of functioning. More

specifically, behavior therapy is said to address "clinical problems using (a) a testable conceptual framework, (b) treatment methods that can be objectively measured and replicated, (c) outcome criteria that can be validated, and (d) evaluative procedures for determining the effectiveness of specific methods applied to particular problems" (Lazarus & Fay, 1984).

Lazarus (1984) has stated that "there is scarcely a clinical entity for which a behavioral intervention strategy cannot be proposed and implemented." The literature includes discussion of behavior therapy in the treatment of these and other problems: affective disorders (De Rubeis & Hollon, 1981), alcoholism (Chaney et al, 1978), asthma (Creer & Kotses, 1983; Dekker et al, 1957; King, 1980, Philander, 1979; Richter & Dahme, 1982), back pain (Cairns et al, 1980; Gottlieb et al, 1977; Newman, et al 1978), cardiac arrhythmia (Benson et al, 1975), cardiac problems (Matarazzo et al, 1982), dental problems (Ingersoll et al, 1977), depression (Lewinsohn & Hoberman, 1982; McLean & Hakstian, 1979), geriatrics (Patterson & Jackson, 1980; Patterson, 1982), headache (Blanchard et al, 1979), insomnia (Ascher & Efran, 1978; Ascher & Turner, 1980; Bootzen, 1972, 1977; Borkovec & Boundewyns, 1976; Jason, 1975; NaHauri, 1979; Turner & Ascher, 1982), obesity (Stunkard, 1982), obsessions (Emmelkamp & Kwee, 1977; Foa et al, 1980; Marks et al, 1975, 1980; Marks, 1981; Rachman & Hodgson, 1980; Steketee et al, 1982), overeating (Stuart, 1967); pain (Fordyce et al, 1973; Fordyce, 1976; Roberts & Rheinhardt, 1980; Sanders, 1979; Stegar & Fordyce, 1982; Swanson et al, 1979), phobias (Ost et al, 1981, 1982), problems of children (Benson 1979; Brownell et al, 1977; Drabman et al, 1978), schizophrenia (Curran et al, 1982), smoking (Litchenstein & Brown, 1982), and urological disorders (Doleys & Meredith, 1982).

The many varieties of behavior therapy are commonly related to a behavioral learning model of psychopathology that focuses on "observable behavior" instead of on "hypothesized personality structures or presumptive subjective experiences" (Phillips & Kanfer, 1969). Speculation, appraisal, and interpretation are in terms of environmental stimuli and behavioral acts rather than inner conflicts and other "conjectural constructs." Modification of behavior is presumably bracketed to research findings and studies in experimental psychology laboratories. Being data-oriented, behavior therapy attempts to avoid speculative inferences about the meaning of events. This is not to deny the importance of such inferences or the usefulness of the reports of subjects about what is happening to them. But these concepts are not employed to explain behavior. The historical genesis of behaviors selected for modification is not

considered material for diagnosis and treatment, even though there is recognition that abnormal behaviors have historical origins. Rather, the circumstances that control and sustain these behaviors in the here-and-now are the central targets of treatment.

It is a common observable fact that encouraging a patient o behave in emotionally constructive ways and helping him or her to derive pleasure or to secure rewards for such behavior may reinforce the behavior to a point where it becomes an established pattern. Such relearning often results in the evolvement of new attitudes and values and sometimes even in cognitive restructuring. Though the auxiliary healing agencies (placebo, emotional catharsis, idealized relationship, suggestion, and group dynamics) play a role in the interaction between therapist and patient and transferential experiences and the working through of resistance undoubtedly take place, the principal therapeutic instrumentalities are directive stratagems and maneuvers designed to provide the individual with a corrective relearning experience. While not always successful (as with any therapy) such "behavior" or "conditioning" therapy has become a valuable instrument with which to approach certain emotional problems, and it has proved successful in many cases that have not yielded in the least to insight therapies. Particularly dramatic have been results in retarded, schizophrenic, psychopathic, addictive, and other patients who do not respond to the traditional interviewing and insight approaches.

Unlike conventional proponents of psychopathology who regard symptoms as surface manifestations of unconscious disease processes, behavior therapists base their operations on a social-learning model (Bandura, 1965b; O'Leary & Wilson, 1965; Franks, 1969; Rimm & Masters, 1974). This conceives of most maladaptive behavior as primarily learned response patterns that may be altered directly by manipulating stimulus variables of which the behavior distortions are said to be a function. Since it is believed that the distortions can be dealt with directly and adequately, it is unnecessary, in the opinion of behavior therapists, to introduce the concept of underlying pathology into their model on either practical or theoretical levels. Behavior therapy is thus organized around the conception of neuroses as learned maladaptive patterns of thinking, feeling, and behaving, conditioned by aversive experiences and sustained by reinforcements that prevent their extinction. It is also recognized that these learned patterns of behavior are superimposed upon biological determinants. Learned habits become fixed and refractory to elimination. Neither postulated unobservable events nor purposive and teleological principles, the bedrock of psychoanalytic theories, are employed as the basis for therapeutic

maneuvers. Behavioral deficits or excesses are considered to issue out of the patient's immediate historical environment. Consequently, a search is organized for pathogenic environmental variables in order to manipulate and modify them. Implicit in behavior therapy is the precept that whatever has been learned can be unlearned by reversing the learning process (Eysenck, 1960a&b; Staats & Staats, 1963; Reyna, 1964). But, by the same token, behavior therapists recognize that learned behavior can also be modified by nonbehavioral techniques (e.g., drugs) and, similarly, that changes brought about other than by learning (e.g., physical trauma) can be modified by some form of learning process.

A number of modes of learning reversal have been suggested. Originally, behavior therapists focused exclusively upon modification of overt behavior and the presenting complaints or "symptoms" of the patients. Gradually, behavior therapy is said to have evolved into its present sophisticated multimodal framework, which— while by no means ignoring presenting complaints—focuses upon all maladaptive systems within the patient, as determined by an intensive behavioral assessment conducted as a cooperative project by the patient and therapist in concert. Cognitions, affects, drives, and certain physiological processes are all considered modifiable in accordance with the principles of classical and operant conditioning, modeling, and related concepts. Classic is the historic case reported by M. Jones (1924a&b) of a child who had developed a great fear of animals in general after being bitten by a rabbit. Jones formulated the hypothesis that if he could get the child to associate rabbits with a pleasant emotion, fear of rabbits—and perhaps of all animals—might disappear. Upon complaints of hunger, he fed the child appetizing foods in sight of the rabbit held at a secure distance. Gradually he diminished the distance until the child was able to tolerate the close presence of the rabbit. This eventually extinguished the fear. D. Yates (1939), treating a girl who was upset emotionally by the presence of men, had her repeat the word "calm" while associating with it at the same time ideas of security, well-being, and peace. She gradually learned that constant repetition of the word in the presence of men sufficed to maintain her emotional composure. The use of aversive stimuli to correct untoward behavior was reported by Max (1935) and Mowrer and Mowrer (1938). Max treated a homosexual patient who was obsessed with homosexual thoughts whenever he came into contact with a certain inanimate object. Presenting this object to the patient and giving him an electric shock at the same time sufficed to terminate the power of the object to excite homosexual thoughts. Mowrer and Mowrer treated enuresis by constructing an apparatus that was placed in the bed of the enuretic child. The bed, when wet, caused a circuit in the

apparatus to close and to ring the bell, thus awakening the child. They discovered that after three or four such experiences the impulse to urinate in itself sufficed to arouse the child.

Modern forms of behavior therapy follow these early reconditioning tactics, but they base their rationale on current ideas about learning theory, particularly classical (Pavlovian) and operant (Skinnerian) conditioning (Hilgard, 1956; Kimble, 1961; Wolpe & Lazarus 1966). Self-knowledge and efforts toward reconstruction of personality, as the psychodynamic therapist views these concepts, are felt to be too time-consuming, productive of untoward side effects, unscientifically founded, and, above all, ineffectual. Accordingly, the reliving of the original formative experiences and knowledge of historical precursors of present problems are deemphasized both diagnostically and therapeutically. Instead, the individual is exposed to stimuli and to autonomic responses that neutralize fear and anxiety (classical or respondent conditioning). Where the repertoire of learned behavior must be expanded, principles of operant conditioning are employed, new behavioral tendencies being shaped by reinforcements toward specific goals.

In the past decade, formulations derived solely from learning theory have been considered too restrictive and concepts from experimental and social psychology have been employed to evolve useful interventions. The resulting techniques are relatively directive and aimed at manipulating the forces of behavior, which are believed to be recognizable, contemporary stimuli. Identifying the direction of the treatment, however, is a collaborative process arrived at by the patient, therapist, and involved "others." Treatment is an ongoing process that is subject to change and periodic review. The aim is always to maximize the individual patient's control of and responsibility for determining the nature and course of what is to be changed. Behavior therapy that imposes directives for change upon a patient is bad behavior therapy. Objectives are explicitly defined by mutual agreement with the patient, and conditions are deliberately controlled in order to change disturbing emotional reactions to provocative situations. Among the procedures used are the following:

1. *Desensitization* by exposing the patient to a rapid repetition of the stimulus and/or the response, with or without reinforcement.

2. *Extinction* of old responses by omitting either reinforcement or the original unconditioned stimulus that followed the eliciting stimulus or the instrumental responses.

3. *Punishment* by subjecting the patient to an aversive stimulus whenever the patient makes an undesirable response.

4. *Counterconditioning* by affiliating a different and opposing response with the conditional stimulus, followed by direct reinforcement of the opposing response.

5. *Cognitive restructuring* by dealing with attitudes and faulty ideas that influence behavior.

Positive Counterconditioning

In counterconditioning, the quality of the anxiety-inhibitory response utilized is related to the ultimately desired reaction. Thus, "assertive responses" are encouraged by the therapist, even to the point of "acting-out," in patients who have neurotic anxieties about asserting themselves with people. This idea is the basis of Salter's *Conditioned Reflex Therapy* (1961), in which, through authoritarian direction, the patient is enjoined to abandon destructive patterns of behavior and to practice new habits that will be of value to him or her. Postulated is the theory that healthy biological organisms are in a state of free emotional expressiveness (excitatory state). On the other hand, unhealthy organisms with emotional illness are said to be in a state of pathological inhibition, which has become a conditioned response and which blocks normal excitation. Therapy must be directed toward unlearning conditioned inhibitory reflexes and replacing them with conditioned excitatory reflexes. This is accomplished by deliberately practicing excitatory emotional reactions until they become established as conditioned reflexes. Thus, patients are encourged to express their feelings openly, accompanying these by appropriate or exaggerated motor reactions. Whenever they are in a situation where they disagree with others, they must deliberately and forcefully express themselves instead of inhibiting their feelings. Spontaneous reactions to new situations are preferred to assumed or conventionalized behavior. Expressing self-praise and promulgating one's own opinions and values are urged as a means of increasing self-confidence. By making them repeat such "positive" and "excitatory" acts, patients are said to be liberated from the harmful effects of inhibition. Thorne (1950) describes a method somewhat along these lines whereby fear reactions may be dissipated through a conditioning process of verbally admitting the presence of fear, of appreciating that it is a common reaction, of anticipating its arousal, and of training oneself to avoid inappropriate responses. Tasks are assigned that enhance emotional control and self-control, and the patient is reminded that many months will be required before success is

complete.

"Relaxation responses" through "systematic desensitization" are recommended for fears associated with almost every aspect of behavior. By presenting anxiety-provoking cues in a climate of pleasure or relaxation, aversive stimuli are, one hopes, mastered in progressively stronger forms. Amenable to this tactic are said to be a variety of emotional conditions, including tension states, anxiety reactions, behavioral inhibitions, phobias, and some psycho-physiological disorders. Among positive stimuli jointly presented with and calculated to neutralize the aversive stimuli are muscular relaxation (Wolpe, 1958; Eysenck, 1960a), pleasurable associations to interpersonal situations (English, 1924; Bentler, 1962), imagery of an emotive nature (Lazarus & Abramovitz, 1962), pharmacological agents that reduce sympathetic reactivity (Walton & Mather, 1963b), and food and sexual fantasies.

A form of this method known as "reciprocal inhibition" was developed by Wolpe (1958, 1961, 1969), who exposed animals with an experimental neurosis, while feeding them, to stimuli at first remotely related to and then more closely approximating the conditioned aversive stimulus. Increasing increments of anxiety were thus mastered until the original conditioned stimulus brought forth no reaction and the experimental neurosis was relieved. Around this finding Wolpe developed his theory of "reciprocal inhibition" to the effect that "if a response inhibitory of anxiety can be made to occur in the presence of anxiety-evoking stimuli it will weaken the bond between these two stimuli and the anxiety." In his technique Wolpe enjoins the patient to identify and to list in rank order a number (say, 20) of categories of upsetting stimuli. The patient is taught how to relax (hypnosis and self-hypnosis may be employed) for several sessions, and then in a state of relaxation is asked to bring to mind, for a few seconds, the the weakest of the anxiety-evoking situations in the anxiety hierarchy. When the anxiety response is zero, the next stimulus in the hierarchy is envisioned. Since relaxation inhibits anxiety, the offensive stimuli are progressively mastered until the most provocative and disturbing stimulus can be countenanced without upset.

A simple illustration of classic conditioning technique may be found in the account of Rubenstein (1964), who describes the conditioned reflex treatment of tubercular patients addicted to morphine. The first was a man of 38 who consumed 8.5 grains of morphine daily. The method employed consisted of the ringing of a bell at the start of each hypodermic injection. This was abandoned after a few days, massage

of the dorsal surface of the forearm being substituted for one minute after each injection. Gradually the dosage of morphine was lowered by substituting sterile injections until, after 4 weeks, the amount was 2.5 grains. At the end of 6 weeks, injections were discontinued. There were no withdrawal symptoms. In the second case, a woman of 38 who was getting 2 grains of morphine daily, the conditioning stimulus was a tuning fork held close to the ear, and the patient counted until the vibration ceased. Replacement of the morphine by sterile water was accomplished without withdrawal symptoms in 10 days, the vibrations of the tuning fork apparently substituting for the morphine. Should Rubenstein's findings be duplicated by other therapists, this would constitute a most revolutionary approach to the treatment of drug addiction. The report lacks detail regarding any conversation between the patients and therapist so that it is difficult to judge what other factors besides conditioning entered into the picture.

Experimental corroboration for counterconditioning is reported in studies by Lazarus (1961) and Lang and Lazovik (1963). Claimed for the desensitization techniques, in contrast to interpretive techniques, are quicker, more effective and more lasting elimination of phobic symptoms. In the study by Lazarus patients with acrophobia, claustrophobia, and impotence were matched in pairs according to age, sex, form, and severity of phobic symptoms. They were then randomly assigned to desensitization and interpretive treatments. Patients delegated to group desensitization were exposed to items of a common stimulus hierarchy in a deep state of relaxation and were asked to signal by raising their hands when an item was disturbing. Treatment was terminated when no stimulus item in the hierarchy upset any of the group members. Traditional group psychotherapy was employed in the control group. One month following therapy, the acrophobic patients were required to climb a fire escape 50 feet high and to take an elevator to the roof garden of an eight-story building from which they had to count the number of automobiles passing by for 2 minutes. The claustrophobic patients were subjected to an equally rigorous task, being required to remain undisturbed for 5 minutes in a tiny enclosed space. Of the 18 patients treated by group desensitization, 13 were completely recovered, as compared to only 2 out of 17 patients in the interpretive group. Of the unsuccessful cases in the latter body, 10 were then treated successfully by group desensitization within 10 sessions. On follow-up, 80 percent of the successfully treated patients had experienced no return of fear.

Employing an apparatus to measure psychogalvanic responses as an index of autonomic reactivity, MacKay and Laverty (1963) demonstrated a progressive reduction of anxiety responses with

desensitization procedures. Paul (1964) subjected four groups of college students with stage fright (1) to insight-oriented psychotherapy, (2) to an attention-placebo situation, (3) to counterconditioning associated with fantasies of public speaking, and (4) to mere assessment procedures (the control group). After 6 weeks, exposure to a stressful speech test and measurement of physiological variables, behavior dysfunctioning, and self-re-ported distress showed that all members of the first three groups showed improvement as compared to the control group, with the counterconditioning group rating far above the others.

Aversive Counterconditioning

Pairing certain behavioral deviations with aversive stimuli sometimes has succeeded in controlling or abating them. Among the earliest treatments of this type was the conditioned relfex therapy for alcoholism using a pharmacological nauseant (Lemere et al, 1942; Lemere & Voegtlin, 1950; Ruck, 1958; Miller et al, 1960). Treatment along similar lines for homosexuality, transvestism, and fetishism has been reported by K. Freund (1960), Glynn and Harper (1961), and A. Cooper (1963). Because of the difficulty in controlling the effects of drugs, several experiments in aversive conditioning have employed faradic stimulation as an aversive stimulus. This presentation of an unpleasant stimulus in close temporal relationship to an undesirable behavior, with the object of extinguishing it, is not as popular or successful as other forms of therapy. The dedication to the behavior, conscious or unconscious, may be too great to abandon it. Or a masochistic need for punishment may enable the patient to endure the painful consequences in order to appease a demanding sense of guilt. Moreover, for some patients aversive methods serve to reproduce the parental precedent of punishment for infractions; the patient will then rebel against the therapist or passively resist getting well. In certain cases, however, when nothing else seems to work and an obnoxious habit or behavior must be controlled, aversive therapy may, surprisingly, be the only method to which a patient will respond.

Currently, several types of aversive schemes are occasionally used, principally those that follow the Pavlovian model and those that are patterned after the operant model. In the former group of therapies are the conditioning of alcoholics with such nauseating drugs as Emetine and Antabuse and, more rarely, with electric shock. Painful shock has also been used in the treatment of cases of self-injurious behavior as headbanging, self-biting, and face-slapping in retarded children and of self-induced vomiting.

Aversive or punishing sequelae are employed less often than withdrawing positive rewards or reinforcements, such as shutting off a TV set during an argument between children over the choice of a program. A more severe disciplinary action is to penalize the individual for reprehensible behavior by levying a fine. Some therapists still use aversive stimulation for delivering an unpleasant stimulus like an electric shock from a small battery-operated unit or snapping a rubber band placed around their wrist whenever they indulge in certain behaviors they wish to control. In cases of hair plucking and skin mutilation that have not responded to other methods, a painful stimulus may replace the masochistic need to torment oneself.

Rapid inhalation of cigarette smoke to a point where the mucous membrane hurts or burns for the purpose of overcoming the smoking habit is another example of aversive control. The use of an alerting system to eliminate bed wetting and of delayed auditory feedback in stuttering has elements of both Pavlovian and operant methods. Compulsive overeating, gambling, and sexual deviations (fetishism, exhibitionism, voyeurism) and obsessive-compulsive symptoms have also been treated with aversive control methods, with undocumented claims of success. A substantial literature has accumulated detailing aversive techniques for the reversal of homosexuality in cases eager to change to heterosexuality (Freund K, 1960; Glynn & Harper, 1961; Cooper A, 1963). Virtually all behavior therapists now question the ethics involved in using aversive measures to treat severe sexual deviations, even at the request of the patient. The emphasis today is on positive treatment strategies, cognitive involvement, and sophisticated evaluation of complex situations, leading to multimodel interventions. While not strictly an aversive technique, use of a diary in which the patient simply charts the frequency of undesirable behaviors for which control is sought appears to lessen the incidence of such behaviors.

Extinction Procedures

Exposure of the individual to graduated anxiety-provoking cues, and the mastery of such stimuli, are said to support an increased ability to tolerate and overcome certain avoidance reactions. Thus a patient fearful of entering elevators may be encouraged to walk into small rooms with the door open, then closed, following which the size of the room used is decreased, until the patient is able to tolerate remaining in a closet for a relatively long period. Thereafter, entering an elevator and stepping out before the door closes, then going up one flight, increasing the trip floor by floor, may enable the

individual to extinguish the elevator fear. Unfortunately, this practice by itself has not proved to be altogether successful. Patients refuse to follow suggestions for a variety of reasons, including the secondary gain dividends they derive from their illness. Nevertheless, stratagems can be devised, tailor-made for each patient, which may on occasion prove successful (Herzberg, 1941; Saul et al, 1946; Kimble & Kendall, 1953; Walton & Mather, 1963a&b). Psychotherapeutic interviewing also embodies gradual mastery of anxiety. At first patients respond with anxiety to certain content, but repetition with increase of the depth of probing, along with permissive responses from the therapist, gradually extinguishes aversive responses as measured by the galvanic skin reflex (Dittes, 1957a, b), generalizing to related forms of behavior (Dollard & Miller, 1950).

In general, extinction procedures require frequent, even massive exposure to extinction trials with not enough interval between trials to build up resistance (Edmonson & Amsel, 1954; Calvin et al, 1956).

Because behavior deficits and neurotic symptoms often become reinforced when they break out against the will of the patient, certain procedures have been introduced that purposefully and deliberately encourage the patient to engage in the disturbed behavior or to produce a symptom in the absence of the usual reinforcement contingencies (Dunlap, 1932; Lehner, 1954). Thus, if an individual's hand shakes while lifting a glass or holding a fork resulting in avoidance of eating with people, he or she is requested to eat or drink in the presence of the therapist and ordered to produce shaking in as exaggerated a form as possible. If he or she has a tic, he or she is encouraged to practice reproducing it voluntarily, then to engage in prolonged rest. This is claimed as the best method of extinguishing tics (Yates, 1958). Stuttering, too, is often benefited by the stutterer admitting to the speech defect to others and calculatedly trying to bring it on, or at least not struggling to hold it back (Fishman, 1937; Rutherford, 1940; Meisner, 1946; Sheehan, 1951; Sheehan & Voas, 1957).

Very often deviant behavior is reinforced by the reaction of individuals in the environment. Schedules in which the person is not reinforced for this behavior sometimes lead to its extinction. Thus, in children, screaming spells, tantrums, refusal to eat, and other forms of misbehavior calculated to attract attention, positive or negative, may be handled by ignoring such performances (Williams C, 1959). These principles have also been adopted in psychotics with some positive results (Ayllon & Michael, 1959; Ayllon & Houghton, 1962).

Operant Conditioning

Operant behavioral approaches offer a prolific group of behavior change methodologies, as well as guidelines for their evaluation. A contingency relationship exists between operants and the environmental events that follow them. Thus, behavioral responses may be set up, accelerated, and strengthened (reinforced) or diminished and eliminated (extinguished) by their succeeding environmental consequences. In applying operant methods, schedules of positive or aversive reinforcement are developed at fixed or variable intervals or ratios, which will gradually shape the desired behavior. This design has been used with variable success for overcoming behavioral deficits, eliminating maladaptive activities, and continuing therapeutic gains. Success is not always possible for the same reasons as in any other therapy: lack of skill in the therapist, secondary gains that reward illness, inner conflictual resistances that obstruct progress, a masochistic need that supports suffering, anxiety that accompanies the achievement of health, and transference reactions that sidetrack therapeutic aims. Operant conditioning probably plays a part in all therapies, in that the therapist reinforces certain verbal and behavioral responses that are in accord with his or her theoretical convictions and the goals toward which treatment is directed. A vast bibliography on operant conditioning is available. A brief review is contained in the article by Karoly (1980).

Behavior deficits or behavioral impoverishment, in which traits that make for a productive adjustment are in default, may sometimes be overcome by developing adaptive responses through operant conditioning. Dramatic examples of what can be done with autistic children who are dissociated from reality and are unable to engage in gratifying interpersonal relationships have been reported by Goldfarb (1943), Freud and Burlingham (1944), Ayllon and Michael (1959), Lindsley (1960), Ferster (1961), Ferster and De Myer (1961), and Gerwitz (1961). As Bandura (1965b) has pointed out, the existence of inadequate social-reinforcer systems inhibit the use of positive attention and approval in these sicker patients. Indeed, other human beings have weak or negative reinforcing value for such patients (Bandura & Walters, 1959; Cairns, 1961; Ferster, 1961). To develop adequate behavior repertoires, ingenious schemes of operant conditioning have been elaborated. Selection of adequate primary reinforcers that are contingent on the execution of desired behavioral sequences and proper programming of rewards without setting criteria for initial reinforcement too high often result in a gradual shaping of behavior toward an adaptive objective. For instance, in the study of King et al. (1960)

on withdrawn schizophrenics, the performance of simple motor tasks was rewarded with verbal approval, pictures, candy, and cigarettes. Gradually these bounties were made contingent on more complicated behavior, such as communication and cooperation with the therapist and other patients in solving simple problems. The result was an emergence from their private worlds toward relationships with others.

Working with nursery school children, Baer et al. (1963) concluded that attention paid to withdrawn children (the conventional approach) merely tended to reinforce detached behavior. The investigators consequently avoided attending to this behavior when it occurred, but immediately rewarded the appearance of any evidence of social interaction. Social responsiveness immediately increased. To test this further, they again consoled and paid attention to the same children when they relapsed into solitary play, with the result that withdrawal tendencies rapidly returned. Reversing this process for the second time and rewarding social interaction, they readily brought the children back to cooperative relationships. As soon as patterns were consolidated, the reinforcers were slowly withdrawn, reinforcement being made contingent on the usual rewards of everyday life. Follow-up studies confirmed the stability of the acquired patterns. Other observers have validated the efficacy of these procedures in both behavior disorders and behavior deficits (Allen E, et al, 1964; Wolf M, et al, 1964).

The use of operant conditioning in unmotivated patients, such as delinquents, has resulted in the elimination of some antisocial patterns. When “hard-core” delinquents were compensated with money, candy, and cigarettes for their service as subjects in talking about themselves and their ideas, constructive activities soon were observed and their delinquent behavior diminished (Slack, 1960; Schwitzgebel & Kolb, 1964).

Response-correlated aversive stimulation is an example of how operant conditioning may be employed. Here unacceptable forms of behavior result in removal of positive reinforcers (such as music) or the delivery to the individual of a disagreeable stimulus (faradic electrical stimulation) (Liversedge & Sylvester, 1955; Goldiamond, 1965). Results depend on the intensity, frequency, and temporal sequence of the stimulus in relation to the response to be eliminated (Church, 1963). By manipulating the social consequences of certain forms of behavior, modifications in behavior may be secured. Thus Wolf et al.

(1964) successfully treated a refractory 3-year-old child whose violent temper tantrums could not be controlled with drugs and physical restraint simply by removing him to another room until his tantrums ceased. In some compulsive-obsessive patients, unapproachable by conventional methods, who are torturing themselves with destructive thoughts and impulses, success had been obtained by use of a small toy (a battery-operated shocking apparatus, activated by closing a switch when the container of a card box is opened) that provides the aversive stimulation. The patients, engaging in practice sessions at home, deliberately bring on their fantasies, then turn on the current until the fantasies disappear. Eventually some are able to divert their thinking from obsessional concerns. Bandura (1962b) aptly cautions that aversive stimuli may through classical conditioning serve to motivate and reinforce undesirable patterns.

Social Learning through Identification (Modeling)

Modification of social responses through patterning of the self after observed models has been described as a usual means of acquiring new behavior repertoires and of changing existing maladaptive ones (Bandura, 1962a, 1965a, 1977; Bandura & Mcdonald, 1963; Bandura & Walters, 1963; Rachman & wilson, 1980) By perceiving the behavior of the models, including associated rewards or punishments for this behavior, marked changes in the observer may be scored in terms of (1) moral judgments (Bandura & McDonald, 1963), (2) control of aggression (Bandura et al, 1961, 1963a, b; Feshbach, 1961; Walters & Llewellyn, 1963; Berkowitz, 1964; Bandura, 1965b), (3) tendencies toward violation of prohibition (Blake, 1958; Walters et al, 1963), and (4) various other responses (Bandura & Huston, 1961; Bandura et al, 1963c).

Conditioned emotional reactions may be acquired by observing pain and fear in models (Berger S, 1962; Bandura & Rosenthal, 1965). Thus, Chittenden (1942) exposed hyperaggressive children to a series of plays in which dolls exhibited alternating aggressive and then cooperative acitivity. The consequences of aggressive behavior (two dolls fighting over a wagon) were shown to be destructive (the breaking of the wagon with unhappiness in the children). On the other hand, constructive interaction resulted in the boys enjoying themselves (taking turns playing in the wagon). An impressive decrease in aggression resulted in the audience in comparison with a matched control group. Other examples of modeling procedures have been described by Levy (1939), Slavson (1950), and Kelly (1955), who

essentially assign to the therapist the task of executing in real life or symbolically the desired behavior.

The efficacy of the therapist in serving as a model for the patient will depend upon the role the therapist plays and how this is conceptualized by the patient. If in a position to mete out rewards or occupy a prestige role, the therapist will have the greatest chance of being accepted for the desired modeling (Lippitt et al, 1952; Bandura & Huston, 1961; Bandura et al, 1963c). Once social response patterns have been obtained, they may be secured by reinforcers.

Cognitive Behavior Therapy

Emphasis on cognitive processes represents a shift from stimulus-response and drive models to the dynamics of systems and subsystems of thought. Psychotherapy, following this paradigm, is organized around the direct influencing of thought systems and the interpretation of events. Behaviorally oriented methods that have taken on a cognitive dimension have been classified under the label of "cognitive behavior therapy." The distinctive quality of these techniques is that they do not attempt to force ideas on the patient but rather seek cooperation by providing the patient with graded tasks and assignments calculated to instill new ways of thinking. Thus, through instruction and modeling patients are taught to replace negative thoughts with thoughts that are more relevant to a proper adjustment (Meichenbaum & Cameron, 1974). Messages may be written out and given the patient for study and reflection. The aim is to soften the projected consequences of worrisome or destructive ideas. Eventually, it is hoped, negative self-statements and irrelevant cognitives that provoke untoward behavior may be eliminated.

Disturbed thoughts and ideas are believed capable of setting off chain reactions ranging from emotional outbursts to behavioral aberrations to physiological upheavals. Such thoughts and ideas, which we may call cognitions, are often the product of faulty belief systems acquired through improper upbringing and false cultural values. The end result is interference with a satisfactory personal and social adjustment. Therapeutic efforts are therefore directed toward the forthright and immediate correction of erroneous ideas.

In contrast to dynamic therapy, which tends to alter cognitions through insight into how past conditionings mold attitudes and behavior, cognitive therapy deals directly with present-day thoughts,

irrational assumptions, destructive self-statements, and self-defeating ideas. Their influence on feelings and behavior is explored with the object of regulating a more harmonious adjustment and helping the patient reduce or eliminate anxiety, depression, anger, and accompanying physiological residues.

The original work in this field was done by Ellis (1962). Several elaborations of Ellis's ideas have occurred, for example, the work of Meichenbaum and Cameron (1974), who have concentrated on the determining effect of the patient's negative self-statements and other irrelevant cognitives on behavior. A. Beck (1976) and Rush (1978) have also contributed substantially to the field through their stress on faulty thinking patterns, particularly in depressive states. When rudiments of adaptive skills are present and anxiety is not too paralyzing, the individual with proper therapy along cognitive lines may be able in a relatively brief period to reorganize his or her thinking skills and to find alternative, constructive solutions for difficulties in living. Intervention programs of this type have been designed for application in a variety of clinical and educational settings (Spivack et al, 1976).

Behavioral Medicine

Behavioral medicine is a term used to describe health and illness as they relate to the biological and social sciences, as well as the techniques that lead to diagnosis, prevention, treatment, and rehabilitation. A large number of publications have attempted to define this important but rather amorphous behavioral field (Berk, 1973; Collins, 1981; Davidson & Davidson, 1980; Doleys et al, 1982; Epstein & Cluss, 1982; Melamed & Siegel, 1980; Miller N, 1983; Pomerleau & Brady, 1979; Swartz & Weiss, 1978; West & Stein, 1982; Williams & Gentry, 1977). A number of subspecialties have appeared that attempt to divide the field into pediatric, adolescent, gerontologic, ophthalmalogic, urologic, dental, and other areas of behavioral medicine, some authorities consider psychological methods that are used adjunctive to medical techniques, as in the treatment of asthma, insomnia, obesity, pain, cardiovascular disease, and habit disorders (smoking, overeating), within the parameters of the field. Hypertension, Raynaud's disease, arrhythmias, and coronary artery disease have been shown to respond to methods related to behavioral medicine (Agras & Jacob, 1979; Benson et al, 1975; Brady et al, 1974; Berk, 1973). An excellent bibliography of behavioral approaches to pain, asthma, insomnia, headache, alcoholism, and other problems may be found in the article by Lazarus (1984).

Conditioning techniques have been used to modify behavior and to control physical symptoms in every age category. In children, problems ranging from nail biting to colic have been addressed. Parents have sometimes been trained in behavior management interventions as primary therapists or adjunctive helpers (Patterson & Gullion, 1968). In adults, there is scarcely a syndrome or symptom complex that has not been approached with behavioral methods. In those elderly patients in whom the deficits of aging have been amplified by environmental impoverishment and relative lack of reinforcements (Patterson, 1982), behavior therapy can help restore a good deal of constructive functioning (Berger & Rose, 1977). It may be valuable in terminal care problems.

Behavioral Prostheses

Several mechanical or electronic devices have been developed that can be carried by patients to help them acquire more adaptive behavioral patterns. Severe stuttering, for example, has been helped by an auditory metronome with a volume and rate control that the patient wears behind the ear like a hearing aid and that delivers rhythmic beats, permitting a pacing of speech and leading to greater fluency (Burns & Brady, 1980). A coordinated behavioral program, which may be used unaided by the prosthesis, is employed to decondition anxiety related to speaking (Brady, 1985).

Social Skills Training

Behavioral approaches are indispensable in the rehabilitation of persons who have failed to acquire or have lost social and self-care skills because of faulty upbringing or the development of psychiatric illness. Deficits and ineptitudes in human relationships and communicative skills are reflected in awkwardness, poor impulse control, and offensive habits and behavior, resulting in rejection and social isolation. Programs designed to overcome social and self-care deficits have been developed around behavior therapy principles and are used primarily in day hospitals and rehabilitation centers, as well as private practice. Individual and group therapy, using role playing and the modeling of appropriate behavior in simulated social situations, have proven singularly effective. Homework assignments are an important part of the program to encourage the generalization of learnings to the specific environment in which the individual will function (Hersen & Bellack, 1976; Trower et al, 1978; Wallace et al, 1980).

The Practice of Behavior Therapy

No two behavior therapists function alike, but all have a common respect for the methodology of the behavioral sciences and an emphasis on some form of stimulus response or social learning theory as a potential but not exclusive conceptual idea. It is this focus that characterizes modern behavior therapy, together with its emphasis on accountability and openness to scrutiny from within and without. The debatable clinical advantages and short-term therapeutic "successes" in the long run are probably of less significance.

As in traditional psychotherapy, considerable flexibility is exercised in the stratagems that are employed, which generally incorporate both interviewing and conditioning tactics. Therapy is usually started with a "behavioral analysis" to describe the maladaptive behavior pattern in objective and explicit terms, to review environmental and other variables that initiate and sustain the behavior, and to outline the tentative treatment plan. Each step of the treatment as it proceeds is explained to the patient, including what will be expected of him or her. "the patient's behavior toward the therapist is examined *only* when it points up important "maladaptive responses" (Storrow, 1965). In the opening phases of treatment, the main tasks are diagnosis, structuring of the therapeutic situation, designation of goals, and permitting the patient to "adapt" to the experimental situation by avoiding sensitive areas. The circumstances that led to treatment are reviewed, with discussion of the patient's general reactions to these. The present is considered rather than the past. Patterns to be changed and the methods to be used in changing them are delineated. To become an adequate agency of reinforcement, it must be established that the therapist is a source of rewards. This is done by developing a relationship with the patient and giving him or her some immediate relief through medication or practical assistance with a pressing problem.

Once the therapist understands the causal relationship between the patient's behavior and other variables, the true therapeutic effort begins when the therapist uses available stimuli to extinguish the maladaptive behavior (Meehl, 1962) and to strengthen adaptive responses. New patterns are most effectively shaped through the principle of "successive approximations" (Skinner, 1953), during which the therapist expects only small steps of improvement, never pushing the patient beyond his or her capacities. "The basic principle is to start with some response pattern remotely similar to the missing

adaptive behavior and to shape the new behavior by differentially reinforcing new responses as they approach the goal." For instance, if a woman is fearful of aggressive behavior, she is encouraged to grouse at her husband or coworkers when she feels like it, and she is complimented when she reports success. She gradually is encouraged to stand her ground when criticized and to assert herself with authority, always being sure that her behavior is not destructively designed. Should the patient be unable to express herself openly, fantasy and role-playing techniques are employed, such as those suggested by Cameron (1951). For instance, she can first imagine herself in a certain role; then she may act it out with the therapist, who plays the part of the threatening figure. Should the reinforcements gained from her environment for her behavior prove unsubstantial, tangible rewards may be given, like those described by I. Stevenson (1962), such as special attention being shown her outside of the interview or reduction or cancellation of the fee for one or more sessions. Leads toward social reinforcement in difficult problems have been suggested by R. Lundin (1961), Storrow (1962), Staats and Staats (1963).

The quickest way of overcoming a response is "to condition an incompatible response in its place" in the form of counterconditioning (Kimble, 1961; Lundin, 1961). Thus, an adaptive response may be chosen to replace an avoidance response. Verbal self-stimulation may be helpful, words and thoughts serving as conditioned stimuli and acting as reinforcers. First "the erroneous assumptions underlying the patient's anxiety and avoidance behavior" are pointed out, "arguing with him about this, if necessary." A cognitive behavioral approach may be indispensable. The patient is then instructed "to bombard himself with opposing thoughts when he next confronts the threatening situation." This approach is similar to that of Albert Ellis (1962).

Mild punishment may be used as a means of suppressing maladaptive behavior. This may be in the form of verbal disapproval or may consist of such methods as those suggested by Stevenson (1962), for example, "increasing the fee for one or more interviews or postponing an appointment when a patient fails to complete an assigned task."

In the closing phases of treatment, liberal approval during the interview is sometimes yielded in favor of rewards available in the environment. Advantages that will accrue to the patient as a result of the new behavior are pointed out. Little difficulty is usually experienced in terminating therapy.

HOW EFFECTIVE IS BEHAVIOR THERAPY? COMPARISON WITH PSYCHOANALYSIS

Some attempts have been made to compare the results of behavior therapy with those of conventional therapy. Reporting on three series of unselected patients (psychotics and psychopaths were, however, excluded from treatment), Wolpe (1958) states that of 210 neurotic patients, 90 percent were cured or much improved after an average of 30 therapeutic interviews. This figure is topped by a claim by Hussain (1965) of 95.2 percent in his treatment of 105 patients. Lazarus (1961) argues that while insight therapy brought satisfactory results in 1 out of 15 cases suffering from phobic reactions, behavior therapy cured 13 out of 18 cases. In a later study of 321 cases, he found that 78 percent had achieved a strikingly good outcome. Follow-up observations show that the results by conditioning methods are durable.

On the basis of these findings, in the formative years, behavior therapists have launched a frontal attack on both the precepts and results of psychoanalysis, branding it as an inferior treatment method that may contain elements that not only do not foster but actually retard improvement or cure. Among the charges are the following:

1. Psychoanalytic treatment is founded on the unsubstantiated premise that emotional problems are the product of repression of unconscious conflicts. The objective in cure, therefore, is to resolve resistances, thus restoring repudiated impulses to consciousness.

2. Statistical reports prove that results with psychoanalytic approaches are inferior to those of other forms of therapy, and particularly to behavior therapy.

3. On any comparison study, behavior therapy scores higher than other types of treatment; indeed, conditioning frequently overcome neuroses that have been treated for years unsuccessfully through psychoanalysis.

4. The evidence justifies substituting behavior therapy for psychoanalysis in the training of therapists.

5. It confirms a community interest in behavior therapy, since it permits the therapist to see large numbers of cases over a short period of time, producing “a higher proportion of lasting recoveries from the distress and disability of neurosis than does psychoanalysis,” at a fraction of the cost.

Insight Versus Reinforcement

Behavior therapy conceives of neuroses as residues of faulty learning and conditioning that are amenable to tactics of relearning and reconditioning. In such retraining, "insight," as we conventionally conceive of it, plays a minor role or none at all. There is little evidence, contend behavior therapists, that "insights" gained during interview psychotherapy or psychoanalysis have any influence in modifying social behavior. For the behavior therapist the term "insight," if it is used at all, pertains to the appreciation gained by the patient of the relevant contingencies in his or her life and their consequences as well as the consequences of responding to available options. Generally, "insights" are the regurgitated sentiments of the therapist, rather than true discoveries of the patient. Studies of verbal conditioning show that almost any response can be elicited from a subject under interview by positive reinforcement from the interviewer and that it may be reduced by withholding reinforcement (Salzinger, 1959; Krasner, 1958, 1962). The content of a patient's stream of thought is thus definitively influenced by suggestive probings on the part of the therapist (Bandura et al, 1960; Murray, 1956). It is perhaps for this reason that patients are constantly feeding back to the therapist the latter's psychodynamic schemes (Marmor, 1962). Rather than being a precursor to change, insight is often a consequence of change, during which, due to a strengthening of the personality, certain ideas are allowed access to consciousness (Alexander & French, 1946). Awareness of the responses made, and of the reinforcements, expedites learning. Awareness alone, however, does not guarantee behavioral change. Rather than waste time exploring hypothetical unconscious conflicts that turn out merely to reflect the therapist's theoretical predilections, is it not more practical as well as scientific to apply oneself to modifying responses through methods that have proved themselves efficacious? Indeed, where patients improve with insight therapies, it is probable that they do so not because of cognitive factors but because they have been subjected by the therapist to differential reinforcements, to counterconditioning, to extinction and to modeling—in other words to principles of learning rather than to the divulgence of unconscious content. Is it not then reasonable that insight therapists give up their esoteric rituals and forays into the unconscious and deliberately apply themselves to effective social learning procedures (Bandura, 1965b)?

Criticism of Behavior Therapy

Modern clinical and experimental research has contributed to the sophistication of behavioral interventions and has extended their usefulness for dealing with many syndromes, ranging from adjustment and habit disorders, to neurotic symptomatology (e.g., phobias, obsessions, compulsions, and depressions), to problems of retardates and psychotics. Questions continue to be asked about the utilities and dangers of behavior therapy, many based on misconceptions, for example, the ideas that the method is too authoritarian, coercive, controlling, and punitive; that behavior therapists avoid history-taking and focus extensive attention on data-gathering; that the removal of symptoms often results in symptom substitution or in only temporary benefits; and that the therapist-patient relationship is not considered very important.

Accusations are still levied at behavior therapists to the effect that they disregard such nonmeasurable aspects of inner experience as feelings and fantasies, and even that some therapists are so tied to a simple stimulus-response ideology that they consider the human brain "an irrelevant and unnecessary intervening variable." These ideas are largely erroneous and contribute to the existing climate of misunderstanding. Although analysts and behavior therapists act as if they were more tolerant of each other's ideas, there is still a good deal of distance and distrust between them that, one hopes, time and constructive dialogue will resolve. Franks (1984) believes that it is important to recognize the pervasive differences between behavior therapy and the Freudian system. Fundamental philosophical, conceptual, methodological, and practical distinctions make meaningful comparisons (other than for certain circumscribed situations) virtually impossible. For example, the two models have incompatible notions about the nature of acceptable data and the goals of therapy, and both the criteria and process of outcome evaluation are different. In the early days of behavior therapy, rivalries resulted in potentially destructive thinking in terms of "better" or "worse." The prevailing climate for many individuals in either "camp" seems now to be that the two systems are fundamentally incompatible and that in the long run advancement will best be served by encouraging each to work within its own framework. A perhaps smaller but vociferous and responsible group believes that some form of integration is both possible and beginning to occur (see Goldfried, 1982).

A great deal of concern has recently been expressed about the ethics of behavior modification and

the infringement of rights of individuals on whom behavior change is practiced. This is particularly directed at work with populations in institutions and prisons where motivation for change may be lacking. It is also pointed out that follow-up studies are not particularly impressive regarding the permanency of change once the individual leaves the milieu in which appropriate reinforcements exist. These criticisms are, however, not unique for behavior modification and can equally be applied to all mental health programs. It is assumed that professionals are sufficiently ethical to weigh advantages against risks, to gain informal consent if possible for programs, and to impose proper safeguards so that individual rights are not abrogated. Monitoring routines by a review committee, supplemented by reports to guardians or advocates of the person whose behavior is to be modified, have been proposed. Preoccupation with the issue of control has been overemphasized. As W. Brown et al. (1975) have stated, "On the whole, the goal of behavior modification, as generally practiced, is not to force people to conform or to behave in some mindless, automaton-like way. Rather, the goals generally include providing new skills and individual options and developing creativity and spontaneity." Contemporary behavior therapists are highly sensitive to ethical considerations and the potential for infringement upon human dignity, rights, and privacy. Historians and behavioral architects stress that the saga of behavior therapy is an evolution from simplistic beginnings to the present form of the discipline (Kazdin, 1978). One major strength of behavior therapy is its willingness to accept modification in the light of new data and thinking and its sensitivity to personal and social needs. Effective behavior therapists recognize both their limitations and the need to grapple with scientific, ethical, and philosophical issues (Erwin, 1978).

One of the drawbacks of any symptom-oriented short-term method of therapy, including behavior therapy, contend dynamically oriented therapists, is that there is little or no time spent on evaluating the individual's personality needs, and particularly the meaning to the patient of his or her symptoms. To impose behavior modification on a patient without thorough cooperation and the resolution of resistances to change will impose, in the least, barriers to ready progress and in some cases will inflict serious dangers. This is not to say that alterations may not be forthcoming, as one may witness in the token economies practiced in a state institutions with unmotivated patients. But when a symptom serves as a defense, initial improvements with forced behavioral techniques, unless they resolve the need for the defense, are apt to be short-lived and may even precipitate anxiety, with further disabling compensations. Admittedly, this is not a usual phenomenon, but it does occur as Bruch (1974b) reported

in her follow-up studies of the effect of behavior therapy on a group of patients with anorexia nervosa. The clinician will obviously be at an advantage if he or she recognizes that an individual's needs for autonomy and self-determination are sacrosanct and that imposing a regimen on any unwilling patient poses hazards that have to be evaluated carefully before undertaking treatment. It is here that dynamically oriented therapists have an advantage over their colleagues who dissociate themselves from approaches that acknowledge the determining power of existing personality drive and conflicts.

There is little question that the techniques of behavior therapy constitute important additions to the armamentarium of the psychotherapist. Employed with skill, they offer effective forms of treatment for the relief of certain inhibitory coping mechanisms and symptoms, such as phobias. They are applicable to a broad spectrum of the population, including less verbal and less educated patients. An improved total adjustment often comes about as a by-product of the control or resolution of symptoms. Proficiency in the use of behavioral therapy techniques may be acquired without extensive or expensive training, an advantage in the face of the current shortage of psychotherapists. Fears and other symptoms resolved through behavior therapy may be permanently extinguished and, instead of symptom substitution, may be followed by constructive influence on many other elements of the personality. Behavior therapists strongly stress, however, that proficiency in newly acquired behavioral techniques does not make one a behavior therapist; nor does it mean one is practicing behavior therapy. Behavior therapy is a conceptual and methodological approach that is both complex and time consuming to master. Techniques may be readily acquired and easily applied by anyone, but this is not behavior therapy.

On the debit side of the ledger we find that, in their zeal, unsophisticated behavior therapists have tended (in the past but less so now) to downgrade other forms of treatment, claiming, first, that theirs is a more scientifically based therapy, grounded in substantial learning theory rather than esoteric personality theory, and, second, that results are statistically better than those reported by therapists of other schools. Such signal successes are credited to the singular corrective powers of conditioning.

Actually, as modern behavior therapy takes pains to stress (Franks & Wilson, 1975), there is little basis for any autocratic assumptions about learning theory. It possesses no special magic, nor does it occupy a preferred place in the vestibule of science. Indeed, there is as much confusion about how complex learning takes place, and as much controversy about which of the prevailing learning theories is

sovereign, as there is in the field of personality theory. It is better to ascribe the effects of behavior therapy to the disciplined use of learning principles and the methodology of the behavioral scientist than to the dubious application of learning theory.

The beneficial effects scored by *any* of the psychotherapies are probably the consequence of the unlearning of old and the acquisition of new patterns. Even psychoanalysis owes many of its gains to constructive relearning. How learning principles enter into the methodologies, circuitously or by design, has been described elsewhere (Wolberg LR, 1966). Learning principles are not the monopoly of any of the psychotherapeutic schools. Nevertheless, it cannot be denied that behavior therapy is one of the few systems of therapy that *explicitly* endeavors to unravel and then *systematically* and consistently apply these principles of learning in the therapeutic situation. Ideally, speculation and subjective intuition—while having their place as an occasional starting-off point—yield to evidence, data, controlled study, and the rigorous application as an *ongoing process* of the methodology of the behavioral scientist. It is this that really gives behavior therapy its unique position and its advantage, if it be an advantage, rather than any grandiose claims to extraordinary successes.

A well-deserved criticism is that early behavior therapists tended to regard conditioning as the cardinal if not exclusive agency in the therapeutic process. Little attention was paid to the factor of spontaneous remission and to the non-specific benefits of the helping process, such as the placebo effect, the relationship dimension, emotional catharsis, suggestion, and group dynamics, which in themselves may account for a certain percentage of recoveries. Nor was the enthusiasm with which therapists apply themselves, and the faith inspired in their patients, considered to be too significant. Neglected also were the factors of transference and resistance that operate in all relationships in which one human being is influenced by another. This, of course, is of primarily historical relevance at this stage. Behavior therapy has matured since these stormy and dogmatic days of infancy and early adolescence.

At this stage it is essential to differentiate between the techniques of behavior therapy that any therapist may acquire and apply as the occasion demand, but which do *not* make the therapist into a behavior therapist, and the consistent application of a conceptual model or framework with which all problems are approached regardless of technique employed or maladaptive function to be altered. Technical eclecticism (the use of any technique that has been empirically demonstrated to work) is

justifiable and perhaps the hallmark of the good therapist. Theoretical eclecticism— the switching from one conceptual framework or theoretical set of constructs to another, from one patient to another—leads the therapist to a conceptual disarray that is akin to philosophical schizophrenia. Lazarus (1971) has elaborated on this important point.

A case described by J. White (1964), as an illustration of the application of learning theory to the treatment of anorexia in a child, brings up some of the problems in accounting for therapeutic results. A child who had become conditioned to eating while on her father's lap stopped eating regularly at the age of 5 when her father died. Various devices were utilized to incite her appetite; however, her eating steadily deteriorated. Therapy consisted of a reconditioning process, the therapist, then other members of the family playing the father's role. Play therapy, four times weekly, was also employed. It was soon apparent that the child, in her contrariness, was using food rejection as a way of frustrating her mother. On one occasion when the child refused to stay in the playroom with both her mother and the psychologist, she was sent home without the cup of coffee promised her. Thereafter, she was rewarded only when she did useful little jobs around the clinic. In 5 months the patient began showing an interest in food. Whether learning theory, relationship therapy, or pure suggestion operated here is quite pertinent to our concern as to what is important in the healing process. The author has successfully treated a number of anorexic children with hypnosis, employing pure suggestive techniques. In one instance cure took place after one session (Wolberg LR, 1965, p. 290).

The most biting criticisms of behavior therapy are voiced by adherents of psychodynamic models of psychotherapy, who consider behavior deviations the symptomatic manifestations of underlying pathological processes. Such criticisms contend that the behavior therapist operates falsely on the assumption that it is possible, from the patient's behavior or expressed complaints, to discern all the variables that require correction. Actually, the aspects of personality that require greatest alteration may be repressed or shielded by manifest defenses or by symptoms that mask more fundamental problems. Applying oneself faithfully to the extinguishing of such symptoms may prove futile, unless one discloses and makes available to the patient the conflicts behind his or her symptoms. This is not to say that many symptoms have not outlived their usefulness as defenses against anxiety, persisting as conditioned responses. In such cases they will yield to tactics of symptom removal, such as are practiced in some forms of behavior therapy. When they serve some anxiety-binding or pleasure-producing purpose in the

psychic economy, however, their origins and function will have to be explored and exposed, and resistances to giving them up "worked through." Only then will conditioning procedures be effective. To this, of course, the sophisticated behavior therapist would reply that there are no hard data demonstrating the need to introduce superfluous intermediary concepts, such as the unconscious or psyche. They would also point out that behavior therapists go to great lengths to explore with the patient the whole range of presenting complaints and pertinent issues, some of which the patient may not be aware of. For example, treating a lawyer by systematic desensitization for the presenting complaint of difficulty in speaking in public may be useless if the real or only partly recognized problem is fear of losing a case in court and of losing face. It is this, among other things, that must be modified rather than the face-saving presenting complaint.

Another challenged assumption in early behavior therapy was that the therapist always can function as an adequate source of reinforcement—approval and rewards meted out by acting as positive reinforcer and disapproval as an aversive stimulus. This is not always true. When the patient has a problem in accepting the therapist as an authority, he or she will not be influenced too much by the therapist's approval or disapproval. In patients who have a need to frustrate, compete with, defy, and fight authority, resistance to commands and blandishments may obstruct reinforcement. Moreover, an unconscious masochistic need in the patient may dictate suffering as a way of life. Relinquishing a disturbing symptom may then constitute too much of a threat. Where there is resistance to accepting social rewards for any reason, reinforcements from the environment will have little effect on the patient. It is necessary in such cases to deal with transferential projections, differentiating the therapist as a real person from the image of authority residual in the patient's past experiences. To do this, reconstructive techniques may have to be employed. Contemporary behavior therapy, then, is both interperson- and intraperson-oriented. Emphasis is on those contingencies within the environment that modify the patient's life style. For example, it is of little use to help an alcoholic reduce drinking or to change a basic life pattern in the clinic if there is return home to the same unfortunate set of contingencies that contributed to the distress (or foibles) in the first instance. Behavior therapists have, therefore, developed techniques such as contingency contracting and cognitive restructuring for modification of the various systems within which the patient has to operate. Such a *systems approach* necessitates concern with virtually every aspect of the patient's social, economic, biological, and physical environments.

Flexibility and ingenuity, coupled with scientific rigor and attention to detail, are essential, if hard to maintain, ingredients of this approach (Franks, 1974; Franks & Wilson, 1975; Lazarus, 1976). At the same time, contemporary behavior therapy no longer neglects the "inner being." Cognition and self-control rather than direction from without are increasingly important in the behavioral approach (Mahoney, 1974). Self-instruction and self-monitoring, utilizing advances in behavioral biofeedback, are considered to be focal goals. Lazarus (1976), with his acronym BASIC ID, provides an outstanding example of the direction in which forward-looking behavior therapy is going, a direction shown by the current interest in differential therapeutics (Frances et al, 1984).

Two major problem areas remain for this new breed of behavior therapist to contend with. By definition, the strength of behavior therapy and its identity lies primarily in its unswerving adherence to the methodology and rigor of the behavioral scientist within a learning theory framework and its unique combination of this with the flexibility and acumen of the patient-oriented clinician. The problem is that the more broad spectrum or multimodal the behavior therapists become, the more they are in danger of losing the behaviorally oriented foundations upon which their system of therapy is founded. From the patient's stance, this, of course, is irrelevant. From the point of view of behavior therapy, which may, of course, be of little consequence in the long run, this is very important.

The other problem area—with which behavior therapists are contending more successfully (Franks, 1974; Franks & Wilson, 1975)—pertain to such vital and timely issues as ethics, accountability, licensing, and its public and its private images. Now that behavior therapy is demonstrably viable and highly visible to both mental health professionals and the public at large (witness the not-altogether unmerited furor about aversive control and token economies in the prison system in the popular press), it is essential that such matters be given top priority along with matters of further research.

Behavior therapists insist that schedules of reinforcement rather than internal psychodynamic factors account for the genesis and continuance of disturbed behavioral patterns. By removing positive reinforcers, deviant patterns are said to be reversible. The origin of these reinforcement schedules may well lie in early parental conditioning and be determined in part by constitutional, biochemical, and even genetic variables. This, all but the most radical of behavior therapists recognize, sets an inevitable limitation upon what reinforcement *alone* can accomplish. Within these limiting factors, the emphasis is

on the contingencies that maintain the behavior now. Behavior therapy has developed techniques for working with these contingencies, whether they be operating primarily in the external environment or largely (or even exclusively) in the imagination of the patient. The reinforcing agencies are sometimes not in the environment but in the residues of parental conditionings imprinted on the psyche that carry on the re-ward-punishing activities irrespective of reality. The individual's superego may be a more powerful reinforcing agency than any external personage including the therapist. Because the force and even existence of this intrapsychic body is usually unknown to the individual, the patient cannot deal with it until, through releasing measures, he or she becomes aware of its nature and manifestations. Liberation of such forces from the unconscious is an important objective in the insight therapies, such as psychoanalysis.

The fact that not all patients are cured by psychoanalysis and that behavior therapy yields symptomatic relief more readily does not invalidate psychoanalysis as a method. Freud himself considered psychoanalysis as a technique applicable to a limited number of patients in whom the objective was extensive reconstruction of personality. By rendering repressed impulses conscious through the resolution of resistances, by working through the infantile neurosis in the more readily resolvable transference neurosis, he attempted to release the arrested personality growth. Rapid symptom relief was sacrificed in favor of future, more widespread change. The goals in psychoanalysis are thus more extensive than those in behavior therapy, even though its application is limited to a selected group of patients who are properly motivated and who possess sufficient ego strength to endure the rigors of depth therapy. It is recognized that release of repressed material may for a considerable period aggravate a patient's symptoms instead of relieving them. It is acknowledged, too, that greater self-awareness does not guarantee that change will take place; it merely motivates the individual to approach life from a different perspective, a contingency that may or may not bear fruit. Behavior therapists are themselves now among the forefront of clinicians prepared to accept and make constructive use of their failures. In this respect the emergence of a searching volume entitled *Failure in Behavior Therapy* (Foa & Emmelkemp, 1983) is a signal event.

To attack a theory simply because therapeutic results are not always positive constitutes an error in logic. For example we have some established theories of kidney functioning and pathology, and we try to design therapies in line with these theories. The reality that we are unable to cure some types of kidney

disease, or even to halt its steady retrogression, means that our methods are still too unrefined, not that our theories are necessarily wrong. In many fields we know much more about what creates derangements than what to do about them. This is the case in the relatively new field of psychoanalysis. Early behavior therapists, with the insecurity and messianic fervor that tends to accompany most new movements of significance, focused upon the "evils" of psychoanalysis rather than the "good" of behavior therapy. Those forward-looking behavior therapists acknowledge the futility and dangers of such a position. They recognize that true science is open-minded and that techniques and modes of thinking that are acceptable strategies for either practice or valid research in one paradigm may not be viable in the other. To the extent that this is recognized both psychodynamics and behavioral approaches are continuing and acquiring adult perspectives. By the same token, psychoanalysts increasingly recognize that all known methods of extinction may not budge some habits and that this does not disprove conditioning as a basic process in learning. It merely points up that we still do not possess sufficiently refined procedures of extinction and new response replacement.

The minimization of insight as an important force in behavior change constitutes a vital shortcoming of most behavior theories. By insight we mean an awareness of forces within the self and of motives and values that sponsor maladjustment. This is not to be confused with hypothetical, often mythological formulations that upheld a therapist's biased doctrines and credendas. Unfortunately, a good deal of folklore is extant in the psychological field, particularly as it applies to personality theory and psychotherapeutic process. Such "insight," fashioned by mimicry, has little other than a placebo effect and, as such, serves a limited purpose. But the human person as a thinking animal operates on the basis of capacity for insight and understanding. A recognition of the irrationality of impulses, a realization of their purpose and origins, and apprehension of one's reality situation structure a person's field and foster the extinguishing of old destructive patterns and the reinforcement of new adaptive ones. It is hardly conceivable that any type of complex problem solving can take place in our entangled social environment without the mediation of insight.

Another point of controversy concerns the statistical reporting through which behavior therapists attempt to verify their claim as the most effective professionals in the psychotherapeutic field. Statistical results reported by any school of psychotherapy must be looked upon with skepticism. The evaluation of results of psychotherapy pose insuperable problems, including, among other things, definitions of

change. For example, in the reports of some groups utilizing insight approaches, symptom relief, for some reason, is not considered to be an acceptable sign of improvement. What is believed to be important is "character change," whatever this may mean in terms of orientation of the particular school. As a short-term method geared toward symptom relief, behavior therapy probably can effectuate palliation in larger groups of patients than can psychoanalysis. Whether it can surpass other forms of short-term therapy in speed, effectiveness, and permanence of improvement is a moot point. A pioneer pilot project of Group Health Insurance, Inc., in which a large group of patients treated by 1200 participating psychiatrists, most of whom were analytically and long-term oriented, limited to 15 sessions per patient, revealed that cure or improvement of 76 percent was reported by the psychiatrists (Avnet, 1965). A follow-up study after an average of 2 ½ years following termination revealed that 81 percent of patients reported sustained recovery or improvement. With a caseload this size, and with psychiatrists employing a host of varied procedures, the rate of improvement is impressive. The fact that a few skilled behavior therapists report a high percentage of improved patients may be ascribed to their skill and experience as well as to dedication to their method, rather than to the specific virtues of the method itself, effective as it appears to be. nondirective and client-centered therapists, transactional analysts, psychodramatists. "Gestalt therapists," directive counselors, casework practitioners, and therapists of a great many other schools report improvement rates of approximately 80 percent and, in some cases, as high as 95 percent. When we consider the diversity of methods employed, the similarity of results is puzzling. Apparently there is release in all psychotherapies of processes of a healing nature that are not described or that are subordinated to the specific procedures heralded as *the* effective therapeutic agencies. A properly controlled comparison series would, of course, help solve this question, but whether it is possible to arrange for such controls in psychotherapy, where the variables are so great that no two cases are even remotely alike, is doubtful.

Not all behavior therapists are convinced of the infallibility of their conditioning, counterconditioning, and extinction instruments. While there is general agreement that phobic patients are helped significantly, there is some question as to whether other kinds of problems respond better to behavior therapy than to other treatment methods. Franks (1965), in summing up many reports, stated what a good number of experienced clinicians are now emphasizing, namely, that we do not yet know for whom or when behavior therapy had best be applied or whether or not it is shorter and the remission

rate in its employment lower than that of conventional therapy. He commented on the *potential* advantages of behavior therapy in its being more goal-directed toward specific symptoms and more adaptable at all levels of intellectual and linguistic sophistication than psychoanalytic therapy. Selection of patients, therefore, need not be so discriminating. A study by E. J. Ends and C. W. Page (1957), who employed group therapy based on learning theory on alcoholics, concludes that this approach was not only not helpful but deleterious, in contrast with approaches that employed client-centered and psychoanalytically oriented approaches. What is lacking in all the statistical and research reports is a description of the quality of the agencies administering treatment, their education, experience, sophistication, bias, and, above all, their personality structures—their capacity to relate, to empathize, to understand, and to control and utilize countertransference to good advantage. These ingredients are probably much more important to results in psychotherapy than are the theories or some of the methods that are being practiced.

Actually, there is little to be gained from the polemic that is taking place between the groups deifying insight and those worshiping behavior therapy. Psychoanalytically oriented therapists, while deriding behavioral approaches as superficial, are constantly though unwittingly utilizing learning principles, including extinction and counterconditioning. Deliberate avoidance of behavioral techniques in patients who cannot benefit from insight approaches alone constitutes an unfortunate defection. On the other hand, not all of the forces operating in any interpersonal relationship, including psychotherapy, are immediately identifiable and manipulatable. The refusal to acknowledge that a patient may unrealistically project negative attitudes that have nothing to do with the immediate situation but owe their force to generalizations toward authority, the original stimulus of which dates back in the patient's life history, will handicap the behavior therapist greatly. Similarly, refusal to believe that reinforcements that sustain symptoms are internally inspired by such disguised rewards as sexualization and masochism will confound the therapist, since he or she will have done everything obvious to foster an extinction that simply does not come to pass. Cognizance of such forces may not always improve the results obtained with behavior therapy, but they enable us better to explain the phenomena taking place within the conditioning situation. The willingness of behavior therapists to abandon their defensiveness, to share the throne of empiricism with other therapists whom they consider unscientifically steeped in the mystique of their arts, and to amalgamate their findings with

those of schools different than their own could lead to an enrichment of psychotherapy as a whole. Out of this unity may come the wedding of the insight and behavior therapies, dynamic explorations helping the individual to structure and refine his or her learning field, and conditioning techniques expediting the unlearning of neurotic and the incorporation of healthy patterns.

A dynamic orientation to behavioral and other problem-solving approaches is taken not for the purpose of expanding the goals of treatment beyond symptom cure or problem solving but for dealing with some of the most powerful resistances that impede progress. These have to do with unconscious needs to perpetuate a childish dependent adaptation, to assuage guilt through masochistic self-punishment, and to project onto the therapist needs and attitudes originating in early relationships with important parental and sibling figures (transference). These drives can distract the patient from aims congenial with the objectives of treatment and make a shambles out of the most dedicated and skilled efforts of the therapist.

In part, behavioral therapists have come to recognize the importance of cognitive factors that operate as resistance and in some cases have adopted recent approaches used in cognitive behavior therapy. What is still lacking is recognition of the importance of unconscious conflict as one of the significant determinants of behavior. Of course, a dynamic orientation is not always necessary, since considerable numbers of patients do not resist behavioral and other symptom-oriented approaches. For those who do not respond, however, the understanding of unconscious motivational deterrents, as well as application of this understanding toward their resolution, can mean the difference between success and failure.

COGNITIVE LEARNING

Cognitive learning approaches are designed to deal as rapidly as possible with symptoms and adjustment problems without probing for causes or attempting diagnosis. This is done by assigning to the patient (who is called a “student” since the medical model is assiduously avoided) a series of problem-solving activities calculated to alter customary attitudinal and behavior patterns. The student and therapist (who is called the “teacher” or “instructor”) jointly agree on goals that have a reasonable chance for alteration, and the format (individual, couples, or group) is specifically organized to deal with

the problem areas in a set number of sessions. Students are encouraged to utilize all existing constructive forces in their environment and in themselves and to accept greater responsibility for their past actions and present learning enterprise. As in behavior therapy, the student's difficulties are conceived of as problems in learning. The value of other behavioral approaches is acknowledged and their methods even utilized, such as operant learning and the proper timing of reinforcements, imitative learning, and the observation of models (e.g., programmed instruction, tape recordings, videotapes, television presentations, movies, books, and actual live plays and demonstrations), and emotional learning (e.g., systematic desensitization). Concentration, however, is on information giving, verbal instructions, role playing, and the proper timing of cues.

An example of how cognitive learning operates is provided by an Adult Development Program of the Department of Psychiatry and Behavioral School of Medicine, University of Washington, which was established in 1970 by Cornelis B. Bakker and Hubert E. Armstrong, Jr. Students in the program are accepted who have a desire to make changes in themselves and their situation, are willing and able to assume responsibility for their behavior, and are ready to approach new ways of dealing with their problems. As many courses as are desired may be chosen from a few hours a day to an entire day. 5 days a week. Some courses are arranged in "pathway" groups of six units of four sessions (3-hour evening sessions, once weekly for 4 weeks). Couples sign up for one unit at a time, which while taken in sequence can be completed in 6 months. The Marital Enhancement Pathway, for instance, enables couples to set goals and master skills to achieve these goals in a graded series. The classes are as follows:

1. *Human territoriality* (learning to bargain to resolve conflicts).

2. *Assertiveness training* (learning to substitute more constructive modes of communication for nonproductive interchanges).

3. *Precision behavior change* (learning to bring mutually agreed upon changes in oneself and one's partner).

4. *Marital myths* (recognizing and learning to overcome false ideas about oneself and the marital relationship that block change).

5. *Fixed role* (practicing through role playing, alteration of behavioral patterns to overcome defects in the marital relationship).

6. *Sensuality and sexuality* (enhancing pleasure in sexual relations in marriage).

Small groups are available for specific goals.

Thus an Assertiveness Laboratory of two 2-hour sessions each week for 3 weeks teaches people to role play to learn to accept responsibility for permitting others to take advantage of them, to learn to say "no," and to recognize and "do what one wishes" rather than "what one should do." A Couples Communication course of 2 hours once weekly for 8 weeks teaches how to negotiate disagreements "without making each other feel miserable." Here each couple is encouraged to practice fighting about an unresolved issue while other couples referee. Each member has a "second," a classmate who helps define gripes, feelings, and demands. An Effective Communication course of two 75-minute classes each week for 4 weeks focuses on learning through structured exercises, such as how to say things in different ways to avoid hurting others, how to exchange compliments, and how to ask for and receive positive comments. A Fixed Role course of two 2-hour sessions each week teaches how in changing one's behavior other people's behavior changes and how to overcome resistance to change. This is done through following a detailed script written jointly with the instructor that permits practice through role playing of a new way of dressing, talking, and behaving. A Human Relations Laboratory of three sessions a month for 2 hours each presents two models: one following the scheme of transactional analysis., i.e., parental injunctions and childish demands operating simultaneously within oneself, mediated by one's inner adult self in relation to specific situations; the other, patterned after Ellis's *A Guide to Rational Living,* explores how interpretations of events rather than the events themselves are the keynote to one's irrationalities. A Human Sexuality Seminar of one 2-hour session for one month teaches how to break down myths about sexuality and to replace them with information to enhance sexual functioning. No attempt is made to deal directly with actual sexual dysfunctions. The Human Territoriality Seminar teaches bargaining skills to avoid being exploited, to gain and defend legitimate demands by standing up for one's own rights, to resolve conflicts, and to increase self-confidence and enjoyment in dealing with people.

Another example has been provided by B. L. Greene (1975), who, working with a more or less homogeneous group of "hard science" professionals at the Midland Community Mental Health Center, who were resistive to traditional psychoanalytic and conditioning cognitive approaches, related to the proposition that behavior is determined by thinking patterns that may be analyzed and modified.

Explored within the therapy session and assigned as homework were goals, attitudes, expectancies, and beliefs with the object of both modifying handicapping perspectives and thought processes and the adoption of constructive alternatives. A wide variety of therapeutic techniques were then exploited to facilitate the achievement of this object. The method is not designed to change basic characterologic defects, which usually will require long-term dynamically oriented interventions. It is a short-term course geared toward enabling a better reality adaptation.

Criticisms of Cognitive Learning

Cognitive learning bases its techniques on the premise that people are capable of changing their behavior by altering the immediate environmental circumstances in which they function. It is claimed that many forms of psychiatric intervention rather than fostering change tend to stabilize undesirable personality patterns. By labeling a person with a diagnosis, we tend to increase the probability that that individual will respond in a way consistent with the diagnosis. Psychological testing, while its validity and reliability are notoriously low (Little & Shneidman 1959; Chapman & Chapman, 1967), stamps the individual with a pathological blemish. By concentrating the attack on the inner psychic structure to the neglect of situational alteration, psychotherapists are said to become counterproductive. The results of attacking the environment instead of the intrapsychic structure, of avoiding diagnosis and psychological testing, and of focusing on methods that directly influence behavior, it is furthermore avowed, tend to shatter the myth of unchangeability of human nature.

In view of the savings of time and costs, cognitive learning offers the motivated patient who is able and willing to learn an opportunity for substantive benefits. In a community mental health program its short-term nature will greatly reduce the patient load. In private practice it may well serve as a way of initiating therapy in many patients in combination if necessary with behavioral and other educational approaches. In some cases, as a result of tension relief, restoration of mastery, and a more wholesome adjustment, patients may show in addition to symptom relief and enhanced adaptation considerable personality growth. Like any other therapy, however, it is not universally applicable. Blocks to learning fostered by inner conflicts, self-destructive masochistic impulses, lack of motivation, a need for failure, irremediable environmental stress circumstances, intellectual inhibitions, and attention failures may obstruct progress. Here other long-term psychotherapeutic approaches are better applied, although their

success obviously is not guaranteed. It goes without saying that a well-designed program geared toward specifically oriented learning and executed by a well-trained, dedicated, and empathic professional is mandatory for progress.

The experience with many cognitive learning programs has been most encouraging, pointing to the inherent flexibility within people that enables them to learn from short-term educational techniques.

There is obviously nothing new about the cognitive educational model. It was popularly utilized in the mid-nineteenth century. It fell into discard with the rise of the psychoanalytic model in the first half of the twentieth century. Its revival is predicated on better information that we now have that we can communicate to clients, much of which comes from dynamic psychology, and on work in experimental psychology laboratories. Persons suffering from severe mental problems or from extraordinary stress situations may not be able to take advantage of the learning techniques offered and may require additional specialized psychotherapeutic and psychiatric help. Success is also dependent on the acceptance of the role that the teacher plays in providing information and guiding the learning process. A psychotherapist who wishes to exploit the value of educational techniques may well benefit from taking a course in executing techniques, such as helping the student to define attainable goals, establishing successful criteria for change, designing courses of study, acquiring essential information for acquisition of skills and changed attitudes, selecting the proper format of studies, and ensuring that motivation in the student continues. An advantage is that staff can be recruited from a wide variety of disciplines, thus reducing time and cost.

THERAPEUTIC COUNSELING (PSYCHOLOGICAL THERAPY)

In Chapter 6 the rationale and the principles of counseling were described and reference was made to the fact that some forms of counseling were reeducative in nature. In recent years formal training in reeducative counseling techniques has been extended to individuals such as ministers, rehabilitation workers, police officers, and paraprofessionals who in their work come into contact with persons with problems. The focus for which help is sought often involves specialized information. The focus also labels the kind of counseling rendered. Among the more common forms are vocational counseling, premarital counseling, marriage counseling, genetic counseling, spiritual counseling, and educational counseling.

In actual practice, irrespective of the specific focus, common principles obtain in relation to such important areas as setting up a client-counselor relationship and managing it toward productive objectives. Some of the older readings in the field are still valuable, including those of Williamson and Darley (1937); Williamson (1939); Rogers (1943); S. E. Goldstein (1945); Garrett (1945); New York State Counselors Association (1945); and Snyder (1947a&b). More recent literature is contained in the section on counseling in Chapter 6 and in the Selected Texts section (page 1397). Audiovisual aids are also described in the designated sections.

Some forms of psychological therapy downgrade technical and intellectual methods, contending that they are non-meaningful in the treatment process. What is considered important is to bring up and express feelings. It is believed that only through emotional arousal can one's potentials be actualized. The traditional therapeutic authority-patient alliance is rejected as a proper basis for personality change. Instead of manipulativeness on the one hand and anonymity or detached noninterference on the other, the climate of the therapeutic relationship is one of empathic warmth, friendliness, and expressed regard for the patient. Neither knowledge of the developmental past nor promulgation of present insights is considered important. The emotional encounter between client and therapist is the basis for significant movement. Defenses against proper relating are dealt with by confrontation and the assignment of tasks. Experiencing the encounter as a different mode of relating eventually is said to lead to self-actualization. Among the different types of treatment that operate on this philosophy are client-centered therapy, psychodrama, Gestalt therapy, experimental groups, EST, and existential therapy.

Client-centered Therapy

The client-centered methods of Carl Rogers (1942, 1944, 1946, 1951, 1959, 1961a&b, 1980, 1983) have long been a favorite with psychologists, although in recent years the impact of psychoanalytic concepts and behavior therapy have made inroads into their popularity. Nevertheless, they are still employed, and aspects of them are utilized in group work, play therapy, community development, and educational, religious, marital and industrial counseling (Snyder WU, 1943, 1947b; Hart & Tomlinson, 1970; Meador, 1975; Rogers CR, 1973).

Essentially, the philosophy around which client-centered approaches are oriented is a humanistic

one, embracing the idea that a human being is possessed of innate goodness, actualizing tendencies, and capacities for evaluative judgments leading to "balanced, realistic, self-enhancing, other-enhancing behavior." A human being becomes ineffective, hateful and self-centered, and then incapable of making proper judgments and responses as the result of faulty learning. This leads to incongruence between what is being experienced and the concept of self. Through the medium of special kinds of relationships, it is possible for the individual to rectify improper learning and to acquire new and productive patterns. Release of the self-actualizing potential will lead a client to emotional growth. It is essential, however, for the therapist or facilitator to be genuine or real (congruent) in the relationship and to possess a caring or an acceptant attitude in order to experience empathically a sensitive understanding of the client. The client, in turn, must perceive these qualities in the therapist (Rogers CR, 1975).

Over the years the theories and methods of client-centered therapy have undergone some revision as a result of experience and research (Rogers & Sanford, 1985), but on the whole the original formulations are still the basic underpinnings of the method. Rogers, drawing to an extent from Rankian methods, based his personality theories on research findings and on his own observations in psychotherapy. These contend that subjectively observable responses of individuals are potentially available to their awareness and constitute the body of their "experience." There are, first, non-symbolic correlates of experience of an organismic nature that exist in the form of sensory, visceral, and emotional or "feeling" responses, through which the raw data of the environment can potentially become available to the individual's awareness. Second, there are symbolic correlates, composed of attending responses accompanied by "free and undistorted awareness" of external and internal events, clearly perceived and faithfully symbolized. The innate human capacity to symbolize permits the individual to register events accurately unless faulty learning has produced distortions. The driving force of life is innately governed by an "actualizing tendency" around which all other motivations revolve (such as tension reduction, the drive for autonomy, etc.). All behavior is holistically organized around this innate tendency and is patterned by the capacity to differentiate between effective (pleasure-producing) and ineffective (pain-producing) responses, a capacity that Rogers terms the "organismic valuing process." If responses are positively evaluated as effective and actualizing, they continue or recur; if they are negatively evaluated as ineffective or nonactualizing, they are avoided or terminated.

Some of Rogers's early concepts draw from the theories of Rank, Goldstein, Sullivan, Maslow,

Angyal, and Lecky. They embrace ideas from existentialism, Gestalt therapy, Eastern philosophies, information theory processing, and group dynamics. They reflect a phenomenological viewpoint, contending that each individual has a "phenomenal field" that determines behavior, and that shifts from time to time according to needs. Aspects of the phenomenal field that one recognizes as part of oneself, such as perceptions about one's physical self and one's relationships with the world, make up one's "self-concept." Significant experiences may exist that the individual does not admit to awareness and that are therefore not a part of his or her self-concept. Thus, certain needs, such as organic experiences and drives, may not be symbolized, rather being "disowned," since they are not consistent with the self-concept. As such, they can create tensions. Values that may become incorporated in the self-concept are those derived from personal experiences and those absorbed from other individuals ("learned evaluative thoughts"). A clash may result between these two sets of values ("incongruence between self and experience"). The fundamental urge in all persons is to preserve their phenomenal selves; impulses and experiences that do not coordinate with the self-concept are perceived as a threat. The individual responds to the "basic estrangement" that results with contradictory behavior and rigidity in the self-structure. If the self-structure cannot meet the demands of the reality situation, if there is a great disparity between ambitions and accomplishments, if responses elicit both positive and negative self-evaluative thoughts, the individual will experience tension and anxiety. He or she will then react with two types of defensive mechanisms to avoid awareness of the contradictory responses: first, by ignoring important responses ("denial to awareness") and, second, by distorting thinking about the responses ("distortion in awareness"). Where defenses that sponsor neurotic symptoms fail the individual, he or she may "break down" and manifest grossly disordered behavior such as psychosis.

The object in treating neurotic victims of faulty learning is to provide them with an atmosphere that does not threaten their self-structure but that enables them to examine, recognize, and reorganize it, thus permitting an integration of their organism and their self and acceptance of experiences previously excluded as alien. The phenomenal fields of both therapist and client are usually sufficiently related to allow intelligible communication and meaningful interchange of feeling. During therapy the client, obsessed with self-criticism and self-devaluing because of failure to live up to the idealized image, soon becomes aware of contradictory attitudes. In the accepting and approving atmosphere of a therapy that is totally devoid of threat and imbued with empathy, the client becomes more tolerant of oneself and one's

failings. Tension abates and a reintegration develops as discordance resolves between the ideal image and the actual self-perception.

Constructive personality change is thus contingent on a number of stipulations. *First,* it is essential that the client be motivated to seek help. This is generally in the form of some anxiety produced by an awareness of a state of "incongruence," in that a disparity exists between the client's self-picture and actual experiences. *Second,* a special kind of human contact is required. In a client-therapist relationship, it demands (1) that the therapist be both empathic of the client's awareness of his or her own experiences and able to communicate what is going on in the client's inner world on the basis of this empathy, (2) that the therapist has ample self-awareness, is honest about personal feelings, and is capable of "being oneself' in the relationship in order to function congruently, and (3) that the therapist possesses a positive regard for the client, accepting fully every aspect of the client's experience and right to be and feel as he or she is. This does not mean that the therapist must be completely free of deviant response patterns as long as they do not force him or her to be authoritative and evaluating. *Third,* it is important that the client perceive, by the therapist's behavior and verbalizations, that he or she is fully accepted, understood, respected, and "cared about," irrespective of experiences, problems, and feelings.

Entering into a relationship situation with a client-centered therapist provides the client with a unique encounter in which he or she is neither challenged nor condemned, every aspect of the client is respected and accepted, and the client can yield defenses without hurt. Out of this adventure, a new conceptualization of the self evolves, with greater capacities to symbolize more accurately sensory and visceral experiences and with reconstitution of one's system to values in concert with the perceived self.

The guiding principle of client-centered therapy is oriented around the fact that the client or patient is the one responsible for his or her own destiny: the client possesses the right of choice of solution for his or her problems, irrespective of the choice of the therapist. Residual in each individual, it is contended, are resources for growth that need merely be released to enable the person to achieve maturity. The therapist strives to unleash growth forces by refraining from imposing patterns and values on the client and by promoting in the relationship the free expression of feeling.

Among the activities of the client-centered therapist are (1) attentive listening to the client's

communications for content and feeling, (2) responding by a friendly non-punitive, empathic attitude and by occasional verbal comments that neither approve nor disapprove, (3) pointing out the client's feelings, (4) structuring the extensions and limitations of the therapeutic relationship, (5) encouraging the client in his or her efforts to manage problems, (6) engaging in answering questions and giving information only when it is essential to do so to help a client work through problems, yet avoiding this directive role at the slightest threat of emerging dependency, and (7) refraining from insight offerings, advice giving, environmental manipulation, censure, commendation, or the posing of questions and suggestions regarding areas of exploration. The client is given complete responsibility for the choice of topic, the extent of concern with it, and the interpretation of the meanings of reactions. The therapist's responses are chiefly in relation to the evaluative ideas that the client verbalizes about himself and other people, and the feelings associated with such ideas. The role of the therapist is solely to direct the client's attention to his or her ideas and not to interpret or clarify.

The feelings of the individual are always accepted in a tolerant, nonjudgmental way and are reflected back to the person in order to bring to the client's consciousness the full pattern of his or her emotional attitudes. At times the rephrasing of the client's utterances helps the client to clarify facts. The catharsis involved in the process, as well as the therapist's activity in reflecting feeling, are believed to lead to genuine self-understanding and insight in the individual's own terms. The release of normal growth potentials helps the client to gain control over discordant forces in the self. The role of the therapist, thus, is to act as a catalyst of growth, a ("change agent") not to impose growth on the client.

Treatment, as can be seen, is oriented around the idea that the individual has the capacity to deal effectively with those aspects of his or her personality of which he or she becomes conscious during the relationship with the therapist. It is assumed that the client can achieve insight in the relationship and can accept and make constructive use of responsibility. Because efforts to interpret, evaluate, or guide the individual are felt to hamper the emerging sense of self-direction and self-growth, a passive role on the part of the therapist is mandatory. Rogers insists that a nondirective approach is not to be confused with a laissez-faire policy, which the patient is apt to regard as evidence of rejection or indifference. A truly nondirective attitude avoids clarification of the individual's attitudes, since this is a form of subtle directiveness. The function of the therapist is to perceive empathically the *feelings* of the client and to communicate this understanding. It is essential for the therapist to discard a preoccupation with

diagnosis, to stop making professional evaluations, to eliminate estimates of accurate prognosis, to abandon all attempts to guide the individual, and to concentrate solely on accepting and understanding the attitudes of which the client permits himself or herself to become conscious.

During therapy there is a gradual shift in the content of the material discussed— from symptoms to explorations involving the self. Changes develop in the perception of and attitude toward the self, with more positive appraisals and a more realistic consideration of oneself and one's environment. Judgments are recognized as originating in values residing within, rather than outside, the self. Perceptions shift from wide generalizations to more limited ones rooted in primary experiences. Symbolizations become increasingly adequate and differentiated. Movement is registered in awareness of denied or repressed experiences and feelings. Changes occur in personality structure and organization toward expanded unification and integration. Anxiety abates; neurotic tendencies decrease with greater acceptance of the self. There is heightened objectivity in the handling of reality, a more constructive mediation of stress, a harmonious expression of attitudes and feelings, and better intellectual functioning. Developing changes in behavior are in line with improved adjustment and maturity. Decreased tension, lessening of defensive tendencies, and greater tolerance of frustration are concomitant.

As has been indicated, diagnosis in client-centered therapy is not felt to be essential to the treatment process. Indeed it is conceived of as a hindrance. Making a diagnosis is also felt to involve the dangers of subordinating the individual to an evaluation by authority, putting the therapist in a godlike role. This opposes an atmosphere of equality. Psychometric tests similarly are not encouraged, for the therapist's attitudes toward the client may be colored by the test findings and the client is ill equipped to handle most of the information revealed by testing. The medical model, with its focus on pathology, diagnosis, and specificity of cure as a basis of understanding or working with emotional problems, is considered inaccurate. Not only is it likely to enhance dependency but it avoids the basis of the prevailing difficulty.

Rogers revised upward his original idea of client-centered therapy as being most useful in essentially normal people who have sufficient personality integrity to solve their problems with a minimum of help from the therapist. His contention is that his method is universally applicable from childhood to old age, from mild adjustment difficulties to severe psychoses, from "normal" to deeply

neurotic situations, from immature dependent people to those with strong ego development, from lower-class to upper-class citizens, from lowly to highly intelligent persons, from physically healthy souls to those with psychosomatic ailments.

It is claimed that transference does not develop too intensely in client-centered therapy since the individual is not evaluated nor held subject to specific rules. Self-esteem consequently is prevented from crumbling, thereby avoiding a dependent relationship. Where transference erupts, it is more or less disregarded; it is simply accepted, not explored or interpreted. In a climate of empathic understanding transference attitudes are said to disappear or to express themselves so minimally that they do not interfere with progress.

Past experiences and future projections are subordinated to the reality of the present, even though it is acknowledged that they might not be symbolized and thus operate to provoke tension. Conscious material is felt to be sufficient, and probings into unconscious motivation are not considered of too great importance.

In practice it has been found by many present-day client-centered counselors that a purely *nondirective* method does not suffice. Reflecting back to the client his or her words often failed to release the spontaneous growth forces postulated in the original client-centered approach. To be successful, therapeutic interventions needed to be conducted in a participant climate, provided by the operator, of accurate empathy, unconditional positive regard, and congruence. This constituted a base for "experiential therapy." Empathy requires that the therapist perceive expressed and unexpressed feelings of the patient, experiencing them as if they were his or her own. Unconditional positive regard necessitates respecting and valuing the patient's self-components. Congruence means manifesting authenticity and sincerity of feelings for the patient, whatever these may be, avoiding phony facades and revealing true responses rather than playing games.

The popularity of the client-centered approach is contingent on the fact that its theories are uncomplicated and relatively easy to understand; its techniques are simple to master, requiring little clinical experience for satisfactory results and involving few dangers to the patient, who actually works out his or her own problems.

Criticisms of Client-centered Therapy

Client-centered psychotherapy is tailor-made for persons who need and respond to a kind, caring, nonjudgmental atmosphere and who are ready for and possess a strong motivation for change. It is helpful to individuals with a relatively sound personality structure who require aid in clarifying their ideas about a current life difficulty or situational impasse and who may be responsive to a "helping process." It is less helpful in the treatment of emotional problems that contain strong anxiety elements. Anxiety is the greatest motivator of all human behavior; it impedes and even blocks the emergence of positive growth potentials no matter how tolerant and permissive the therapist may be. Anxiety nurtures resistance that can effectively prevent thinking about, or spontaneously focusing on, significant conflictual patterns. Left to one's own devices, the individual will usually avoid coming to grips with deep anxieties. He or she will even choose to retain neurotic defenses, warding off inherent impulses for growth. It is doubtful that anxieties rooted in unconscious conflict can be dealt with effectively by approaches that deal exclusively with conscious ideation. It is essential, then, that a therapist enter actively, at times, into a neurotic cycle. Resistances may have to be dealt with in a blunt and even forceful way. Similarly, even though the person may acquire self-understanding, anxiety may prevent his or her utilizing insight in the direction of change. Here, directive measures of challenge and confrontation may be required before inertia yields. Thus choice or rejection of a traditional client-centered therapy will depend on whether or not the individual is deeply disturbed emotionally, has existing ego strength, and the nature of the problem for which he or she seeks help.

For some patients, a completely accepting atmosphere will do little to interrupt repetitive, destructive defensive operations. Without arguing the advantages of a humanistic over a medical model, traits of genuineness and empathy, such as described by Rogers, are of distinct advantage in any kind of therapy and are indispensable aspects of a therapeutic personality. Such traits and the conduct of therapy along caring, nonjudgmental lines may reduce the severity of introjected authority imprints and help soften a harsh image of the self. They will not suffice, however, in dealing with pathology residual in unconscious variables that are provoking problems in adaptation. Dealing with such variables will require interventions other than or supplemental to the recommended client-centered techniques.

The field of client-centered therapy has, nevertheless, made an important contribution to

psychotherapy by pointing out basic elements in the "helping process," by emphasizing some essential principles in interviewing, by encouraging research into process and outcome (Seeman & Raskin, 1953, Cartwright, 1957; Shlien & Zimring, 1970), by stimulating a vast amount of professional literature, and by elucidating the management of certain phases of treatment, especially termination.

Directive Approaches

Directive approaches put the therapist in an active role in determining which of the basic problems of the patient to attack, the immediate and remote objectives, and the promotion of a plan of action. Persuasive and commanding tactics are often employed, the therapist exerting strong pressures on the patient, even purposefully mobilizing tension or reducing it with supportive techniques if tension becomes unbearable. Goals are thus more or less vested in the therapist, who makes an effort to dissect, tear down, rebuild, and resynthesize the personality.

A number of techniques aimed at these goals were originally delineated by F. C. Thorne, (1944, 1945, 1946, 1950) under the title *directive psychotherapy.* For instance a patient might be given information with the object of reorienting his *Weltanschauung.* This was done by confronting the patient with factual information about himself in an effort to get the patient to reevaluate his or her attitudes. The case history was used by Thorne both as a diagnostic and as a therapeutic aid, helping in establishing rapport, promoting catharsis, giving reassurance, and fostering insight. A more active technique was the therapeutic use of conflict. Where certain maladjustments were sponsored by too little concern, conflicts might deliberately be induced. Thus, the patient was provoked to reconsider attitudes in the direction of reality. The patient was then presented with his or her inconsistent behavior in a strong confrontational way in an effort to motivate him or her to resolve it. The extent of directiveness was gauged in each patient and varied from forceful coerciveness to a relatively participating relationship. Thorne, however, recognized that the term "directive psychotherapy" was too limited and nondescriptive of his method, which was of an eclectic nature, and he advocated a comprehensive integrative approach.

Concern with the past, issues of transference, and other dynamic principles are not considered vital or necessary for behavior change in directive approaches. Principles of cognitive behavior therapy are

apparently operative in certain forms of directive treatment and may be important in some individuals who are seeking a strong authority who can influence and regulate their lives.

Rational emotive psychotherapy is the name given by A. Ellis (1957, 1958b, 1965, 1973) to cognitive therapy procedures that combine formulations from semantic, persuasive, directive, and behavior therapies. Treatment tactics are organized around the hypothesis that aberrant emotions are controlled by faulty thinking processes, such as illogical "self-talk and internalized sentences." A search is consequently instituted for irrationalities in the patient's ideational stream that result in negative, unrealistic, and self-defeating behavior. Generally, this exploration will reveal the origin of illogical ideas in the attitudes of parents, teachers, peers, and, above all, the credos supported by the culture. The effective therapist must bring the patient's self-defeating verbalizations to his or her attention, show how they cause and maintain disturbance, reveal the irrational links in the internalized sentences, and teach the patient how to rethink and reverbalize these in a "more logical, self-helping way." For example, a commonly accepted misconception is that the individual must depend on, be loved by, and approved of at all times by others. In the patient's upbringing he or she is taught that to be self-sufficient is to be selfish. To reverse the behavior that this distortion produces, one must substitute the idea that universal approval is impossible and that dependency is self-annihilating. Self-sufficiency is by far a much more wholesome way of life, and it is in this direction that the individual must move. There are countless other illogical ideas to which the person falsely subscribes that operate to cause and to sustain neurosis. Release from these ideas can be brought about only by rethinking and reconceptualization. Toward this end, the therapist may employ many relationship-building and expressive-emotive techniques—analytic, persuasive, and behavioral—as long as the patient's self-defeating propaganda is ultimately defeated and a new rational philosophy of living substituted.

A number of other cognitive rational reeducative approaches, such as the "assumption-centered" psychotherapy of Anderson and the "problem-centered" method of Wertz, have been proposed. In each, the patient is confronted with his or her ideas and behavior that are maladaptive and is offered corrective solutions.

According to Frank (1984) one of the basic features shared by all forms of psychotherapy is that when they are effective they correct the demoralization produced by symptoms. Patients seek help only

after their morale has been shattered by symptoms. Such patients are often victimized by an "assumptive world" with distorted ideas about themselves, their future, and the world around them, which leads to symptomatic distress. By altering the meaning or expounding on the function of a symptom through psychotherapy, the "assumptive world" can sometimes be altered or rectified. Corrections in the "assumptive world" can result in changes in thinking and behavior which reinforce the gains produced by any form of psychotherapy. In *programmed psychotherapy* (Young H, 1974) the patient is given a series of significant problems and appropriate solutions to illuminate and revise assumptions. These problems are related to events in the patient's past history and are also taken from the histories of patients with similar problems. Psychotherapy as a form of instruction aimed at reorganization of "assumptive worlds" is considered in the section on cognitive learning, which is focused more on external than internal variables. Concerned with the latter (i.e., with identification of inner forces that create assumptive distortions and impede problem-solving techniques) are approaches such as those described by Brunner (1966) and M. T. McGuire (1968).

Combining the ideas and methods of psychoanalysis, individual psychology, rational emotive therapy, and behavior modification within an existential framework, Harold Greenwald (1974, 1980) has described a useful treatment in individual, group, and family therapy that he calls *Direct Decision Therapy* and that he dates back to 1970. The patient is asked to state as clearly as possible the nature of his or her problems and the goals he or she wishes to achieve. The patient and therapist jointly examine past decisions that created the problems that prevented the patient from reaching the goals. The therapist helps the patient become aware of these faulty decisions as they are expressed in the patient's activities, attitudes, and philosophy of life. The gains ("payoffs") for the decisions are examined. The original basis for the decisions is explored and is contrasted with its utility in the here and now. Next the patient is invited to examine options or alternatives that could enable him or her to function in a different, more constructive way. Once the patient has made a decision to change, methods are discussed regarding how to do this. Often the patient describes the method that he or she would like to try—Gestalt, hypnosis, rational emotive therapy, behavior therapy, and so on. The therapist obviously participates in making and implementing this choice.

Reality therapy is another directive method organized around the central theme of "identity as a core problem" (Glasser, 1965; Glasser & Zunin, 1972). In therapy the patient is guided away from

methods by which he or she avoids reality and is motivated toward success. The first principle is "involvement" by the therapist with the patient to demonstrate "that he cares, that he is warm and friendly ... willing, if indicated and appropriate, to discuss his own experiences and to have his values challenged and discussed." The therapist reassures the patient of confidence in him or her and communicates the belief that the patient can become happier and can function in a more responsible, effective, and self-fulfilling manner. Treatment is organized around the relationship with the therapist rather than the content of verbal exchange. The second principle of reality therapy is the focusing "on behavior rather than feelings." Doing is more important than feeling, and the therapist orients the conversation around the patient's daily actions. The third principle is concentration on the present and future rather than the past. If past critical events are mentioned, the patient is asked what was learned from them. Past character-building experiences are reviewed in relation to present success-oriented strivings. Constructive alternatives are explored. The fourth principle is helping the patient arrive at a value judgment about what he or she is doing to contribute to his or her own failure. The fifth principle is evolving a realistic life plan (perhaps put in writing in the form of a contract between patient and therapist) and assuming responsibility for seeing it through. The sixth principle is making it clear to the patient that no excuses for failure to execute the plan are acceptable. If failure occurs, a new plan is jointly made or the old one modified. The seventh principle is avoiding punishment, sarcasm, ridicule, or hostile statements; transference, when it occurs, is immediately dealt with and dissipated rather than encouraged.

Some therapists have used a form of treatment called *Releasing* to counter a potent source of stress that stems from the frustration that results when one urgently wants to change something that seems immediately difficult or impossible to change. The target of the desired change may be a current or anticipated irritating happening, a past event or memory, a physical need that cannot be fulfilled, indeed almost any stimulus, impulse, emotion, striving, or situation that is upsetting to the person. The consequence of this compelling urge or "wanting" is an overinvolvement with the target and an overpush to rectify it, resulting in further tension and anxiety. Awareness of what is going on, even insight into its dynamics, may not succeed in removing the existing distress. What is sometimes helpful is a cognitive shift that diverts the individual from engaging in self-defeating overpush maneuvers. Recognizing that some people inescapably become locked into cycles of stress, techniques such as the

"Sedona Method" have been used in workshops to help people "let go" of their investment in "wanting" (overpushing) to change things, which results in their stirring up troubles rather than resolving them. In this way, one hopes, they are "released" from overinvolvement and achieve peace of mind and freedom from tension.

Releasing techniques have been elaborated by a number of writers and lecturers. Patricia Carrington (1984) has written a textbook on "releasing" and has developed audiotapes that provide step-by-step instructions on how to use this method to reduce stress and enhance the quality of one's experiences. Included in the book are clinical examples of how to use the technique. According to Carrington, the procedures of "releasing" are not designed to replace psychotherapy, which deals with different psychological dimensions. In some cases, however, "releasing" techniques can operate as an adjunct to psychotherapy, particularly during the difficult phase in which insight is translated into action to alter unproductive patterns. There are some similarities between the "releasing" method and cognitive behavior therapy, persuasion, and desensitization; all work toward the same goals in a somewhat different way.

The goal of "releasing" exercises is to "let go" of trying to change whatever it is one wants to change, such as the behavior of another person, unalterable events, or past happenings. Effort or force (overpush) are eschewed. "As we let go of wanting to change any one thing (however insignificant it may seem to us at the moment)," says Carrington, "we simultaneously let go of whole networks of related events which are stored in our memory banks." "Letting go" of "wanting to change something" does not make a person passive or take away the motivation to overcome a problem. This is an important point because some people assume that letting go of the "wanting to change something" means that they have to detach and abandon the *desire* for constructive change. The "wanting" in releasing methods refers to the compulsive overpushing that does nothing to solve a problem. "Releasing," on the contrary is said to clear the mind so that a person can make constructive choices.

What may confuse some persons is the language used in "releasing." The word *releasing* simply means "letting go or yielding compulsive thoughts and behavior and not dredging up buried emotions." Explosive outbursts of emotional catharsis may occur in the course of practice sessions, but this is serendipitous. A good deal of the success of "releasing" is based on the suggestibility of the subject and

faith in the guide or teacher who is promoting a different way of thinking. As with any other technique, not all persons are susceptible to "releasing." It is designed to deal with the effects of conflict and with conditioned behavioral patterns and not with their sources. It does not propose to reconstruct personality but merely to redirect patterns of thinking. Understandably, it is not intended as a cure for serious emotional problems that call for more intensive treatment approaches. It may occasionally reduce stress in a subject who accepts its precepts and lacks a masochistic dedication to self-defeating behavior and who does not submit to other obdurate resistances to change.

Jay Haley (1963b) has described a type of directive therapy for the short-term management of patients, as well as for strategic interventions during long-term therapy, during which the therapist enters into an alliance with the patient's symptoms. Assuming that the dynamic function of symptoms is essentially power-motivated, Haley believes that the operations of the therapist should be pointed toward wresting control from the patient. Once the symptoms are clearly delineated, the therapist instructs the patient to do what he or she would ordinarily do anyway, such as indulge in the symptoms and withhold information.

The object is to encourage the resistances of the patient, but at the same time to bring them under the control of the therapist. Then it is suggested that symptoms will appear, intensify, and lessen under certain circumstances. Finally, the patient is enjoined to execute the symptoms in such a way that he or she cannot possibly continued them or until he or she begs to give them up. For instance, compulsive symptoms may be encouraged by the therapist until the patient requests a change, whereupon "permission" is granted to relinquish them. An obese woman with a yen for rich desserts may be ordered to restrict herself to only this item of food, which she may incorporate to her heart's desire. When she has surfeited herself to the point where sweets repulse her, she may then be given permission to eliminate them from her diet. A compulsive patient who is punishing himself with a distressing symptom is asked to discipline himself whenever the symptom appears—in other words, to castigate himself for treating himself so badly with his symptom. Ways of self-punishment may be worked out that will benefit rather than hurt the patient. Thus, a man who is convinced he must exercise more for his health is instructed that whenever his symptoms are intense, he will get up in the middle of the night and do deep knee bends. The relationship of these tactics to counterconditioning is apparent.

Criticism of Directive Therapy

Criticism of directive psychotherapy is voiced, particularly by psychoanalysts and client-centered therapists, in terms of the imposition on the patient of the therapist's goals and sense of values and the reestablishment of the disciplinary atmosphere of the child-parent relationship. Under these circumstances, liberation from the yoke of one's authoritarian conscience may be impeded, leading to an interference with growth toward assertiveness and independence. A disadvantage claimed is that the patient is kept on a dependency level longer than is necessary. Where the aim in therapy is to make the patient self-sufficient and capable of finding security within himself or herself, directiveness may inhibit this aim. In looking for security or support from the outside, the patient may be inhibited in developing an autonomous stand in life and in becoming a stronger being through his or her own resources. Another criticism of directive therapy is that hostility is often mobilized by the very nature of the magisterial relationship. This prevents the patient from becoming liberated from a punitive and severe conscience fostered by an irrational attitude toward authority. While the new ways of conduct that are developed may be better than those the patient has followed most of his or her life, they do not alter the intrapsychic structure. The patient virtually remains a child who has merely incorporated the mandates of the new parent-therapist. Critics of cognitive therapy attack the "guiding" influence of the therapist, whose own values and assumptions may not necessarily be pristine and accurate. In this way the therapist functions like a clergyman or educator whose philosophies or viewpoints are sometimes suspect.

Not all of these criticisms are justified. Actually, at certain points in all therapies a cognitive position is taken, as in psychoanalytic interpretations, in which bias is not too unusual. All good psychotherapists probably do a species of cognitive therapy after gaining an understanding of the existing fallacious ideas harbored by the patient.

The therapist's attitude and mode of dealing with a patient's rebelliousness at directive mandates will determine the direction of the behavioral change. Unless their dependency needs are too great, many patients will learn to cope with the directiveness of the therapist and to evolve new ego strengths out of their own spontaneous needs. If the therapist acknowledges the patient's right to criticize and shows respect for the patient's autonomy, the patient may be able to effect some change in concepts toward authority as universally obstinate and punitive. A value of directive therapy is in the techniques

that have been evolved, which may be adapted to some aspects of a therapeutic program, particularly during the resistive phase of translating insight into action. Freud himself acknowledged that some patients require forceful mandates when their resistance blocks constructive action.

CASEWORK THERAPY

Traditionally, social casework is a guidance or counseling technique based on the casework interview and employed by social workers. The aim is to help individuals find a solution to problems of social adjustment that they are unable to handle in a satisfactory way through their own resources. This process is usually divided into three parts: the case study, the plan, and the working out of the plan with the client. Casework, employed in this way, can be either preventive or remedial. In recent years the casework method has been enriched by knowledge from psychoanalysis, psychology, sociology, and other behavioral sciences. This has fostered an interest in broadening the function of the caseworker from management of manifest social problems and the utilization of community resources toward increasing the inherent capacities within the individual to cope more effectively with his or her environment. Interpersonal and social problems are resolved both to help clients meet unfulfilled needs and to adapt more adequately in their relationships with people and society. Toward this end, inner psychological difficulties are dealt with in addition to external vexations. The expanding role of the social worker is dealt with in greater detail in chapter (16) "Who Can Do Psychotherapy?"

In examining modern casework procedure we find that the process of helping is remarkably similar to that of psychotherapy with educational goals. The complaint factor is usually a social or relationship problem, and the motivations that prompt consultation are focused on external rather than internal problems. The ultimate objective is to enhance social functioning, but the means to this usually necessitates some change within the client's attitudinal and value systems as well as the customary modes of problem solving. To reach this goal, the client is encouraged to express feelings about accepting and utilizing help while the caseworker responds empathically to communicate understanding. Basic is a proper diagnosis to determine the nature of the problem, the changes that can or cannot realistically be implemented, and the most expedient means of bringing about these changes. The initial inquiry *(the social study process*) secures important information about the client, the social situation confronting the client, and the difficulties that bring him or her to the agency. To help in the survey, as complete

information as possible is obtained regarding the client's assessments, feelings, and judgments. Information other than that revealed by the client is secured from authoritative sources, such as hospitals, schools, courts, and agencies. Skilled interviewing is mandatory to obtain reliable data that will contribute to a workable diagnosis and the estimate of possibilities of change. Helpful also are planned visits to the client in the family setting. The *social treatment process* is geared toward strengthening the client's adjustment skills as well as reducing destructive environmental pressures. The practitioner must be on the alert to obstacles that block the client's coping capacities and ability to utilize available environmental resources. The amount of active help and support given by the worker varies with the existing strengths of the client. As the latter gains in understanding and problem-solving talents, less and less active help is extended. Reasonable short-term goals are designed with the object of giving the client greater confidence in reaching long-term, more difficult objectives.

It is obvious that what is being described in this process is a treatment that focuses on social change; however, it is one that inherently and inescapably aims for enhancement of growth processes within the individual, a diminution of regressive tendencies, and a more realistic appraisal of inner capacities.

Focus on the individual's capacity for self-direction expands ideal goals of casework from mere solution of the complaint factor to actual intrapsychic change. The means toward this reconstructive end will vary with the theoretical orientation of the practitioner. In the past, social workers, increasing their operations, concentrated largely on the field of psychoanalysis and drew their inspiration from two sources, the theories of Otto Rank and Sigmund Freud.

The school of *functional casework* (Kasius, 1950), oriented around the teachings of Otto Rank, attempted to help people seeking specific services in social agencies in such a way that the use of the services became psychologically constructive for the individual. The relationship with the caseworker therapist was considered a "helping process," in which the individual experienced a new, constructive way of observing himself or herself and of relating to another person. The relationship served as a kind of laboratory in which the client acted out, with a representative of authority (the therapist), the full range of attitudes and patterns such as belligerency, detachment, ingratiation, and the need to control or to be controlled, that were habitually cherished toward authoritative persons. The therapist handled these projections as a necessary part of the client's accepting help and, in tolerant recipience, reflected

back to the difference between the projections and the existing realities. This enabled the client to become aware of his or her characteristic ways of relating and permitted the client to accept in a more realistic manner the kind of help being offered. The client was charged with direction for processes of change; choices and goals were conceived of as his or her right and responsibility. Within the limitations of the structure of the agency, the client was free to move toward self-responsibility and self-acceptance. The relationship between therapist and client was thus believed to serve two aims: first, the solution of a specific problem and, second, the evolvement of a more mature personality.

The school of *diagnostic casework* with theories, drawing largely from the teachings of Freud and his contemporaries, tried to provide a corrective emotional experience for the individual through the medium of a positive relationship with the caseworker-therapist. The relationship was not the central core of treatment as in functional casework, but rather it was a vehicle toward increasing the client's ability to solve problems on a more adult level. The attitudes of the client and the kind of relationship that he or she sought with the therapist were used diagnostically, but they did not determine the direction of therapy. This was geared toward dissipating inner conflict and expanding ego strength as well as reducing, by social planning, existing environmental pressures. Objectives were variably graded to meet requirements of the diagnosis and the specific needs of the client. Techniques, which included emotional catharsis, reassurance, guidance, clarification, and interpretation, were used in whatever ways best served to increase the capacities of the ego. The focus of discussion was on the client's problems, particularly on ways of overcoming obstacles to their solution imposed by inner feelings and social reality. There was a continued evaluation and reevaluation of the problem from cues supplied by behavior patterns and attitudes, from the client's responses to the therapeutic situation, and from reactions to interpretations and suggestions made by the therapist. Projected irrational feelings and attitudes were recognized and discussed, leading to greater awareness of current patterns of behavior and of their origins in earlier relationships. The client gradually was led to see connections between present attitudes and conflicts and those harbored toward parental and other important personages in the past. The goal was a strengthening of ego capacities, a reappraising of reality issues divorced from anachronistic expectations, a developing of a sense of being valued, and an incorporating of acceptable social concepts and standards. As in functional casework, dreams and other derivatives of the unconscious were accepted, but they were not handled or interpreted unless the caseworker was trained

to do reconstructive therapy.

These differential points between the functional and diagnostic schools are not as rigidly drawn now as they were in years past. This is because both systems have not fit into the contemporary practice scene, which is branching off into many areas, including the behavioral field and group work.

Since casework practitioners must be concerned with both intrapsychic and social systems (the family, groups, community), they need several models to understand their interactions, for example, psychoanalytic theory and social system and role theories. Perhaps it was inevitable that analytically oriented practitioners would move from classical theory to that of ego psychology. According to this, the ego is conceived of as the mind's regulating mechanism toward management of needs and feelings. The ultimate aim of casework is toward enlarging the capacities of the ego to select more rewarding aims and objects. Stressed is an assessment of the client's motivations causing resistance to taking help and of utilizing help effectively in the interest of improving healthful adaptive patterns. Immediate and long-term goals are particularized, including situational changes to enhance improved client functioning.

Frances Upham (1973) has outlined a method of ego analysis to influence the developmental process that has been interrupted by pressures with which the individual in the past was unable to cope. The practitioner serves as an identification model, as a supportive ally to enhance existing strengths, and as an educator to teach new skills in modifying the environment and evolving more constructive coping patterns. Once a helping relationship is established between client and practitioner, a search is made for any resistances. To resolve these, the practitioner attempts to clarify misunderstandings, supply information, outline alternatives, and negotiate differences between expectations and possibilities of fulfillment in the medium of empathic understanding. Positive transference is not interfered with, but negative transference is handled actively by discussion and interpretation. An agreement is reached regarding the kind of help that will be administered and the goals to be attained.

The practitioner in working with the client attempts to assess the available coping strengths and weaknesses that will help or hinder the treatment plan. This estimate is based on a developmental model during which more elaborate ego patterns are progressively evolved on a biological timetable. The practitioner gauges modes of perception that help orient the individual to reality, enabling him or her to

relate to other human beings and to play essential roles in the service of adaptation. The practitioner makes an assessment of cognitive capacities, of adaptive and maladaptive patterns, of adequacy in managing drives, needs, and feelings, of maturity in handling relationships with others, of abilities in utilizing executive competence in carrying out goal-directed activities, of sophistication in integrating patterns toward appropriate functioning, and of the sense of identity. Such assessment acts as a basis for interventions to increase the client's capacities and lessen limitations. It enables the recognition of adaptive patterns that require strengthening as well as the recognition of maladaptive ones that necessitate change.

As it will be seen, such a method draws from psychoanalytic, social, and role theories and flexibly accepts supportive, reeducative, and reconstructive goals, recognizing that these must be graded to the motivations, resistances, and adaptive plasticities of the individual. While unconscious motivation and conflict are accepted as key sources of behavior, and transference is acknowledged as perhaps inevitable, free association and dream analysis are not employed. The focus is on resistances and defenses that operate currently, and there is greater emphasis on the present than on the past.

Behavior theory is also influencing the current dimensions of casework. Some practitioners find in behavioral approaches shortcuts to dealing with specific symptoms and complaints, and some practitioners concentrate on group approaches that they believe are more practically attuned to the needs of clients.

Casework practices are not static but relate to continued advances in the field of the helping processes. In recent years, for economic and other motives, caseworkers have been increasingly entering the field of "clinical social work" and moving into private practice as clinicians, offering increasing competition to psychiatrists and clinical psychologists.

RELATIONSHIP THERAPY AND "ATTITUDE THERAPY"

Relationship therapy was the name given a half-century ago by John Levy (1938) to a process in which the focus of treatment was organized around the patient-therapist relationship. While admitting projection into the relationship of many attitudes and feelings related to the past, interpretations were

made in terms of feelings experienced in the present, F. H. Allen (1934) also described a system of relationship psychotherapy with children that acted as a positive growth experience, releasing forces that make for more complete development. The work of Taft (1933) on the relationship aspects of casework may during this epoch be considered in this category.

As the name "relationship therapy" implies, the relationship is the vehicle that both promotes change and serves as a target for an inquiry into basic interpersonal patterns. The therapeutic encounter constitutes for the patient a new experience with a human being, which permits full expression of needs and strivings without retaliatory injury or rejection. The awareness gained in this unique setting helps patients readapt to their situations and achieve some of their potentials. Actually, what has been described as relationship therapy has been recognized as constituting a vital aspect of all therapies.

In "relationship therapy" the therapist provides a corrective emotional experience for the patient by absorbing the patient's neurotic behavior and not responding to it with expected anger or indignation. Instead, a non-critical interpretation of the behavior is offered, with suggestions of an alternative style for handling oneself. Sometimes the therapist will model a more constructive way of managing the environmental provocations that beset the patient. Relationship therapy may be helpful for individuals who are unable to utilize expressive insight-oriented therapy and yet need to change destructive patterns. This method is embodied, without labeling it as such, in many counseling, educational, and behavioral approaches in which the therapist adopts the stance of a non-punitive, helpful authority figure guiding the patient toward a more productive way of life. It can be helpful in developmental and other crises. Whether it can replace a punitive parental introject with a more tolerant figure and thus lessen hostility and guilt is difficult to say, but over a long-term period we may anticipate a softening of a harsh superego if countertransference is kept under control while the patient doggedly and sometimes brutally tests the sincerity of the therapist.

The term *attitude therapy* was used originally by David Levy (1937a) to describe a process of treating children by working with the disturbed attitudes of their parents. At present, the term is sometimes employed to describe a reeducative procedure focused on the current dispositions of the patient. Distortions in attitudes are examined, their origins discussed, and their present purpose appraised. Following this, attitudes that make for harmonious relationships are introduced as topics for

discussion, and the patient is helped to incorporate these as substitutes for morbid habitudes. Thorne (1950), for example, suggests a reeducative method that identifies "core attitudes" that cause varied maladaptive secondary traits and characteristics. The core attitudes, once identified, are neutralized by presenting opposite healthy sentiments to promote a reorganization of attitudinal constellations. Since the patient will not yield old ways of thinking readily, repeated emphasis on a new point of view is essential to achieve desired results. A systematic reconstitution is attempted of the patient's outlook as it affects various areas of the patient's life. Reinforcement of new attitudes is achieved by providing the patient with a corrective emotional experience within and outside of therapy. Some of these techniques have been utilized in the methods of cognitive therapy.

DISTRIBUTIVE ANALYSIS AND SYNTHESIS (PSYCHOBIOLOGIC THERAPY)

Adolf Meyer (1915, 1948), founder of the psychobiologic school, emphasized that the human being was an "experiment in nature," the product of an integrated fusion of somatic, neurological, and psychological organizations fashioned by social conditionings. It was impossible, he claimed, to isolate any one of the many structures that made up the totality of a human being. They all had to be considered in relation to the living individual and not regarded as detached units. Furthermore, Meyer urged an empirical viewpoint, utilizing the contributions of any of the various branches of science that could shed light on the total behavior of the individual. A person was to be studied as a functioning unit in society and as a part of nature by means of the scientific method. Because a human being evolved from lower forms, it was necessary to investigate human physics, chemistry, biology, embryology, anatomy, and anthropology. Because a human being differed from lower forms, it was essential to examine the more highly developed qualities that distinguished a human from the lower species. The most intricate function was that of mental activity, which Meyer termed "mentation" or "the minding function." This included the ability to sense, imagine, discriminate, communicate ideas, learn, recall, think, and reason.

In studying human behavior it was necessary to take into account everything significant in the life history of the person, including heredity, body build, temperament, developmental history, illnesses, traumatic experiences, and the interaction of the individual with parents, siblings, and other important personages. It was necessary to consider intellectual, spiritual, and sexual development, school, vocational, marital, and community adjustments as well as interests, ambitions, moods, habits, and life

goals. Toward this end the therapist was enjoined to exploit all methods of diagnosis. It was vital to understand that each individual had a different capacity for bearing stress. Hence, it was necessary to evaluate the strength of the personality through an assay of one's assets and liabilities.

The psychobiologic approach, with its emphasis on eclecticism and its consideration of every facet of the individual's functioning as material for inquiry, had a great influence on the mental hygiene movement in this country. It gave rise also to an eclectic therapy known as "distributive analysis and synthesis," or "psychobiologic therapy."

In psychobiologic therapy (Billings, 1939; Kraines, 1943; Muncie, 1948), therapist and patient cooperatively engage in a systematic examination of all forces that go into the shaping of the patterns of the patient, namely, hereditary and constitutional elements, early childhood conditionings, and later experiential influences, including educational, economic, work, marital, interpersonal, and social factors. An initial workup consists of a thorough exploration of both the patient's problem and personality. This usually involves an inquiry into the individual's life history, a physical examination, and psychological testing. A psychiatric social worker, clinical psychologist, internist, and psychiatrist can function together as a team here in making a proper study.

The character of the complaint, the history of its development, and the patient's past and current attitudes toward it are discussed thoroughly. All available sources are explored, with the help of a psychiatric caseworker if necessary, to determine hereditary, constitutional, and experiential elements of importance in explaining the patient's reactions. The patient's social, sexual, work, educational, and recreational adjustments are considered, as are interests, ambitions, habits, cravings, and conflicts. Since the therapeutic objective is the retraining of unhealthful attitudes and the elimination of immature reaction patterns, it is essential to obtain as clear an idea of the patient's personality in operation as is possible.

A physical examination is important not only to detect existing organic conditions, but also to reassure the patient and to inspire confidence in the competence of the therapist. X-ray and laboratory facilities are utilized where indicated. Psychological testing, particularly projection tests, yield data as to personality resources and liabilities, existing anxieties and conflicts, and the nature of the patient's

defenses against anxiety.

The initial workup is invaluable in estimating the best type of therapy to utilize at the start, the prognosis, and the possible duration of treatment. It allows for a much more scientific approach to the patient's problems.

Factors divulged in the initial study, which have operated to mold the individual's personality and to produce the present disorder, are examined systematically in a series of interviews. The past is considered important in providing an understanding of the makeup of the individual. The past is translated, however, in terms of the patient's present attitudes. The formulation of difficulties is couched in concepts consonant with the patient's current capacities for understanding. The therapist always attempts to avoid leading the patient into material that he or she is unable to face, and the therapist tries to circumvent the stirring up of guilt or resentment that may interfere with progress. The manner of thinking displayed by the patient, and general reaction tendencies, are carefully studied. A life history chart may be constructed, detailing important facts in the patient's case, including family background, socioeconomic influences, and significant childhood and adult experiences.

Once a blueprint is obtained of the formative and presently operating influences in the patient's neurosis, the therapist strives to help the patient make constructive use of what has been discovered. This is not done in a mechanistic and authoritative way. Treatment following Meyer's inspiration is a matter of negotiation between patient and therapist for the most favorable solution. In this process the relationship between therapist and patient is important to understand, always implicitly and at times for explicit analysis.

> To the greatest degree possible I rely on the spontaneous contributions of the patient to keep the process going, but I do not exclude my right to bring up new or unfinished topics pertinent to the problem. And always the historical roots of the problem in overt or covert material from the past are used to illuminate the points where education in living went astray. Then comes the effort to discover unused learning opportunities—unused because of emotional blocks. Dependence on the therapist is not denied the patient, but encouragement to assume the risks involved in the reeducation process is given. There is constant feedback—as there must be in meaningful negotiation. (Muncie. 1976)

Discussions cover in great detail those facts that have influenced the patient and his or her problems. The patient, one hopes, through these discussions, gains insight into the difficulty. During

each interview positive and constructive elements are accented, successes are emphasized, and hopeful elements are brought to the fore. This is to counterbalance and to counteract negative, destructive forces and liabilities. The patient's assets are constantly considered against liabilities. A "synthesis" is then made of those factors that can help in adjustment, and the patient is encouraged to deal with life through a healthier perspective. The patient is encouraged to correct disturbing environmental situations and to avoid or to control traits that adversely influence adjustment. The patient is also inspired to develop adequate compensations. As treatment goes on, and more material becomes available, the therapist's initial hypotheses may have to be reformulated.

A number of techniques (such as suggestion, guidance, reassurance, persuasion, and confession and ventilation) may be used jointly toward the goal of a more constructive adaptation. If analytically trained, the therapist may deal with the more deeply repressed material, utilizing psychoanalytic techniques, such as free association and dream interpretation. While the clinical material of psychoanalysis is accepted in psychobiology, psychoanalytic theoretical explanations are considered intuitive and metapsychologic rather than scientific. Therefore, a broader biosociological explanation is attempted for which there is experimental evidence or reasonably assured probability.

Pointed questions are asked and areas of discussion are delineated, but the patient is stimulated to think things through for himself or herself. The focus in therapy is usually on present situations and symptoms of which the patient is aware rather than on unconscious attitudes and mechanisms. The relationship between the patient and therapist is explicitly analyzed only when found to be necessary, and no attempt is made to induce the patient to relieve past experiences, although an understanding of present reactions in the light of past conditioning can be helpful.

These techniques may, in an incredibly short time, help to restore a patient to an emotional equilibrium, symptom free and capable (because of the knowledge that has been gained) of avoiding pitfalls that have hitherto created anxiety. Additionally, the patient may learn to utilize his or her assets to best advantage and to get along in life far better than before. Correcting difficulties in relationships with people may relieve much anxiety, tension, and hostility. Knowledge of his or her character weaknesses may make life more tolerable. Discovering positive qualities within himself or herself help raise the patient's pathologically low self-esteem. The dynamic sources of the individual's emotional

problem are sought to the degree necessary to achieve understanding. The relationship with the therapist may inspire curative forces that influence personality growth.

The philosophy and methods of psychobiologic therapy have been incorporated into the body of many, perhaps most, of the current psychotherapies without giving credit to the rich contributions of Adolph Meyer, Wendell Muncie, and other pioneers in this field.

INTERVIEW PSYCHOTHERAPY (PSYCHIATRIC INTERVIEWING)

"Psychiatric interviewing" is the appellation attached to certain interview procedures that attempt to bring the patient to a state of awareness by focusing the interview on pertinent problems. Most types of psychiatric interviewing are forms of insight therapy with limited goals—focused or conscious stresses and conflicts—since deeply repressed elements of personality are not exposed to awareness. Transference material and dreams are utilized rarely, if at all, as foci for interviewing. What is essential is an effective doctor-patient relationship, the employment of goal-directed planning and management, the focusing of content on specific aspects of behavior, and use of minimal activity (Fine-singer, 1948).

The ultimate goals in treatment are formulated in advance, considering the preliminary diagnosis, the patient's needs, and the therapist's clinical experience. Intermediate goals are determined by what is happening in the therapist-patient relationship and by the kind of material that is brought up during discussions. Focusing of the interview is generally, at first, along lines of an inquiry into existing symptoms, attitudes, and problems. Next, there is a search for repetitive patterns in the patient's behavior. Then, the effect of habitual patterns of current behavior is explored with an investigation of the meaning and function of such patterns as well as their historical origin. Flexibility must be observed in intermediate goals, and there is usually a shift from one to another, determined by the needs of the situation. Interpretations are made for the patient, as required, and, from time to time, there are summarizing statements.

A focusing of the patient's attention on relevant topics is essential to avoid rambling. This may be achieved by exhibiting interest or by displaying disinterest in specific topics brought up by the patient. The therapist employs as minimal amounts of activity as are consistent with therapeutic plans and goals.

Only when the patient fails to respond does the therapist become more active. A careful regulation of the relationship is essential, being balanced between emotional support and the stimulation of tension to activate therapeutic progress.

Interviewing procedures consist of studied nonverbal and verbal responses. Included in the former are facial expressions, nodding, glances, gestures, postural changes, and vocal inflections and intonations. Low-activity verbal responses are preferred; they consist of articulate syllables with rising inflection, repetition of the patient's last uttered word, elaboration of a phrase, mild commands, and questions of a general or specific nature aimed at exploring a certain topic.

Greater activity is required only where material is not readily obtained. Technical procedures here include a repetition of the patient's statements with special emphasis, rearrangement, or juxtaposition, statements of a descriptive, elaborative, or summarizing nature, and direct questions in relation to associations. Difficulties in communication may be handled by questions related to the manifest problem and by mild or more active encouragement to talk. Methods of marked activity are used only when absolutely essential. These consist of suggesting reasons for reticence, interpreting the reasons, provoking emotional reactions through rapid probing, focusing on the relationship, forcing the patient to verbalize material, or displaying affect. Extreme active measures are rarely indicated, such as active reassurance, shared experiences, gratifying the demands made by the patient, and shifting the relationship in the direction of a social experience.

A less structured method of therapeutic interviewing, directed toward goals of insight, has been described by Stanley Law (1948), which he believes can be learned and practiced by general practitioners.

SEMANTIC APPROACHES TO THERAPY

J. Ruesch (1957, 1959) and R. Spiegel (1959) have hypothesized that abnormal behavior is accompanied by physical and social interference with communication. The more intense and repetitious the interference, the more extensive the traces that exist to plague the person. Therapy, focused on improving the patient's communication process, may lead to a better ability to relate interpersonally, and

also to acquire a more cogent understanding of oneself, in regard to one's inner life, past experiences, and current interactions.

Formal study of human evaluative processes, particularly in relation to signs and symbols, is the goal of the field of "general semantics." Semantics deals with systems of symbols, including language structures, and the uses made of these systems by individuals and social groups, as well as the influence on the systems of existing social values and individual behavior tendencies (Korzybski, 1941). Therapeutically employed, semantics tries to teach the individual the principles of scientific thinking through a more valid use of communication.

The rare employment of semantics as a therapeutic method necessitates a high degree of intelligence in the patient and requires special semantic training for the therapist. During treatment, a mutual examination of verbal forms used by both therapist and patient is conducted to see whether exact meanings are being communicated. There follows a detailed evaluation of the patient in relation to language efficiency and the prevalence of semantic problems. Finally, semantic retraining is employed to teach the patient the more exact use of symbols and terms. Adequate problem solving presupposes a sufficient mastery of language and use of symbols to enable the person to state difficulties, differentiate them, make inferences, and draw conclusions from facts. The person must know something about the uses and abuses of symbols. These are the foci of investigation in semantic therapy.

W. Johnson (1946) has outlined the effect of semantic difficulties on adjustment. One syndrome of maladjustment is the product of unrealistic ideals in life which bring about disappointment and frustration. Part of the problem is due to the doubt that governs the individual's ideas, making it impossible for the person to conceptualize clearly what he or she wants from life. The person is, therefore, inevitably disappointed in efforts to gain pleasure in living. Another source of maladjustment is the inability to identify or even state problems coherently because language is poorly organized and lacking in clarity. This vagueness in thinking, embracing faulty notions about oneself and fallacious concepts of the meaning of life, interfere with the formulation of realistic goals.

Semantic distortions include oververbalization, which may serve the function of avoiding silence, of concealing the truth, or of searching frantically for meanings. Underverbalization is another response,

which is often motivated by a fear of failure, demoralization, or perfectionistic strivings. There may be great verbal rigidity involving content, modes of phrasing, and moods. There may also be a defect in the capacity to discriminate levels of verbal and nonverbal abstracting. Other disturbances of communication occur that require careful analysis and diagnosis.

In therapy, once a good relationship with the therapist is established, semantic training and reorganization are practiced. Interpretations are given the patient as the semantic defects become apparent. Training proceeds as rapidly as the patient's resistances will permit. As the patient becomes capable of formulating the problem cogently, he or she greatly expands the ability to communicate with freedom and clarity. Verbal rigidities relaxing, the patient becomes more conscious of the real difficulties, feelings about oneself, and life goals. By being able to put the problem into meaningful words, the person is helped to achieve greater volitional control over emotional processes.

When we evaluate the semantic approach to therapy, we have to consider that all emotional ailments are associated with problems in communication. These involve, among other things, vagueness in phrasing and defects in conceptualization. As long as there is an unclearness in the use of symbols, the individual is unable to define, differentiate, or think critically about his or her attitudes, values, and life goals. It is likely that a good part of the existing communication difficulty in emotional illness is the product of repression—a purposive attempt to cloud issues in order to keep painful aspects of the personality outside the range of awareness. During any kind of psychotherapy patients, by mastering anxiety, become capable of expressing themselves more and more clearly and of verbalizing in increasingly explicit terms that which they had hitherto merely been able to feel. This restores the patients' ability to deal more adequately with the sources of their problems.

In summary, semantic approaches to therapy put the emphasis on the patient's difficulties in communication. Emotional illness is believed to arise from problems of symbolic functioning. The focus of the therapeutic effort is on defining and clarifying symbols, making the patient's use of them more precise. As the individual formulates ideas more clearly, interactions with others become more meaningful.

REEDUCATIVE GROUP THERAPY

Group therapy may have the reeducative goal of altering attitudinal and behavioral patterns (Pratt, 1907; Slavson, 1944, 1946, 1947; Solomon & Axelrod, 1944; Rome, 1945; Luchins, 1947). The group setting offers the patient a splendid opportunity to relate to others and to observe distortions that develop in such relationships. Benefits accrue to the patient from experiences with other members within the group. A protective as well as challenging milieu fosters the growth and expansion of cooperative attitudes that may eventually replace neurotic strivings.

Dynamics derived from a study of the process of individual psychotherapy do not seem to suffice for such group experiences. In searching for a comprehensive and operational theory of reeducative groups, we are obliged to enter the field of sociological research. Some efforts here have been made to apply research in group dynamics to therapeutic groups (Bales, 1950; Cartwright & Zander, 1960). In recent years communication theory and systems theory have added some important dimensions (Durkin, 1975).

Group therapists contend that the group experience can liberate and give direction to what is socially significant in the indivdual. A person is by nature a group creature and needs to associate closely with others in order to operate adequately as a human being. Unfortunately, disturbances in relationships of emotionally ill persons eventually alienate them in the group, i.e., society. The therapy group provides an atmosphere for resolution of some of these distortions. An overcoming of neurotic impulses may follow experiences of becoming less defensive toward others. This may lead to greater tolerance of personal lacks and failings.

During the past few decades a great deal of work has been done, particularly by social psychologists and sociologists, on how people relate in groups. Description of the observable variables in a group and delineation of the dynamics of interaction are the contribution of the field which has come to be known as *group dynamics.* This field is distinctive from that of personality dynamics, of which psychoanalysis is the best known representative, which, applying itself to the *why* of human behavior, deals with the motivational determinants. Some of the data from studies of group dynamics are applicable to therapeutic groups. Unfortunately, there is still very little communication between group therapists and social psychologists.

Perhaps the major contribution to group dynamics was made by Kurt Lewin, who, utilizing field therapy, focused attention on the complex and shifting nature of group life (1947, 1948, 1951). Lewin emphasized that in a group there is an interdependence of the individuals, which characterizes the "dynamical whole," and that a change in one subpart can effect change in the state of any other subpart. A group was thus more than a sum of its parts; it had unique characteristics of its own. Individual psychodynamics could not explain behavior since the individual was subject to social forces in the form of pressures by the group. Such *group pressure* could effectuate changes in behavior. Under Lewin's leadership, experimental studies attempted to delineate the internal structure, processes, phenomena, and laws of group life as well as to apply these data to such practical problems as group productivity, leadership, and cohesiveness, which occurred in industry, education, correctional work, and other fields. The research and bibliography in group dynamics have been substantial, including among others the work of French (1941, 1944), Festinger (1942, 1947), Bavelas (1948, 1952), F. Deutsch (1949, 1951), Cartwright (1950), Homans (1950), Bales (1958), and Hare (1962). The contributions of Bion (1951) have been especially noteworthy. Bion pointed out that members of a group at first look for a leader on whom to depend but soon realize that this is a fantasy and that one must look to oneself for survival. They then form pairing couples, which also leads to disappointment when one realizes that no one can be fully depended on to fill a hoped-for role. This encourages impulses toward fight (quarreling among themselves) or flight (leaving the group). Working through these impulses can have a therapeutic effect.

The concern of psychotherapists with group dynamics is predicated on the basis that behavioral changes are constantly being consummated through the individual's interactions with family, peer, occupational, religious, and other groups of which he or she is a member. Processes may thus be observed taking place within the individual in his or her relationship with others, in the course of which certain kinds of change come about. A study of the dynamics of change illuminates some of the allied operations in psychotherapy. Moreover, it helps differentiate the contingencies that precipitate out in all groups, irrespective of structure, from those that are specifically parcels of the psychotherapeutic experience.

Common to all groups are a number of phenomena: (1) all groups possess some kind of structure, (2) the members assume or are assigned special roles, (3) goals toward which the group strives are implicitly accepted or explicitly defined, (4) a communication network mediates the interactions among members, (5) group norms are applied with varying pressure to each individual (social control), and (6)

both cohesive and disorganizing forces are at all times operative.

Dynamic interaction is the essence of group activity. Never static, the group constellations alter themselves as new fusions, enmities, and alliances allocate different roles for the members. A status hierarchy emerges, which determines the nature and direction of communication. Interacting patterns are evolved that reflect role expectancies.

Observation of different groups in operation discloses a number of consistent processes (Wolberg LR, 1966):

1. Individuals upon entering a new group bring into it all of the distortions and expectancies that are parcels of their personality structure, while attitudes directed toward them by the other members similarly reflect their prejudices. These immediate impressions are rectified as interaction continues, perceptions tending to become more reality-oriented ("consensual validation").

2. A status struggle often occurs at the beginning of group formation during the establishing of leader-follower hierarchies. Members reach out for leadership on the basis of a number of inner needs, such as identification and dependency. Leadership characteristics are not the same for all groups; they depend on the culture and needs of the group. Intelligence, dominance, self-confidence, vitality, the ability to relate to the goals of the group, and the capacity to participate socially have been found to be important in all groups.

3. The norms developed by the group represent rules of behavior designed by the group to achieve its expressed or implied goals. Group norms applied to an individual define his or her role expectations. The individual also possesses norms that are related to personal values and goals, which may or may not conflict with group norms.

4. All groups approach one or more of four goals: (a) the group goal of problem solving in relation to some area of concern involving all members (as in a parent-teacher or industrial group), (b) the group goal of resolving expressed or undefined social-emotional problems, for example, shared anxieties (as in an executive-training group where group dynamics are emphasized), (c) the goal of supplying an individual in the group with a solution to a personal need (as in a social or educational group), and (d) the goal of solving emotional difficulties associated with personal and relationship disturbances (as in a therapeutic group).

5. The structure of the group, and the activities that it sponsors, will, more or less, be modeled by the goals toward which the group directs itself. Generally, goals relate to resolution of an explicitly defined external problem that concerns the group or to a less well-defined social-emotional problem within the group that is reflected in shared anxieties.

6. Group size influences the responses and movement of the group. As numbers in the group increase, information and suggestion giving become more pronounced. This is accompanied by a diminished request for and expression of opinions and by a lessened agreement among members. Groups of two (dyad) show high tension, avoid antagonism and disputation, ask for opinions (but shy away from giving opinions), and focus on the exchange of information and on reconciliation. The optimal size of a group is five, a smaller or greater number being less satisfactory to members. Discontentment is expressed if the group gets too large. Each additional member expands the potential relationships among the individuals and subgroups. As the group increases in size, members feel inhibited and threatened, and the leader becomes more removed from the members. Greater difficulty exists in reaching a consensus.

7. The superiority of group over individual performance has been tested. It has been found that manual productivity is greatest in groups, but intellectual productivity is not necessarily increased. Problem solving within a group framework is enhanced in some individuals but retarded in others. Group discussion, however, makes individual judgment more accurate. Recall of information is expanded in a group setting.

8. A variety of situations make for greater group productivity. Productive groups are composed of members whose skills are appropriate for the tasks. The most resourceful and accomplished groups are small, are cohesive, are of the same sex, have a satisfactory communication network and feedback, and are led by a skillful leader. Autocratic leadership encourages greater quantitative productivity, while democratic leadership results in optimal morale. In authoritarian settings authoritarian groups achieve greater output; in democratic settings egalitarian groups are more efficient. Personality characteristics that result in compatibility of individuals in a group and in free communication make for expanded group productivity. Tasks are best accomplished by a group in which rules are appropriate for the tasks. Where cooperation is expected, there is greater individual incentive, friendliness, communication, and productivity; self-oriented needs in a member here tend to disrupt the group. Application of stress, if not too strong, encourages greater productivity; if too strong, the group yield diminishes. Productivity is retarded by any conflicts that develop in the group.

9. Conflict often appears when the roles of two members clash (“role collision”), where an individual plays two opposing roles (“role incompatibility”), and where group members

cannot agree as to expected roles ("role confusion"). It also develops where the personality structure of an individual does not coordinate with the role expectation that is dictated by his or her position in the group. Ethnic, status, intellectual, and educational differences among the group members may act as sources of tension and conflict.

10. Cohesiveness is expanded and disruptive forces are minimized where the members know and like each other, where the prestige of the group is stressed, where members are rewarded on a cooperative rather than competitive basis, where they possess strong mutual interests and are democratically led, and where communication processes are facilitated.

11. Both deviance and conformity are present in members of a group. The more highly the individual regards the group, the more he or she needs its prestige, its output, or the friendship of its members—the more he or she will want to conform. Interactive processes in the group are released by a deviant. This has an effect on group morale, group decisions, and group cohesiveness. Every group exerts pressures on its members to conform to accepted norms. Where a member deviates in behavior from the norm, that person is subject to one of four choices: conform with group norms, change norms to align them with those of the group, operate as a deviant, or retire from the group. Deviant members are pressured to yield to majority opinion, which some will accept. Conformity is encouraged where the majority maintaining a contrary view is large, where membership in the group is valued, and where one's opinion must be stated publicly. Yet a minority viewpoint is possible where the minority possesses high status, is considered expert, or is especially popular. Thus, a leader may promote his or her ideas in the group and find them accepted even though they clash with sentiments of the group majority; yet the leader will also have to abide by group norms once they are solidified.

Membership in a group influences the way an individual perceives reality, his or her decision making, and the nature of his or her values and prejudices. Often the individual will suppress a correct perception or judgment in favor of the majority opinion, particularly from respected sources, firmly convinced that conclusions have been independently reached. Where a person is highly motivated to remain in a group, he or she is more prone to resist arguments, however logical they may be, that are opposed to the group norms. This principle has been found empirically useful and probably accounts for certain dramatic changes, hardly possible in individual therapy, that come about in therapeutic and some social groups (Alcoholics Anonymous, Synanon, etc.).

Group dynamics share with psychotherapy the common goal of altering norms in the individual. The manner in which this change is implemented differs in the two disciplines. Psychotherapy approaches the problem of change by dealing directly with the forces of emotional motivation and conflict; group dynamics operate more peripherally through the influences of group interaction and pressure. Each of the disciplines complements the other. During individual psychotherapy the patient continues to be permeated by pressures from family and peer and secondary groups. In group psychotherapy the individual is in addition subjected to group dynamic vectors.

The pressures of the group for individual conformity are great. A problem posed here is that if group standards are abnormal, it will be difficult for an individual to change a pattern supported or sponsored by the new group. Should behavior be altered in isolation, the deviancy will come under attack when returning to the old group, and one may be forced to assume a previous role. Thus it would seem, as Lewin pointed out, a group change may have to precede transformation in attitudes in a group-rooted individual. One may, however, retain the gains by leaving the customary group for a group whose norms are more consonant with the newly developed ideas. Or one may assume a leadership role and change the norms of the habitual group to coordinate with one's own.

R. Dreikurs (1950) speaks of the "unique social climate" experienced in group psychotherapy. Among its distinctive qualities is the fact that the therapy group acts as a natural testing ground for observation and experimentation with the phenomenon of group values. It has been discovered that the values operating in a therapy group geared toward reeducational objectives are best democratic or egalitarian, as each member, regardless of achievements or deficiencies, is granted equal status and rights in the group. Another value stressed in the social climate of the group is honesty and frankness, the ability to reveal oneself freely without putting up a front. The therapist, too, functions as an equal among equals, who can assume the responsibility of leadership because he or she knows more about human relationships than the other members of the group. Binding the group members together is the need for mutual trust, for belongingness, and for mutual identification.

In addition to the phenomena of group dynamics, which operate in all groups and on which the therapeutic results of educational groups are to a large extent dependent, Slavson (1957) has pointed out that "in therapy groups there constantly occurs verbalized and nonverbalized interpersonal action

and reaction, partly as a result of therapeutic projections and partly because of the inevitable effect persons have upon one another, such as contagion, mutual induction, interstimulation, intensification of emotions, sympathy, empathy, and others. These cannot be considered, however, as group dynamics but rather as interpersonal interactions." Interpersonal factors are constantly operative in groups and complement the effect of group dynamics as well as the more irrational transference phenomena that are exploited in analytic groups.

As each patient interacts with other members and behavior is discussed frankly, and often with affect, he or she gains greater self-understanding by allowing feelings to be harbored and expressed in an accepting climate. The group may stimulate destructive patterns in interpersonal relationships, but eventually the members may be able to participate without exploiting their neurotic character drives. For instance, a power-hungry person may learn in time to merge closely with the group without being controlled or hurt. A negativistic individual may discover that yielding to others does not mean abandoning one's personal rights and freedom. A detached patient may derive positive pleasures from slowly entering into group activities. As group members relate to each other freely, they learn to compromise as well as to give and receive. Thus they begin to develop cooperative participation, helpfulness, and friendliness, which may in time replace destructive interpersonal feelings. H. T. Glatzer and Pederson-Krag (1947) have emphasized the importance of these interpersonal patterns. The group setting provides individuals with a theater in which to play out their impulses and fantasies. It is not uncommon for group members to create surrogates (father, mother, siblings) and to project transferentially onto them archaic needs and defenses. These, when detected, may be interpreted to the patient by the therapist. Immediate emotions are dealt with and handled, particularly those the patient can face without too much anxiety. In this way, the patient gradually becomes aware of his or her feelings and even of some of the origins of neurotic conflicts. The object is to help people come to terms with themselves.

Activity Group Therapy

Slavson (1943) has described a type of reeducative therapy called "activity group therapy," which is used with children in the medium of a social club. Complete permissiveness prevails and the youngsters are free to express all types of behavior. This usually results in a cathartic ventilation of

feelings. Arts and crafts materials are supplied, refreshments are served, and outings are arranged. Children's activity groups are usually composed of eight to ten members whose ages are relatively comparable; for instance, children from 6 to 9 may constitute one group, those from 9 to 13 another. The participants are encouraged to be freely emotive and expressive. There is no special focusing on problems, although aggression, destructiveness, withdrawal, and other disturbed kinds of behavior that endanger the child or others are dealt with in a firm but kindly manner. A permissive and understanding environment is the keynote. The setting of limits is essential, for instance, in regard to destroying property, taking things from one another, and persistent fighting. The group functions as a secondary family, with the therapist as substitute parent. Relationships established with the therapist and with others in the group may lead the members to a more realistic conception of the world and of themselves. This awareness is gained within the action setting, and not through interpretation.

Activity groups with adults have also been developed around special interests and needs of the participants. Thus, sports, crafts, games, photography, painting, sketching, carving, mosaics, and other hobbies and recreations may form the focus around which the group is organized. In hospitals, day hospitals, and therapeutic communities, occupational therapy (see Occupational Therapy), special programs of exercise (Coulter, 1966), and social clubs (Bierer, 1944, 1948) may be the means of bringing together persons who eventually begin to relate to each other. In outpatient set-ups, dramatics, music (see Music Therapy), dance and movement (see Dance and Movement Therapy), poetry (see Poetry Therapy), and social activities (see Social Therapy) may constitute the central diversion that enables the audience to communicate and to release their feelings. Caseworkers have developed a social group work process around the rehabilitative needs of their clients (Hendry, 1948; Konopka, 1947, 1960, 1963; Kunstler, 1955; Lindeman, 1939; M. Murphy, 1959; E. Phillips, 1957; Schwartz, 1959; Trecker, 1955; G. Wilson, 1941; Wilson & Ryland, 1949). This provides enrichment of school-day and after-school programs as well as activities for the handicapped and the aged. Health education, recreation, camping, athletics, dramatics, arts and crafts, social dancing, forums, lectures, and other constructive measures are combined with skilled guidance to meet the various needs of clients. The introduction of an activity provides structure to individuals who otherwise would be too inhibited to interact.

Directive-Didactic Behavioral Group Approaches

Bringing small groups together to discuss matters of special interest to the members constitutes an important reeducative measure. Such topics may concern health, marital relationships, child-parent difficulties, and social and community problems of the widest range. During the sessions the participants bring up subjects for discussion which may then become the central theme. In less active groups the therapist may deliver prepared talks or lectures around which the deliberations may proceed. Even Bible-reading classes have formed the basis for therapeutic assemblages (Marsh, 1931). There is some advantage to organized presentations in settings where personnel changes are the rule, and relatively little disruption is experienced when the regular group leader is replaced by a new leader who continues with mimeographed or printed material. Books and readings may be assigned as part of the proceedings. A tendering by individual group members of their problems and histories serve as periodic interesting diversions (Pratt, 1953). Sometimes group relaxation (Jacobson, 1938) and group hypnosis (Wolberg LR, 1948, p. 180) precede talks and discussions. These methods have the advantage of calming the group by enhancing the placebo effect and putting the therapist in the role of a benevolent healer. Persuasive arguments may better be received under these circumstances.

Some therapists who work in hospitals have stressed the importance of "will" therapy, which emphasizes self-help and encourages the continuance of group discussions after patients leave the institution. An example of such a self-help group movement is Recovery, Inc. (Low, 1950).

In groups led by a therapist dedicated to behavior therapy, group hypnosis with desensitization techniques may be employed, particularly with phobic patients (Lazarus, 1961). Behavioral groups are usually most effective with patients sharing common symptoms, such as agoraphobia, fear of flying, a smoking habit, obesity, sexual problems, or deficiencies in assertiveness. Behavioral techniques may then be appropriate for all the patients. Subgroups are usually organized on a short-term basis for up to 6 months. Among the group therapy approaches incorporating principles of learning theory (Mowrer OH, 1950, 1953) are those developed by Saslow and Matarazzo (1962) and Small et al. (1963), which regard emotional difficulties as learned disturbances subject to extinction, reinforcement, and reeducation.

In hospital setups didactic groups have been operating for many years, providing special topics and guided discussions for patients who are too detached, regressed, or deteriorated to enter into spontaneous interactions (Marsh LC, 1931, 1935; Klapman, 1946; Low, 1950; Klapman & Lundin, 1952). Persons who have been apprehended or imprisoned for antisocial tendencies, such as sex offenders, juvenile delinquents, prisoners and paroled convicts, often benefit from guided group conferences. Alcoholics and drug addicts profit from didactic approaches combined with repressive-inspirational measures, such as practiced in some Alcoholics Anonymous and Synanon groups.

Nondirective (Client-centered) Group Therapy

Therapists espousing the philosophy that inherent self-actualizing tendencies may be released in an atmosphere of permissiveness, "genuineness," and empathy have applied their concepts to work with groups (Hobbs & Rogers, 1951; Hobbs, 1969; Gordon, 1955; Lifton, 1961). In accordance with client-centered theory, the therapist operates to confront, guide, and clarify feelings and distortions that prevent the group from realizing itself as a constructive body that can release the growth potentials of each member. In an atmosphere in which the free exploration of feelings and communication to other members is encouraged, self-understanding and self-acceptance emerge. The activities of the therapist are geared toward conveying to the clients "through gesture, posture, facial expression as well as by verbal means, the therapist's *congruence,* his sense of acceptance and of confidence in the ability of the client, with the help of the group, to resolve his problems... . The therapist does not interpret, probe, evaluate or reassess... (Smith et al, 1963).

Family therapy

It has been said that a family is an autocracy ruled by its sickest member. Often this member is not the "primary patient" who is sent out for help. What we generally observe within the family structure is an unstable homeostasis maintained through interlocking neurotic roles that the various members play with one another. Such roles are usually concealed from the awareness of the participants by perceptual blocks, and their resolution is staunchly resisted, particularly in families with either a psychotic or borderline member. The evolving network of interlacing patterns is remarkably stable, and sometimes contagious, being passed along in almost pure culture from one generation to the next. Other patterns are

constantly being influenced and modified by defenses and reaction formations. Affectionate, supportive, domineering, submissive, exploitative, punitive, aggressive, indulgent, cooperative, sadistic, masochistic, detached, seductive, inhibited—these and other traits are adopted through identification with parents or are compounded in the crucible of family life in response to the pressures, deprivations, and indulgences brought to bear on the individual. Constantly in play are configurations that operate in the service of both healthy and neurotic adaptation.

The permutations of traits among the parents and siblings become diverse as controllingness is met by compliance or rebellion, overprotection by helplessness or compulsive independence, neglect by defiance or distrust. Incompatibility between father and mother, between parental and social values, between intrinsic family standards and the laws of the prevailing subcultural group generate complex subpatterns in all of the inhabitants in the home. These, derived from the incorporation of and resistance against attitudes present within the family, often act as sources of conflict. Neurosis or psychosis that breaks out in one or another of the members is merely an event in the family drama and may actually constitute a means of helping the constituent members achieve a kind of tenuous balance. Should the developing problems precipitate intolerable symptoms in a member, he or she may be the first emissary (the "primary patient") from the disturbed family group.

It is apparent from this that disabling emotional problems in any single individual must be approached within the context of relations with the family group. The patient's difficulty is usually a symptomatic manifestation of a disorganizing family unit. Only rarely do we find that only one member of a family is emotionally ill; generally several and even all members share the disturbance that manifests itself most dramatically in the "primary patient. "The emotional equilibrium of a subgroup may be maintained by the sacrifice of one member or another subgroup in the home. The "scapegoating" of selected persons is a common phenomenon in establishing a balance, which easily becomes disrupted should the victims begin to emancipate themselves. Thus mother and daughter may war against father, who seeks his peace in alcoholic overindulgence, the latter becoming the grievance around which battles are fought. A father's competitiveness with his son, with subtle imposition of expectations beyond the resources of the child, may drive the latter into a schizoid retreat, which then marshals further aggression from the father and detachment by the child.

Subgroup splits may be along several lines, varying roles being assumed as the alliances are joined or relinquished by changing needs. New alignments are encouraged by a host of forces, including the maturational demands of growing children as they proceed from the helplessness of infancy through the defiant turmoil of adolescence into adulthood—as well as disintegrative trends in contemporary society itself, expressed in pressures toward conformity, impingement on personal freedom, and social upheavals that interfere with the sense of identity, feelings of security, and the need for belongingness essential for the requirements of a stable personality. Manifestations of alienation and conflict may take the form of minor engagements between parents and siblings, with dogfights and cursory clashes; or they may be expressed in violent prolonged eruptions. Generally, however, a cold war of attrition is waged between family subgroups, open combat being avoided because of guilt feelings or fear of hostility. This subversive warfare is most wearing on the belligerents; eventually the weakest members break down. Encouraging such collapse is a precipitating event, such as the imposition on the individual of demands that require a new role, for example, a change in occupation, death of a family member, sexual maturation, marriage, or the birth of a child. The family pathology may manifest itself either in outright neurotic or psychotic disorganization of one or more members. Or the family itself may fail to fulfill its traditional function of child rearing and responsibility to the community because of such disruptions as abandonment, unwarranted divorce, and delinquency.

The family then, as the cradle of health and illness, must be considered in any appraisal of individual emotional illness. It is both the fount of neurotic contagion and a potential resource for therapeutic intervention. Acceptance of this doctrine has sponsored a systematic family approach, which has proved to be productive in both diagnosis and treatment of individuals and groups. Even though therapy ultimately may be focused on one person, a recognition of the family vectors operating on that individual in the past and present is vital. Bringing the family together and working with various members who need help has, in many instances, resulted in a better understanding of one another and in an improvement of their mutual relationships.

The origins of family therapy are vague. The field of social work for years dealt with individual problems in a family setting. It was not a coincidence that Nathan Ackerman, who worked with a child guidance social agency over fifty years ago, began exploring the possibilities of the family as a vehicle for growth as well as pathology. J. E. Bell (1953) and Jackson (1959) published some of the earliest ideas on

the family as a focus for treatment, and in 1958 Ackerman made a seminal contribution with his book on the psychodynamics of family life.

In the short time of its existence, family therapy has witnessed the evolvement of a surprising number of models (Ackerman, 1954, 1957, 1957b, 1958a, b, 1960, 1961, 1965; Albert, 1960; Bateson, 1959, 1960, 1961; Bateson and Jackson, 1963; Bell JE, 1961; Bell & Vogel, 1960a, b; Boszormenyi-Nagy, 1962; Boszormenyi-Nagy & Framo, 1965; Bott, 1957; Brim, 1960; Carroll, 1960; Ehrenwald, 1963; Elkin, 1962; Ferreira, 1960; Fleck, 1960; Framo, 1962; Friedman, 1962; Fry & Heersema, 1965; Goodman JA, 1962; Grotjahn, 1960; Haley, 1962a, b, 1963a; Jackson & Satir, 1961; Jackson & Weakland, 1961; Kadis & Markowitz, 1963; Lidz, 1958; Masserman, 1959; Parloff, 1961; Rubinstein, 1964; Satir, 1963, 1964; Spiegel, 1958; Watzlawick, 1963; Weakland, 1962). While no specific methodology has emerged from current work in the field, various strategies of relationship and communication have been developed, such as split family, intergenerational, couple, individual as well as conjoint family sessions (Stein, 1966). Flexibility in approach is most helpful (Deutsch D, 1966). Treatment of family members or a spouse may follow individual therapy ("consecutive therapy"). Treatment may be done by different therapists ("collaborative therapy") or by the same therapist who utilizes both group and individual treatment ("concurrent therapy"). Treatment may involve the entire family in the same room ("conjoint therapy") as well as individual treatment for one or more members ("combined therapy"). It may involve the treatment in the same room of more than one family ("multiple family therapy"). It may employe co-therapists or multiple therapists when necessary. Procedures are improvised in accordance with the clinical perceptiveness, theoretical orientation, inventiveness, and idiosyncratic working methods of the different therapists. For instance, some approaches draw their substance from social and role theory (Murphy G, 1947); communications theory (Watzlawick et al, 1967); general systems theory (Bertanlanffy, 1968); intergenerational systems theory (Bowen, 1978); social learning (Weathers & Liberman, 1978); interpersonal perception (Liang et al, 1966); behavior theory (Patterson et al, 1975); psychoanalytic theory, with an accent on Freud, Adler, Horney, or Sullivan, contingent on the favored school of the therapist; transactional analysis (Berne, 1963); or Gestalt therapy (Perls et al, 1951). Irrespective of orientation, the family therapist seeks to eliminate destructive symbiotic bonds that tie family members together.

The aims of family therapy are not only to resolve current problems and difficulties but to teach the

family to solve further impasses by itself, to communicate more clearly with one another, to develop strategies for avoidance of conflicts, to accept one another's handicaps and differences without blaming and scapegoating, and to foster "functional processes for appropriate balancing of competing values such as family cohesiveness and individuation, balanced separateness *and* togetherness, stability and flexibility, to name only a few" (Bodin, 1984). Family therapy is of prime importance in crisis intervention (Everstine & Everstine, 1983). Indeed there is no limit to the conditions for which family therapy may be suited since family relationships affect and are affected by the entire host of afflictions to which people are subject. The essential separation on which maturity rests is usually impeded unless there is a working through of aggressive feelings the members have toward each other (Rubenstein et al, 1966). It is to be expected that the family at first will resist altering its fixed patterns of interaction. Attempts will be made to coerce the therapist into supporting the neurotic cohesiveness and divisiveness that fosters the family neurosis.

Improvement in one member of a family may be resisted and sabotaged by the others who need the identified patient to be ill to maintain their own and the family's homeostatic balance (Lewis JM, 1984). The resistance will be especially great in mother-child symbiotic patterns, and particularly in overcoming "double-bind" verbal and nonverbal communicative links (Bateson et al, 1956; Jackson DD, 1959). It may be possible to detect in the family relationships how parents communicate their unconscious demands to their children. The therapist will, at first, be enlisted to serve as judge and to allocate blame. As patterns are challenged, new alliances and fusions are sought. The therapist is then promoted to the role of omniscient adviser who can provide answers and gratifications. When these are not forthcoming, new subgroups and pairings organize spontaneously, around which different patterns of conflict develop. The working through of these collusions eventuates in more realistic attitudes. Establishing better communication among the members helps them to allay guilt, to resolve defensiveness, and perhaps to realize that the pressures to which they are exposed are motivated by forces that have little to do with them. More tolerance of and compassion with the problems of the aggressor alleviate resentment and hopelessness. Rebelliousness and other forms of acting-out may be replaced by more wholesome ways of standing up to and relating with the aggressor. Eventually, new values and healthy modes emerge.

There is a tendency to overemphasize the existing family pathology without giving due recognition to healthy elements that are present and that may be mobilized even in the sickest family constellations.

Family therapy may activate latent resources not apparent during phases of family crisis when members collide with and withdraw from each other. How effective this can be is illustrated by the experiment of family-oriented therapy in 50 cases of acute decompensation applying for admission to the Colorado Psychopathic Hospital (Pittman et al, 1966):

On the assumption that the suicidal act or psychotic collapse was one manifestation of family disorganization, the therapeutic goal was as rapid restoration of the family equilibrium as was possible while developing new roles among the members. An immediate evaluation of the family problem was made, and absent relatives were summoned to the hospital. The patient's symptoms were considered as efforts at communication and were interpreted to the patient as such. Guilt feelings and reluctance to cooperate on the part of relatives were dealt with firmly. The involvement in the patient's problem of each family member was demonstrated, responsibilities were outlined, and tasks assigned. The patient and family were faced with the grim fact that the presenting symptoms of the patient were escape mechanisms and that a modification of family roles and rules was the best way to proceed. Role assignments were considered important, and tasks were allotted to each family member. This ended the functional paralysis in the household. A team visited the home in 24 hours to see that the tasks were being carried out. Medications were prescribed when necessary. Any social agencies already servicing the family were included in the planning. Responsibility for the patient's symptoms was imperatively placed in the family to reinforce the need for cooperative task performances. As new rules were made and role assignments set up, daily visits were sometimes necessary to help meet the needs of the different members and to see to it that the treatment plan was being followed. Pressure was exerted on the patient and family to change, their responsibility to change was preemptorily assumed. The success of this experiment was demonstrated by the fact that hospitalization was avoided completely in 42 of the 50 cases; 6 cases required temporary care for an average of 17 days, and only 2 cases needed long-term hospitalization. An average of 6 home or office visits per family was required, and some member in 75 percent of the families was referred to another agency for long-term outpatient services. Ten of the 50 families called again about a subsequent crisis, but this usually required only telephone handling.

In patients who have been hospitalized, conjoint family group therapy has been done with four or five patients and their families meeting together as a group led by a therapist and co-therapist (Laqueur & LaBurt, 1966). The objective of such meetings is not to solve problems or give advice, but to improve

communications within the family and to explore attitudes likely to form sources of difficulty in the family that may lead to a relapse of illness in the patient when returning home. The families have an opportunity to learn from each other by analogy, indirect interpretation, mimicking, identification, and objective description. (Techniques in family therapy are described in Chapter 52.)

Conjoint Treatment of Married Couples (Marital Therapy)

The realization that no psychopathological condition exists in isolation, that it is an appendage of more extensive psycho-pathological processes within the family structure and social matrix, has resulted in a recasting of individual psychodynamics in the mold of family and social dynamics. A consequence of this orientation has been to see both husband and wife together as well as individually, or in groups with other married couples, even though symptoms occur in only one partner. Experience persuades that a feedback of pathological processes goes on from one to the other partner and that these must be dealt with definitively before either one can get well. In studying marital alliances, it becomes apparent that in many cases the choice of a marital partner rests on the hope that the prospective spouse will fulfill urgent unconscious needs that have been consciously rejected and repudiated. The most compelling of these needs are transferred by the mechanism of projective identification to a spouse who one hopes will introject and act them out. Reciprocal needs in the spouse follow the same dynamic and result in an interlocking projection-introjection collusion that makes psychotherapy difficult unless both partners are involved in the therapeutic plan. Otherwise, improvement in one spouse can result in disruption in the homeostatic balance of the other, encouraging a sabotage of the partner's treatment.

A variety of treatment tactics have been used in this conjunctive effort, including counseling, casework, small group process, group therapy, and intensive psychoanalysis with a Freudian or neo-Freudian accent. Among the most important intervention strategies, in addition to the psychoanalytic (Abies & Brandsma, 1977; Sager, 1976), are systems therapy (Haley, 1976; Minuchin, 1974a&b), client-centered approaches (Guerney, 1977), behavior therapy (Jacobson & Margolin, 1979), and combined therapies (Paolino & McCrady, 1978). Formats include crisis counseling, collaborative therapy, concurrent therapy, conjoint marital therapy, conjoint family therapy, combined-collaborative therapy, and multiple group therapy. The extensive early writings include Bird and Martin (1956), Boas (1962), Bruyn and deJong (1959), Dicks (1953), Dreikurs (1950), Eisenstein (1956), Ellis (1958a&b), Faucett

(1962), Green S. (1954), Greene & Solomon (1963), Grotjahn (1960), Gomberg (1956), Goodwin and Mudd (1961), Harrower (1956a), Hastings and Runkle (1963), Harper (1960), Herbert and Jarvis (1959), Jackson and Grotjahn (1958b), Kadis (1963), Kohl (1962), Katz (1965), Laidlaw (1950), Leichter (1962), H. E. Mitchell (1963), Mittelman (1944a, 1948, 1956), Oberndorf (1938), Perelman (1960), Sager (1966a&b), Satir (1965), Saul et al. (1953), Sarwer-Foner (1963), Tharp (1963), A. Thomas (1956), A. S. Watson (1963), and Whitaker (1958).

Later contributions include those of Alger (1967a, b), Berman and Lief (1975), Bolte (1970), Fitzgerald (1969), Framo (1973), Greene (1972), Hurvitz (1970), Martin and Lief (1973), Minuchin (1974a), Sager et al. (1968), Watzlawick et al. (1967). The extensive bibliography in the field indicates the wide prevalence of marital pathology.

Couples in trouble often consult marriage counselors, ministers, lawyers, and even friendly people of goodwill to advise them on proper steps to straighten out their entanglements. Where the partners are not too seriously plagued by neurotic drives, where their defenses are flexible and reasonably intact, and where they essentially love and respect each other, they may at least temporarily be held together in marriage by such consultations. Usually, however, the sources of serious marital problems are rooted in inner conflicts and stem from the operation of personality disturbances that resist pressure, education, convention, and the lessons of morality and proper decorum.

The prescription of tasks and exercises that are intended to influence couples to be less abrasive toward each other, to communicate more constructively, and to foster a balanced relationship will therefore not succeed in those couples whose behavior is intractably motivated by urgent unconscious needs and impelling inner conflicts. For example, if a wife transferentially relates to a husband as if he represents a hateful brother with whom she was in competition during early childhood, she may resent being nice to him and continuously fail in her therapeutic assignments. A husband who is struggling with a dependency need, idealizing his wife as a mother figure who must love, nurture and take care of him, may be unable to give up acting irresponsibly, resisting the independent role his wife insists he must assume as a condition for more fruitful living together.

We should not minimize the utility of the various persuasive, behavioral, and cognitive techniques

practiced by counselors to expedite marital congeniality. They can be valuable, but they will miss their mark if one utilizes them while ignoring the enormously important developmentally inspired motivational forces that are constantly maneuvering marital partners to act against their best interests. These more insistently dictate the terms of conduct than any injunctions, maxims, precepts, recipes, prohibitions, and interpretations presented by the most skilled and dedicated marital counselors.

Most therapists dealing with marital difficulties agree that the complex triangular transferential problems inherent in working with a couple make treatment difficult. As Ackerman (1964) has pointed out, the therapist's role is that of a participant-observer, who must be forthright and at times even blunt. As the therapist moves alternately in and out of the pool of marital conflict, it is necessary to make free and undefensive use of oneself. Sager (1964) has suggested five levels of involvement in conjoint sessions:

1. Elucidation of the current source of irritation between the spouses.
2. The working through of role, function, rule setting, and who is in charge.
3. Consideration of how roles intermesh or clash (complementarity).
4. Recognition and analysis of defensive behavior.
5. Understanding and dealing with transferential reactions.

V. M. Satir (1964a&b, 1965) encourages the couple to be authentic and spontaneous and to risk committing themselves to reporting all feelings and thoughts without inhibition. Through what she calls "communication analysis," she attempts to help each partner change so that self-maintenance is substituted for "parasitic operations." An analysis of the respective ideas of the interaction of parents as marital partners is encouraged ("model integration analysis"). Often one finds in such analysis that marital partners attempt to accomplish in their relations with one another what was lacking in the families of their origin. What they assume with each other is not a husband-wife association but a parent-child or sibling relationship ("role-function discrepancy"). A number of processes become apparent in the working through of role discrepancies. First, the individual attempts to perpetuate his or her style of matching current experiences with previous expectations ("manifesting self"). Second, there is

recognition that the individual has separate needs and modes of operation apart from the spouse ("separating self from the other"). Third, accepting the uniqueness of the separate selves, there are attempts at decision making, considering the needs of the partner ("making room for the other"). Fourth, a search is conducted for compromise settlements of life needs, negotiating for what is suitable ("ways in which differentness is acknowledged"). To achieve these goals best, the therapist must report to the couple fully and clearly what he or she observes in the marital interaction. The therapist acts as a "model of communication," asking questions, intervening, giving answers, and demonstrating how to pose questions, and to negotiate for meaning. The therapist serves as a resource person, presenting a delineated structure that encourages change in a way that permits the marital pair to identify and use its own resources.

The advantage of treatment of two individuals connected by blood, marriage, or friendship, together or separately, according to Grinker (1966), are many, such as revelation of new areas of information, a more precise clarification of issues, stimulation of intense affect, mobilization of repressed content, provocation of transferential and countertransferential reactions, increased reality testing, and reduced acting out, all of which provide for a corrective emotional experience and help shorten therapy. On the other hand, there are disadvantages in that the released heightened emotions can be upsetting to both patient and therapist: The divulged material of one or the other partner puts a strain on confidentiality and trust; the atmosphere becomes provocative of intense transference and countertransference, leading to acting out on the parts of therapist and patients; the trap doors to repressed or suppressed feelings and impulses are lifted too rapidly to permit proper control and working through of the material; and the therapist is more easily led into a sadomasochistic triangle.

The actual techniques of marital therapy are detailed in Chapter 52.

Criticism of Educational Group Therapy

There is little question that an educational group, chiefly through group dynamics, can influence values and behavior significantly. It may provide the individual with opportunities for constructive learning and serve as a means of working through some distortions in the basic personality structure. The benefits of reeducation, however, are too often registered as an overlay, superimposed on

unchanged underlying impulses and attitudes that will, in situations of stress, tend to displace the newly acquired characteristics. Unless intrapsychic restructuring has occurred, results may be impermanent. This is not to depreciate group dynamics, nor to say that true cognitive alterations are not effectuated through reeducational groups. They do occur, but they cannot always be relied upon.

Wolf and Schwartz (1962) have pointed out the difficulty of relying on group dynamics as a therapeutic force: "The group dynamic emphasis brings with it a failure to differentiate one patient from the next and occupies itself with phases of group development... . The use of group dynamics in interpretation and as a means for affecting change in the individuals that constitute the therapy group is a misperception and a rejection of both intrapsychic and interpersonal processes." The authors consider that in a group directed toward personality change, one should consider group dynamics as they emerge as resistance phenomena that must be resolved. "A group therapist who occupies himself with group dynamics is catering to the patient's resistance. To contemplate the seeming homogeneity of response is to give undue importance to the superficial and obvious reaction and to disregard the covert and unconscious individual responses."

There are some group therapists, such as Bion (1961), who attempt to circumvent the limitations of reeducational therapy by utilizing group dynamic phenomena, when they appear in a group, as material for analysis of the group as a whole on the basis that resolution of the "group neurosis" will effectuate reconstructive changes in the individual members. This approach is described by Bach (1954) in these words: "The group is a state or projection screen onto which the total repertoire of conscious, pre-conscious, and unconscious needs are internalized, projected, acted out, recognized, and corrected through a group-center therapeutic work process." H. Durkin (1957) has stressed that group dynamic and psychotherapeutic processes are on the whole mutually reinforcing. Both group dynamics and interpersonal reactions are present in all groups. They may be destructive as well as constructive for the individual. If therapists apply themselves to support the beneficial elements, with analysis and resolution of destructive aspects as they come up, a reeducative group may serve the individual remarkably well in fostering a more wholesome adjustment and in liberating tendencies toward greater self-realization.

PHILOSOPHICAL AND RELIGIOUS APPROACHES

Essential in human adjustment is a salutary philosophy that gives direction to one's needs and substances to life's goals. Philosophical and religious systems abound that lend purpose and meaning to existence. Embedded in these ideologies are ways of adjusting to inequities, of executing obligations to others, of finding peace and contentment. More remotely, they seek to alter the individual's sense of values.

A fundamental goal of psychotherapy is to effectuate a change in value systems through an altered perception of one's inner self. Philosophical and religious approaches aim for and sometimes accomplish the same purpose through a different means, namely, by direct attempts to influence modes of looking at things through entreaty, logic, argument, or authoritative mandate. Such approaches are often embraced in an effort to bring about peace of mind, to bolster personality defenses, and to open up outlets for promptings that could otherwise neither be countenanced nor expressed.

Since psychological needs are diverse, no single religious or philosophical credo appeals to all persons. Variant drives and defenses make for endless protocols that are organized to fit specific designs. Thus, ungratified mothering will open the door to the acceptance of philosophical or religious systems that promise protection, love, and pleasure from some "God-mother" or "earthmother," if not immediately, then in the hereafter. The price of submission, condign obedience, and indulgence in ritual and prayer, is small indeed for the size of the bounty promised. Illustrative of how philosophies may substantiate coping mechanisms are the mystical cults that reinforce detachment and introspection and the stoical systems that put a premium on masochism and self-punishment. Credendas and codes can neutralize a severe conscience that puts an embargo on impulse expression. For example, acceptance of hedonistic philosophies will in guilt-ridden persons help promote pleasure as a prime purpose.

It is interesting that, in organizing values, modern humankind still exploits philosophical systems that parallel those developed hundreds and even thousands of years ago. Thus, *hedonism* may be commandeered as a credo to give sanction to impulses for unbridled pleasure seeking. In conditions such as psychopathic personality, alcoholism, drug addiction, and sexual perversion, a doctrine that endorses pleasure as a mainstay of life may lend patronage to an irresponsibility that is prompted by uncontrollable inner needs. *Epicurianism* may be espoused as a means of balancing an incubus of guilt in

persons with consciences that refuse to lend sanction to life's delectations without restraint. Worries are purged from the mind as wanton waste, with encouragement of (1) regulation of one's life to anticipate unpleasant events so that they may be avoided, (2) arrangement of matters so that as much pleasure as possible may be crowded into each day, (3) elimination of those pleasures for which one has to pay too dearly, (4) the judicious cutting off of thoughts that mobilize pain or create tension, and (5) the banishment of profitless recriminations about the past or anticipated fears of the future. In the canons of *stoicism* the detached soul often finds refuge. *Skepticism,* the philosophy of doubting, serves some obsessive-compulsive personalities in their quest to achieve tranquility. By scrupulous doubting and withdrawing into the self, the skeptic attempts to escape unhappiness. This suspension of judgment ("isosthenia") results in a state of mental balance ("epoche"). We might speculate that the basis for the skeptical maneuver is a defense against a severe, dogmatic, and authoritarian conscience. The skeptic is fired by a desire to avoid the controlling hand of fate. By doubting, the person negates it thus gaining liberation from the shackles of cosmic doom. In this way the person neutralizes anxiety. At the same time the refusal to arrive at definite judgments perhaps falls in with the coexistence of ambivalent value systems often a product of inconsistent disciplines in childhood. Diametrically opposed to the values of skepticism are those of *dogmatism*, which, as a philosophy, may be exploited for inner harmony and peace of mind. This is the sanctuary of a severe and authoritarian conscience that seeks constant control because of a devastating fear of uncertainty and the unknown. The dogmatist seeks to mold fate to his or her own controlling prospectus. It may be seen, then, that the values of certainty and truth—and the need for a precise structuring of reality in the dogmatist and the value of doubting in the skeptic that negates certainty and structure—are both manifestations of obsessive-compulsive personality structures and constitute different modes of coping with precisely the same kind of anxiety.

Individuals reared in a religious atmosphere, or achieving a decision through a need for personal salvation, may at times become dedicated to the adoration of God, either as a symbol of power and protectiveness or in the form of ethical self-devotion—for instance, as a Christian in the morality embodied in Jesus Christ. They may then conceive that what appeals to their souls as deserving of worship is what they feel their souls may trust, which has the ability to deliver them from evil, sin, fear, and death. In this way they will, according to their interpretation, attempt to conform to the purpose of the life of their Savior, with expressions of devotion to God and love for humanity in accordance with the

theological creeds and sacraments and in the church, synagogue, temple, or mosque within which they find their identity. Those aspects of religion that possess greatest meaning will be cherished whether they involve ritual, sacrament, logic, belief, faith, or the privileges of church membership. The values for the individuals will be contingent on their needs and range from the comforts of group belongingness to the enhancement of the spiritual aspects of the self and the enrichment of moral goals. This is not to say that neurotic objectives may not be sought through the exploitation of religion's instrumentalities; for religion, with its Divinities, ceremonials, dogma, and taboos offers the neurotic individual rich resources for the projection of strivings, demands, and defenses that keep him or her in psychological homeostasis. Whatever the motives, belief in God and reliance on prayer, according to a recent Gallup poll, are on the upswing, and more people in the United States today than in the past three decades believe that religion is having an increasing influence on U.S. life. Sixty-one percent of those interviewed feel that religion can answer all or most of today's problems. Even in countries that have tried to abolish religion as "the opiate of the people" efforts have not been too successful.

On the other hand, the values of science may become for some individuals, at least temporarily, of supreme importance in supplying answers to the ultimate meaning of reality. They will then extrapolate from the data of their observations the functional relationships between pertinent variables in the hope of bringing some order to the phenomenalistic chaos that invests their lives. Through the doorway of empiricism, rather than faith, they will approach purpose and meaning. And yet they will, realizing the limits of reason, attempt from time to time to liberate themselves from the tyranny of their senses by introspection and subjectivism.

Transcending the empirical sphere into the hazardous world of speculation, some people in their quest for meaning, take a journey into arcane zones. Accepting the dictum that "things may not be quite other in themselves than that which by the laws of our thought they necessarily appear," people weld together concepts by the powerful force of faith. In search of experience beyond knowledge, they penetrate into the penumbra of *mysticism.* Justifying their illusions of reality, they argue that humans are limited by the testimony of their senses. Perspectives of reality are always relative to the percipient. No universal standard exists or can exist except that which each person discovers by retreating into the self. Liberated from the fetters of reason, the individual can blend with the Absolute and then perceive the ultimate nature of reality. His or her mind, the individual may believe, is directly linked to the Cosmic

Mind, which All-seeing and All-knowing can fashion his or her destiny and direct his or her journey through infinity from gloomy evil toward the luminous fields of spirit, love, and truth. It is to be expected that the mystical path to tranquility is the refuse of some who are unable to brook the harsh realities of their existence, whose coping mechanisms have failed them, or who have lost their faith in the dignity of humanity and the virtue and safety of the material world.

Organization of one's life around philosophical religious, or, for that matter, "scientific" values is an inescapable aspect of mental functioning. These centralizing points are woven into the complex tapestry of adjustment. They may be adapted, changed, or discarded as the shifting needs of the individual dictate modification.

Mysticism

Mysticism possesses properties that have led a number of psychotherapists to explore its therapeutic potentials, some even attempting to blend mystical formulations into their treatment systems, as, for instance, Zen Buddhism (Suzuki, 1947; Watts, 1957; Ben-Avi, 1959). The mystical striving is twofold; first, there is an attempt to achieve communion with the Absolute (the Highest, the One, God, Brahma, the Order of Heaven, Being of beings) and, second, a desire to grasp through introspection the ultimate nature of reality.

The Absolute is conceived of in various symbolic forms as an encompassing, irresistible, indwelling power that can overcome the temporal, the changing, the relative, the impermanent, and other aspects of existential anxiety. The Absolute establishes stability, methodical arrangement, and permanence in the universe. Since it is impossible to approach it through the senses, the establishment of the Absolute is attempted by epistemological arguments, by mandates in sacred writings presumably divinely inspired and enforced through religious discipline, and by mystical experience.

Approach to the Absolute through mystical experience has an old and elaborate history. In such experience there is no need for intermediaries, such as oracles, priests, historical revelations, or prayers; rather direct and personal contact is made, resulting in an identification and fusion with the Absolute substance. Description of the austerity of mortifications suffered, of the rapture of the visions, and of the

intoxication of the senses as the soul finds its resting place with the Absolute have produced some of the world's most florid and poetic literature. The mystical experience may become a part of multiform religious or philosophical systems. Historically, it was organized into bodies of practice among dissatisfied adherents of the inflexible, formalistic, and legalistic religions who sought to detach themselves from the ossification of formulas and ceremonies toward a liberating union with a divine spirit.

A search for the Absolute has preoccupied philosophers and theologians throughout the ages. Its most prominent forms have been found in Eastern systems, for example, the Brahmanic and Buddhist religions, which promote the illusory nature of reality and the goal of absorption in mystical essences toward ecstatic enlightenment ("nirvana," "satori"). Reeducation of the self to plastic passivity as a precurser to the transcendental experience is encouraged by sets of rules outlining contemplative and ascetic rituals that are said to result in an expansion of consciousness and in the promotion of self-control.

In all mystical systems direct personal experience is approached through states of absorption in which the individual becomes aware of oneness with the Absolute. By various stages the mystic achieves this union. Through meditation the student invokes reason, memory, and will, concentrating on some scene or subject. In Western religious systems, the student may employ a preparatory prayer for Grace, focusing on several points in the image he or she creates, then pouring devotion out freely into the Colloquy. In Eastern systems an attempt may be to suspend reason, employing certain aids, such as breathing and body control, as in Yoga; or practice of the arts, like archery or flower arrangement in Zen Buddhism; or indulge asceticism to bring the body under regulation to extinguish desire and reduce the self to submission. Gradually, reason gives way to inner contemplation, and even to hallucination. Excitement, rapture, despair, and varied other emotions may develop within the matrix of a delicious solitude.

A symbolic dialect unites mystics of all persuasions. In different words there is described the same adventure: the "paradox" of existence, the "journey" into the unknown within, the periods of "darkness" and "light," the excitement and enlightenment at achieving the strange and wonderful world of inner reality, and the "marriage" with the Absolute or Divine.

What patients derive from mysticism is illustrated in a letter to me by a professional man who had immersed himself in it.

> For me there is nothing "mysterious" about mysticism. Rather, it gives a clear view of how to best live my life for myself and others. "Mysticism" is a commitment to life and reality, nothing less than a seeking of total conscious awareness and identity with life itself. Not a merging of the ego beyond the cognitive, sensory, and emotional structures which, though they are so necessary for our day-to-day productivity and happiness, nevertheless, can be seen as limits when we set our sights on our relationship to God and the cosmos. (The questions, "Who are we? Why are we here? Where are we going?") The ego and awareness naturally expands as we progress from infancy to adulthood and finally obtain the perspective of old age. For some, this process occurs experientially, for others—they crawl their way through life still dragging their childhood fears and fantasies behind, creating for themselves in their lives an ensnaring chaos, from which the consciousness longs only for escape, not greater understanding. For me, once or twice a day, meditation, or rather, contemplation, and active fixing of attention, has gone hand-in-hand with my psychotherapy in accelerating my awareness. It gives me the conscious experience of my larger self, or the whole knowing and loving the whole at every point —my awareness being just a point in this sense. It is the realization that I am a lot more than I thought I was.

Eastern Systems

Hindu Philosophical Approaches: Yoga

Historically, Hinduism preceded Buddhism. It was a polytheistic system, with sacred writings (Vedas and Brahamanas) that developed into an elaborate sacrificial and ritualistic movement. Essentially, it conceived of an absolute spirit, the Brahma, as the source and goal of all things. Creative, conservative, and destructive principles were reflected in the divine personalities of Brahma, Vishnu, and Siva, who respectively represented creation, preservation, and destruction. While many forms of Hindu religion have evolved from its early origins, there is generally accepted the doctrine of *Karma,* which makes humans accountable in the present or in their reincarnations (transmigration of souls is a principal belief) for their good and bad actions. Karma of the spirit can drive humans to evil, toward a concern with matter and selfishness, or toward selfless good and love.

Modern Hindu systems of philosophy are employed to help the distressed. These, according to Vahia (1962), conceive of the basis sources of conflict or disturbed peace of mind as threefold:

1. Too intense emotional attachment to external things, such as possessions, status and power, which inevitably produces destructive competitiveness.

2. A delusion that humans with their finite mind can understand cosmic reality, which is actually

beyond human comprehension.

3. Inharmonious interactions with other people, such as (a) excessive attachments, (b) too powerful emotional yearnings, including love, (c) inordinate jealousy, and (d) unreasonable anger.

While these conflicts are universal, the special way in which they operate is unique for each individual.

Measures, valuable for the achievement of peace of mind, will vary with the personality. Three main categories of people exist, and the approach will differ in each. First, there are those who operate on the basis of intellectual understanding; the second are swayed primarily by sentiment and emotion; the third are insistent on a practical solution without analyzing the problem or bothering about feelings.

Those persons who wish to learn the essential techniques may seek the guidance of an expert. No attempt is made at the start to understand the problem. Rather, the person is taught the principles of relaxation. Various postures are tried until the best one is discovered. Voluntary muscles are relaxed; then an attempt is made to bring the involuntary nervous system under control. Once respiration is regulated, heart action and management of other aspects of the cardiovascular system are attempted. By special exercises, the stomach and intestines are also relaxed; the autonomic nervous system is brought under voluntary management. This will require a long period of work under supervision.

Complete muscle laxity enables the individual to proceed to the practice of meditation in order to achieve a void where the intellect is suspended. What is desired is a new objective kind of understanding. Concentration is shifted from the sources of problems to an object of faith and love, focusing on the latter as a way of removing the investment in the conflict. For example, one may focus on the idea of God or a prophet. Hinduism is an ideal religion on which to meditate. The concept of God becomes a concept of "everlasting unchanging cosmic reality… . This, the only Reality, is free from life and death, or pleasure or pain … from love and hatred, pride and prejudice." By identifying oneself with this reality, one may eschew emotional involvement and best be able to study the forces that have led to one's difficulties. A state of mind is achieved "where peace prevails and turbulence, if any, is only transitory." In this way one can eventually "remain unaffected by any event of stress and strain."

Eastern philosophical systems were not designed as forms of psychotherapy. They were oriented around promoting spiritual growth and achieving a oneness with the Universal. The resulting serenity and tranquility, however, may palliate a mind in turmoil and shift values toward harmony with the world, thus indirectly registering a therapeutic impact.

Appraising what may be accomplished in this approach, we observe a combination of supportive and reeducational modalities:

1. Relaxation helps to resolve tension and to relieve anxiety.

2. Meditation redirects thoughts from anxiety-laden sources toward those that sponsor a more constructive life orientation.

3. Guidance from the helping agency helps to buttress defenses and to insulate oneself from sources of anxiety by (a) encouraging detachment from emotional situations, with avoidance of competitive strivings and a removing of oneself from involvement with other persons, (b) making oneself dependent on a power stronger than oneself through mystical cosmic unity, and (c) promoting independence by means of introspection and self-realization.

Yoga, a form of Hindu mysticism, had its origins in an idealistic monism, the Vedanta philosophy, which conceived of the world as a conscious spiritual principle permeating all things, the *Atman.* "The wise who perceive him as being within their own Self, to them belongs eternal peace, not to others" (Katha-Upanishad, ii, 5, 12). A modification of this philosophy in the *Sankhya* system assumed "the eternal coexistence of a material first cause and a plurality of spiritual elements or Selves, *Puru-sha."* A schism in the *Sankhya* movement developed that added the concept of God. This, the *Yoga* system, advocated a mortification of the senses, brought about by such measures as prolonged fixation of the eyes on the nose, protracted assumption of rigid postures, to liberate energies, and a new awareness. The purpose was to bring about an ecstatic vision of the Deity and perhaps the acquisition of miraculous powers.

Hoped for was a permanent union with the Supreme Being.

To achieve the concentration essential for this, eight stages are deemed necessary:

1. Self-control *(yama*) obtained by such devices as chastity, nonstealing, nonviolence, truthfulness, and avoidance of greed.

2. Religious observance (*niyama*) through chanting of the Vedic hymns, austerity, purity, and contentment.

3. Assumption of certain postures C*asana*).

4. Regulation of the breath *(pranayama*) with controlled rhythmic exhalation, inhalation, and temporary suspension of breathing.

5. Restraint of the senses *(pratydhara*) by withdrawing of the senses from their objects.

6. Steadying of the mind *(dharana)* through fixation on some part of the body, such as the nose or navel.

7. Meditation *(dhyana)* on the true object of knowledge, the Supreme Spirit, to the exclusion of other thoughts.

8. Profound contemplation *(samadhi)* with such complete absorption and detachment that there is insensitivity to heat and cold, pain and pleasure.

The "Yogin" who arrives at perfecting the last three stages (*samyana*) achieves an ecstatic mystical state that stimulates ability to have an awareness of the past and future, of what has happened in previous births, and knowledge of "everything that exists in the world and in his own body." Proper application of the *samyama* promises "complete control over everything in the universe," "traversing anywhere at will," and other miraculous powers, including, finally, a complete release of the intellect from the self, purity, and eternal liberation in the form of separation of matter from spirit *(Raja-yoga* or *Kaivalya).*

Modern practices of Yoga essentially avoid asceticism in quest of the mystical experience of "awakening." The ultimate goal is fusion with the Absolute, during which the person experiences the highest wisdom and most profound truth of being, thus gaining possession of his or her real self through expanded comprehension and self-realization (Bagchi, 1936; Behanan, 1937; Yesudian & Haich, 1956; Yeats-Brown, 1958; Wood, 1959; Malhotra, 1963; Majumdar, 1964).

Buddhism and Zen Buddhism

A young prince, Gautama Siddhartha, at the age of 29, during the sixth century B.C., struck with the suffering of humankind, deserted his family to search for the true meaning of life. For years he wandered, attempting in vain to reach the "truth" by fasting, self-torture, and meditation, which were prescribed by the traditional Brahmanistic teachings. One day under a fig tree, known later as the Bo Tree or tree of enlightenment, he suddenly achieved a glimpse of the truth. This was to the effect that the cure for unhappiness was a renunciation of selfish desires and a mastery of the self. He then taught others his discovery of how to find true happiness, and he became known as Buddha, the Enlightened One.

The great popularity of Buddhism was due to its making salvation available to all through personal efforts without the self-torture that existed in the older Brahmanism.

Among the teachings of Buddha were three basic concepts:

1. The soul of a person passes after death to higher or lower animals depending on whether the person performed good or bad deeds in his or her lifetime. The purpose of this transmigration is to overcome all desire. Then the soul no longer has individuality and may enter "Nirvana," a peaceful state of oblivion.

2. Release from conscious existence is hastened by pursuing the Eightfold Path of Right Faith, Right Intention, Right Speech, Right Conduct, Right Livelihood, Right Effort, Right Thinking, and Right Meditation.

3. There is no supreme God.

Over the centuries the teachings of Buddha underwent revision. Buddha, himself, became considered a god who had miraculously come into the world. Sacrifices of flowers and images were made in his honor. Elaborate rites and ceremonies were evolved. Legends were developed about Buddha and his might. Prayers to Buddha began to replace personal effort. Self-mastery gradually became forgotten as the most important goal.

The principles of Buddhism include the following four main ideas: (1) life is imbued with suffering; (2) suffering is the product of desires seeking fulfillment; (3) control of all desire and self-

mastery can end suffering, hence celibacy is sometimes encouraged; and (4) pursuance of certain rules of living and of proper attitudes and knowledge leads to the overcoming of desire. The final objective in life is Nirvana, a blissful contemplation and peaceful state of oblivion, characterized by an extinction of the material personality and achievement of enlightenment.

Among the Buddhist sects, that of *Zen Buddhism*, a kind of introspective mysticism difficult to reduce to words, has most attracted Western psychotherapists. It is difficult for the Western mind, oriented as it is around logic, intellectualism, and determinism, to conceive of Zen. Satori ("enlightenment and awakening") experience is predicated on a suspension of the reasoning facilities, which are held to be a hindrance to the release of the intuitive essence of being. Zen is dedicated to the idea that one may solve all problems through intuition and enlightenment rather than through logical abstractions such as constitute the methods of the West. Zen cannot be taught easily since each person finds his or her own path through search and struggle.

A number of excellent books have been written about Zen (Blofeld, 1959; Conze, E., 1951, 1954, 1958; McGovern, 1922, 1923; Rhys-Davids, 1899-1938; Sasaki, 1960; Suzuki, DT, 1949, 1952, 1953, 1957a, b, 1959; Takakusu, 1947; Thomas EJ, 1931, 1933, 1935; Watts, 1957; Yama-kami, 1912). Practically all advocate the achievement of the extraordinary Satori experience (a oneness with Buddha) "which is devoid of emotion and intellectual content" through study with a Zen Master. One method commonly employed by the master is meditation on a Koan, a riddle for which there is no set solution. The Zen Master operates by posing paradoxes, such as, "What is the sound of one hand clapping?" At the same time the Zen Master puts the student in an untenable situation. For instance, the master may threaten the student with a stick, saying, "If you call this a stick, I will beat you. If you say this is not really a stick I will beat you. And if you say nothing I will beat you." This establishes for the student a paradox that cannot be unraveled through customary modes of problem solving. Somehow the student must work out a reply that will satisfy the Zen Master. In the process of doing this, the student will have developed a unique mode of conceptualizing reality that dissociates him or her from habitual points of reference.

Another means to Satori may be through random activities such as flower arrangement or by practicing archery, as described by Herrigel (1953). What one strives for is an experience of being that cannot be described except in such terms as "free-movement of the spirit" and "an original and nameless

essence." This is achieved by "methodical immersion in oneself' leading "to one's becoming aware, in the deepest ground of the soul, of the unmanageable Groundlessness and Qualitylessness—nay more, to one's becoming one with it." The experience cannot be reduced to words ("one knows it by not knowing it"), but it is said to liberate and change the human being. Only by true detachment can one become completely empty of the self and then "become one" with the "Transcedent Deity." In breathing exercises, in practicing archery, "I learned to lose myself so effortlessly in the breathing that I sometimes had the feeling that I myself was not breathing, but strange as this may sound—being breathed." What Herrigel is particularizing are psychological phenomena characteristic of all forms of mystical experience, which is, as has been indicated, the essential substance of Zen Buddhism.

Cultist Movements

A growing number of movements have developed that appeal to alienated young people seeking to dissociate themselves from the values and life styles of their parents and groups with which they are customarily identified. These cults appeal to school dropouts, drug abusers, borderline cases, youngsters with severe personality disorders, and individuals in emotional turmoil. Many of these youngsters are simply unhappy souls who have been unable to complete their developmental growth to reasonable separation-individuation. On the surface they appear and act normal (Ross, 1983). Rejecting the usual religious and political tenets that are accepted in their families, they seek self-fulfillment through mysticism and a faith in an esoteric leadership onto which they can project their infantile needs and hopes. Heads of such movements are usually charismatic and grandiose gurus, ministers, or exploitative laymen whose pronouncements are sufficiently ambiguous so that the devotees can interpret them however they wish. Participants come to these movements of their own free will, recruited by acquaintances or friends who have become ardent supporters and salesmen. A brief exposure to such dedicated groups convinces the new recruits that they have finally found a resource that alleviates their anxieties and satisfies their search for purpose and meaning. Perhaps for the first time, these individuals feel accepted by their peers and find their dependency needs gratified by submitting to the rules of the leader (with whose grandiosity they may inwardly identify) and the mores of the group members, who become for them a new and more accepting family. Needless to say, these developments are often viewed with horror by a recruit's parents, who may, in their turmoil, seek ways of extricating their child from

what they consider a most destructive and bizarre way of life. Should the parents succeed in removing their deviant from the group by kidnapping or legal means, an attempt will often be made to deprogram the presumably brainwashed victim. Such efforts usually prove unsuccessful, unless the deviant is sufficiently motivated to seek help from a professional who has had experience in dealing with his or her problems. Coordinate family therapy is usually essential.

Among the most common cults are the Hare Krishna movement, Arica, and the Unification Church of Reverend Sun Myung Moon. In 1965, A.C. Bhaktivedanta Phapupadha came to the United States to bring to the needy the benefits of his transcendental teachings, including *Bhakti yoga,* which endorses dietary and sexual abstemiousness and various taboos against intoxication, gambling, and aggression. The Hare Krishna movement sponsors community living devoted to the worship of Kirshna, one of the incarnations of the god Vishnu, "to help man in distress." The followers of this sect in the Western world assume the dress and life style of the ancient Vedic society and devote themselves to a simple religious existence, chanting the glories of Krishna as a way of perfecting their lives. Many other movements, such as the Self-Realization Fellowship of Paramhansa Yogananda, have attracted enthusiastic followers who claim that the Vedic teachings have brought purpose to their lives and harmonized their physical, mental, and spiritual natures.

The Arica Institute was founded in 1971 by Oscar Ichazo a Bolivian. Presented as a course of training, it teaches meditation to obtain a state of liberated consciousness; deep body massage to release mental stress; "protoanalysis" to understand the destructive ways the body seeks to express stress; "psychoalchemy" to transfer physical into psychic energy; "Kinerhythm," in which slow movements help evoke ecstasy and "yantras"; "Pneumorhythm," which combines breathing with rhythmic counting to expand consciousness; "Opening the Rainbow Eye," which provides a state of "satori" in which all internal and external experiences are seen clearly; the "Alpha Heat" ritual to free the mind of worry, regret, rivalry, hatred, envy, pretense, fear, jealousy, and prejudice; "Trialectics," which teaches the logic of unity to permit the analysis of reality; the "Cutting the Diamond" ritual to complete the mystical union; "Hypergnostic Analysis" of internal meanings and connections of things; the "Golden Eye" ritual to observe the voyage of consciousness inside the body and to transfer consciousness; and the "Psychic Shapes" ritual, which sponsors the internal recognition of the Unity of God. These practices and rituals have attracted hundreds of thousands of followers who often gather in communes where Arica is taught.

The Unification Church, founded by Reverend Sun Myung Moon and which has received a great deal of publicity in the press, is intended to rectify the "moral confusion" and "the absence of a clear sense of values" that threaten America's spiritual heritage. Presented as signs of such corrosion are child abuse, prostitution, abortions in girls below the age of 18, fatherless children, juvenile crime, drug deaths, suicide, murder, robbery, assaults, burglary, and divorce. More generally, followers believe there is a universal lack of well-being and a sense of unfulfillment and unhappiness. All these woes stem from "confusion in the hearts of individuals." What is necessary is a revolution within men and women that only God can bring about through a "new revelation." Reverend Moon claims that this truth, which current religion, philosophy, and ethics have been unable to supply, was personally revealed to him by God, who appeared and selected him for the mission of revelation. Thereafter, Reverend Moon journeyed into the spirit world many times, and God instructed him to teach the revelation, the Divine Principle, in every corner on earth. It is now taught in all languages in 127 nations. Through this revelation, says Reverend Moon, alcoholism and mental illness can be cured, physical healing occurs, and racism and nationalistic prejudice disappear. Fresh hope, love for one's fellow brothers and sisters, and happy marriages are said to become a way of life. These bounties are available to those who join the Unification Church. And thousands upon thousands of people do in order to live the prescribed life and to receive the important revelation (Galanter et al, 1979).

To detail the specific beliefs and rituals of all the different cultist movements would encompass a textbook in itself and would merely repeat what has been written elsewhere (Patrick, 1976; Edward, 1979; Levine & Salter, 1976; Ungerleider & Wellisch, 1979; Levin & Zegans, 1974; Marmor, 1984). Suffice it to say that the psychopathology in some of the leadership and followers is relatively high. Nonetheless, the movements seem to serve some purpose in stabilizing disturbed individuals who otherwise would become drug addicts, delinquents, psychotics, and victims of suicide. It is an indictment of society that more rational group resources have not been made available. It may be that the successes of experiential groups (see Chapter 52) serve the same purpose as religious cults by supplying some populations with avenues for gratification of their personality needs, albeit in more socially accepted and less peculiar ways.

Western Religious Approaches

In the Book of St. Matthew (17:14-18) there is recorded the following miracle:

> ...there came to Him a certain man, kneeling down to Him and saying,
>
> Lord have mercy on my son: for he is a lunatick, and sore vexed: for oftimes he falleth in the fire, and oft into the water.
>
> And I brought him to thy disciples, and they could not cure him.
>
> Then Jesus answered and said O faithless and perverse generation, how long shall I be with you? how long shall I suffer you? bring him hither to me.
>
> And Jesus rebuked the devil; and he departed out of him: and the child was cured from that very hour.

Religious healing, recorded in the successes of Jesus, is legendary.

> And great multitudes came unto him. having with them *those that were* lame, blind, dumb, maimed, and many others, and cast them down at Jesus' feet; and he healed them.
>
> Insomuch that the multitude wondered, when they saw the dumb to speak, the maimed to be whole, the lame to walk, and the blind to see: and they gloried the God of Israel. [St. Matthew 15:30-31]

The inspiring effects of divine influence are testimony to the fact that a human being has the potentiality for extraordinary response to the proper authoritative mandates. Faith cures are irrefutable. Under favorable circumstances the ravages of physical and psychological illness may be palliated. Some may even be permanently resolved.

The relief of inner turmoil through faith is dramatically described by St. Augustine:

> How then do I seek Thee, O Lord? For when I seek Thee, my God, I seek a happy life. I will seek Thee, that my soul may live. For my body liveth by my soul; and my soul by Thee.... When I shall with my whole self cleave to Thee, I shall nowhere have sorrow or labour; and my life shall wholly live, as wholly full of Thee. Thou fillest, Thou lifteth up, because I am not full of Thee I am a burthen to myself.... Woe is me! Lord, have pity on me. Woe is me! lo! I hide not my wounds; Thou art the Physician, I the sick; Thou merciful, I miserable.... And all my hope is nowhere but in Thy exceeding great mercy.

A study of comparative religions elucidates the vital role that religion has historically played in the emotional adjustment of people. Its survival as one of the most potent of institutions for the supplying of some vital human needs is manifest; in the face of the most devastating attacks by science on the

authenticity of its sacred documents, it continues to function unabated. This, Montaigne claimed, was because religion is "man's only succour from his native state of helplessness and uncertainty." Carl Jung (1933), denouncing Freud's antireligious attitude, wrote that "man has never yet been able singlehanded to hold his own against the powers of darkness—that is, of the unconscious. Man has always stood in need of spiritual help which each individual's own religion held out to him."

The survey of the Joint Commission on Mental Illness and Health (1960) indicated that, on the whole, persons who regularly attend church have less discomfort than those who do not. Whether religion can be serviceable for a specifio patient will be contingent on the person's special needs and his or her propensity to employ religious principles for healthy or neurotic gains.

There is no doubt that dramatic relief from neurotic suffering is possible after religious conversion. Through conversion the individual may harmonize with the order of the universe and feel a oneness with the world or a union with God. Riddled by anxiety, tortured by self-doubt, the person in anguish is susceptible to the help held out through salvation by the evangelist. A reeducational experience develops as the person moves in the conversion from defeatism to hope. By confessing wickedness, the convert attains both forgiveness and the means to a blessed existence. Feelings of insignificance are replaced with a sense of distinction as one of God's instruments. Competitive strivings are abandoned; hate changes to love, tolerance, and compassion. Remarkable shifts in attitudes and behavior may follow. Such experiences have been reported in detail by William James (1941) in his *Varieties of Religious Experience.* The consequence of these transformations is another matter, since psychic stability is sometimes restored at the expense of general psychological integrity. Many patients come to psychotherapy after extensive efforts of religious devotion have failed them. Other patients who have received psychotherapy find themselves more fulfilled by affiliating themselves with a religious movement.

Religion in some form is employed by many people to bring happiness and solace to an otherwise turbulent existence. It is conscripted as a vehicle for values that fill the person's life with purpose and meaning. It is also utilized to substantiate neurotic defenses, justifying these by a blind adherence to codes and authoritarian mandates (Conigliaro, 1965). If religious credos serve the individual's personality needs, they may facilitate adaptation and contribute to the social good. If they conflict with

the individual's needs, they will interfere with adjustment and militate against social good.

A number of notable attempts have been made to reconcile psychiatry, psychotherapy, and psychoanalysis with religion (Ryle, 1945; Santayana, 1948; Tillich, 1952; Moore, 1953; Toulmin, 1953; Wisdom, 1955; Niebuhr, 1955; McLean, 1959; Zilboorg, 1956, 1962; Lee, 1957; Bartemeier, 1965). Implied in most of these contributions is the idea that even a psychotherapist in search of values may find these in religious experience. Psychotherapy, it is alleged, releases the individual to choose constructive values, while religion is a suitable supply depot for such values.

Conflict between psychiatry and religion, however, still continues, sustained in part by an inability to define religion. If by religion we mean the striving for worthy ideals and values, most scientists would concede its merits. On the other hand, if we mean the acceptance on faith of fixed creeds and beliefs regarding the origin of the world and the ultimate purpose of life and the abiding by ethical standards as absolute in relation to an eternal law, most scientists would register their opposition.

Amidst the conflicts of science and religion many individuals search within themselves for meanings of faith and attempt to define God in their own terms shorn of the dogma and ritual of the church. In the systems that they evolve, ancient ideas of logic and cosmology are discarded and scientific concepts of the material world are accepted in a realm of their own. To some, God continues to be accepted as the essential element, the embodiment of the highest ideal of self-sacrificing love, which can lead humanity to peace and fulfillment. For others, a revision of religious belief prevails that has gone so far as to challenge the essential doctrines of the church of their origin and to make out of the Savior a noble mortal rather than an incarnation of God. God is accepted as a principle of order and goodness, rather than as an extramundane Creator who rules the universe. The highest religious achievement is identification with the principle of goodness and the achievement of ethical self-realization.

Actually, we have witnessed in official circles of the church a reinterpretation of some of its doctrines and a revision of standard documents. There are many now who are capable, without conflict, of maintaining communion while accepting a scientific conception of the world. We have seen also a softening of the stand of science in the form of recognition that religious fulfillment satisfies a fundamental human need.

Psychotherapy and the newer direction in religion thus share a number of common goals. They both strive to bring about better self-understanding and a full utilization of latent creative potentials. Psychotherapy attempts to do this by bringing the person to a fuller realization in terms of past experiences and the residual distortions that hamper his or her present interpersonal relationships, while encouraging new and more productive behavioral patterns. Religion encourages the search for new meanings by affiliation with the Divine Being and by worship and prayer that can suffuse the human spirit with hope, with strength to resist deviant drives, and with new directions that will lead to self-fulfillment. Both psychotherapy and religion seek to alter destructive values in the individual and to lead one toward humane values that will accomplish the greatest social good, such as honesty, loyalty, charity, love, courage, and compassion for suffering. Both psychotherapy and religion promote salutary family and community relationships as virtuous to the highest degree.

Existentialism

Existentialism is a philosophy that has attracted many psychotherapists in Europe and the United States, who have, on its premises, developed "ontological" or "existential" treatment procedures that attempt to combine existentialist doctrines with reeducative and reconstructive methodologies (Binswanger, 1947, 1956; Boss, 1957, 1963; Frankl, 1948; Havens, 1967; Holt, 1975; Husserl, 1931; Jaspers, 1963; Laing, 1967; May R, 1950, 1959; Minkowski, 1970; Tillich, 1952).

More or less, existentialism is oriented around the writings of Søren Kierkegaard (1813-1855), who revolted against the impotence of Hegel's philosophy of "pure thought" as a means of coping with the paradoxes and contradictions of human existence (Kierkegaard, 1951). Fruitless, contended Kierkegaard, were faith and coercive divine grace, proffered as a means of salvation; Christ was no substitute for true experience in the world. Nor was science of any greater use, for the human search for facts as an escape from moral decisions was not possible. Haunted by perpetual despair and dread *(Angst*, anxiety), which "eats away all the things of the finite world and lays bare all illusions," a human could not remain a mere spectator, finding refuge in evanescent comforts. He or she was forced to assume responsibility and to make a choice. Duty might dull the person's consciousness; it might, in a romantically optimistic way, enable the person to evade responsibility. It could not, however, eliminate responsibility. Essential was a free choice to which the individual committed as a whole in the

recognition that human values were insignificant indeed. In the crisis of existence, the only true refuge was a leap into religion in which a person related to the infinite. Freedom of choice was a fount of anguish because individuals had a limited time in which to act. They needed courage to be. When the immortal soul was at stake, the choice would crucially determine which way to turn.

The phenomenological descriptions of inner turmoil, such as have so vividly been described by Kierkegaard, are of a different order of conceptualization than psychological ideas of drive and defense. Kierkegaard, being a religious man, stressed the choice of religion as a means of surcease from anguish. Later existentialists, however, made other choices, such as agnosticism (as in the writings of Jean Paul Sartre) oraestheticism. Karl Jaspers, in *Man in the Modern Age,* considered that the chief threat to modern humankind lay in our complex technology. *Philosophie,* published in 1932, spoke of the importance of the persistent quest for knowledge as a means by which humans actualized themselves.

These ideas were enhanced by the phenomenological concepts of Edmund Husserl, a German philosopher, who contended that human experience was corrupted by attempting its analysis through the physical sciences. Only through reflection ("transcendental phenomenology") could one best realize essential structures, vital relationships, authentic existence, and "the experiences of phenomena." Science with its focus on causation contributed to human alienation by crushing individuals' creativity and intuition. Human beings were not puppets upon whom reality could be thrust. They were free agents with freedom of choice and responsibility for their own values. In 1927, Martin Heidegger, a pupil of Edmund Husserl, wrote *Sein und Zeit*, which followed Husserl's feeling, as expressed in his *Logische Untersuchungen,* that human beings needed to focus on their inner experience as a way of apprehending the outer world.

Heidegger detailed some of the important inner experiences underlying our scientific understanding. His description of humans' preoccupation with the inevitability of death had a profound influence on existential formulations.

Periods of crisis in world history, such as during and after war, bring forth the philosophy of protest against the world. Various interpretations of existentialism have been made by different devotees of this philosophy. Jean Paul Sartre stresses the need to preserve human loneliness from the encroachment of

others. Karl Jaspers and Gabriel Marcel emphasize the interpersonal communication of "loving conflict," during which each participant retains his or her uniqueness. Other prominent existentialists who have contributed to the theory are Karl Barth, Martin Buber, Emil Brunner, Paul Tillich, Reinhold Niebuhr, H. Spiegelberg (1960), and E. Straus (1963).

Drawing from Kierkegaard's original conceptions, psychiatrists such as Karl Jaspers (1947), Ludwig Binswanger (1942, 1947, 1955, 1956), Viktor Frankl (1955, 1967), and Medard Boss (1963) adapted existentialist ideas within a framework of psychotherapy. Incorporated was Heidegger's conception that concern with others was the key to the optimal development of the self and that endurance of anxiety was more essential than attempts to deny or evade it. According to Heidegger, the basis of existence is a sense of nothingness that vitalizes the self with meaningfulness. This idea borders on mysticism, although existentialism is not a mystical philosophy. Heidegger insisted that the self reached its highest stature in its struggle with anxiety, guilt, and the ubiquitous threat of death. To this idea Binswanger added the concept of the self reaching its fullest development in the experience of love: indeed the keystone of existence, he believed, was the achievement of "we-ness" through love. But love is threatened and broken down by anxiety and isolated by excessive independence and overidealization of the love object. With the shattering of love, the self suffers damage and returns to nothingness. Frankl introduced the entity of the "existential neurosis," derived from the inability to see meaning in life. Through "logotherapy," he avowed, a search could be organized into the patient's world view with the object of helping the patient to adjust it to an "authentic existential modality." Novel approaches to existential therapy reflect varying interpretations of existential philosophy, blended with the specialized psychotherapeutic techniques of the authors.

Since the conceptual model of existentialism is ontological, it is difficult to understand it in mechanistic terms. We are dealing with frames of reference unlike those that the average therapist has known. It seems futile to describe such phenomena as "being in the world" and "I am" in purely verbal terms. Inherent in these ideas are self-acceptance, tolerance of limitations, the ability to scale down ambitions, acknowledgment of prevailing creativity, self-realization, and self-determination, shorn of neurotic cultural values and demands. These goals are achieved and achievable only in a special kind of empathic relationship, which presupposes a willingness on the part of the therapist to enter into the world of the patient.

While the therapist utilizes habitual psychotherapeutic tools, for example, the various reeducational techniques, they are employed from a perspective of "reverent love" toward the human being "encountered" as a patient, sharing with him or her a common plane of existence. The therapist moves beyond drives and mechanisms in dealing with the person as he or she is. In fundamental "being-togetherness," the patient's and therapist's modes of being are related. In such a climate of "care" and understanding, the patient gets the courage to emulate the therapist's healthy style, and so moves on to "be" in the matrix of a uniqueness of self. There is much in this conception of the therapeutic relationship that resembles the "genuineness" and "empathic understanding" advocated for the "client-centered" therapist. The explication of the phenomenon of self relating to self, however, is much more embellished and particularized.

Logotherapy is a special existential approach, elaborated by Viktor Frankl (1955, 1961a, b, 1962, 1963, 1966), which includes two distinctive reeducative procedures, "paradoxical intention" and "de-reflection." It proposes to fulfill "the innate spiritual drive in man" by exploring the "meaning of human existence." The "will to meaning," according to Frankl, is one of the deepest motivating forces of humanity, even more fundamental than Freud's "pleasure principle" or Adler's "will to power." When human beings no longer question the meaning of their existence, they become ill. This is because they cannot function in an "existential vacuum." A basic conflict precipitates as a result of this inability to "emerge spiritually above the level of his own psychic and physical conditions." This conflict is not rooted in psychological complexes; it is focused in spiritual and ethical issues and produces neuroses of a unique quality, which Frankl calls the "noogenic neuroses." Approximately 12 percent of all neuroses are said by him to be of the "noogenic" variety.

Such "noogenic, spiritually rooted" neuroses require for their solution the existential approach of logotherapy "in contrast to psychotherapy in the narrower sense of the word." In logotherapy, the patient is helped to find new values and to develop a constructive philosophy in life. "The logotherapist is not primarily concerned with treating the individual symptom or the disease as such. Rather, he sets out to transform the neurotic's attitude toward his neurosis." Responsibility is put firmly on the shoulders of the patient to "push forward independently toward the concrete meaning of his personal existence." The patient "must choose it on his own, search for it, and find it."

Logotherapy helps the patient evolve three kinds of values which will lend meaning to existence: "creative values," "experiential values," and "attitudinal values." The patient is shown how to make life meaningful by "the experience of love," which enables the patient to enjoy "truth, beauty and kindness ... and human beings in their uniqueness and individuality." The patient is shown that suffering may be useful in helping to change his or her attitudes. For instance, an irremediable situation may have to be endured. "Where we can no longer change our fate by action, what matters is the right attitude toward fate ... we must be able to accept it." The goal of the logotherapist, then, is to evoke in the individual the "will-to-meaning," which is specific and personal for each person. Only when this goal is fulfilled can one survive the most unfavorable conditions. The dimension of helping to find "meaning" is above and beyond what may be done for the individual through exploration of the dynamics of his or her intrapsychic processes and by probing his or her interpersonal relationships through the traditional psychotherapeutic and psychoanalytic techniques. The latter tactics become futile or only partially successful unless there is restored to the person the spark in his or her being that gives life purpose and meaning. In the words of Nietzsche, "He who knows a Why of living surmounts almost every How." The explicit answer to the question of what constitutes the "meaning of his existence" can be answered only by the patient under the guidance of the therapist.

Even in dire distress or under depriving circumstances in which activity and creativity are blocked, a person "can still give his life meaning by the way and manner in which he faces his fate, in which he takes his suffering upon himself. Precisely in this he has been given a last chance to realize values." Frankl agrees with Goethe, who emphasized that "there is no condition which cannot be ennobled either by a deed or by suffering." Thus, "the right kind of suffering is itself a deed, nay the highest achievement which has been granted to man." In this way the patient may be aided in utilizing daily vexations and sufferings as a means toward finding purpose in living. By putting a positive value on suffering, the victim may overcome "trends in our present-day civilization where the incurable sufferer is given very little opportunity to be proud of his unavoidable and inescapable suffering and to consider it ennobling rather than degrading."

Persuasive tactics are employed in logotherapy to get the patient to adopt a more constructive attitude toward his or her difficulties. Frankl illustrates this in a case of a nurse who suffered from an inoperable tumor and who experienced despair centered about her inability to work in her cherished

profession. "I tried to help her understand that to work eight hours or ten hours or God knows how many hours a day, is no great thing. Many people can do that. But to be as eager to work as she was and to be incapable of working yet not despairing would be an achievement few could attain." An appeal was then made to her sense of fairness to the patients to whom she was dedicated in her work, since she was depreciating them when she assumed that a sick person's life had no meaning. "In so doing you take away from all sick and incurable people the right to life and justification for their existence."

A shift in point of view effectuated by the therapist's promptings may interrupt a neurosis. Frankl illustrates this point:

> I should like to q another case of a colleague, an old general practitioner who turned to me because he still could not get over the loss of his wife who had died two years earlier. His marriage had been very happy and he was very depressed. I asked him quite simply, "Tell me, what would have happened if you had died instead of your wife, if she had survived you?" "That would have been terrible," he said. "Quite unthinkable. How my wife would have suffered."
>
> "Well, you see," I answered, "your wife has been spared that, and it was you who spared her, though, of course, you must now pay by surviving and mourning her." In that very moment his mourning had been given a meaning— the meaning of sacrifice. The depression was overcome.

What Frankl brings out is that he had succeeded in giving a new meaning to the experience of his patient's suffering. What precise dynamics were involved in the patient's attitudinal shift, other than appeasement of his sense of guilt, we do not know; however, the tremendous impact that a respected authority may have on a susceptible patient by a timed interpretation is clearly brought out, particularly in helping the patient face death, suffering, and other disasters in life.

Because happiness can rarely be achieved intentionally, the patient is enjoined by the logotherapist to avoid striving for its achievement. Rather, the patient is shown that happiness will come as a byproduct to the attainment of other values. Nor should "unpleasure" be evaded. Logotherapy contends that intention may prevent the occurrence of an event. This principle may be applied to fighting neurotic symptoms. By the technique that Frankl calls "paradoxical intention," the patient is sometimes "encouraged not only to accept the neurotic symptoms but even to try to exaggerate them. Thus the patient increasingly learns to put himself 'above' the symptom." Paradoxical intention, which mobilizes the "capacity of self-detachment," is particularly suited for the short-term treatment of obsessive-compulsive and phobic patients. The fearful anticipation of an event often succeeds in bringing

on the reactions developing from the event. Patients with strong obsessions tend to fight off their obsessions and compulsions. If they stop fighting their symptoms, and even joke about them, the symptoms may diminish and disappear. The patient is requested to think about or to experience in his or her mind that which is unpleasant, terrifying, or embarrassing. In this way the patient develops, as in behavior therapy, an ability to counteract his or her fears. Paradoxical intention, says Frankl, is contraindicated in psychotic depressions. It is a basis around which more modern ideas of paradoxical therapy have been organized (Borkovec & Boudewyns (1976), Ascher & Efran (1978), Fay (1976).

Another logotherapeutic technique is "de-reflection," which enhances the "capacity for self-transcendence." Here the patient is first helped to an awareness of unused or forgotten capabilities and potentialities. "It is a kind of appeal to the patient's deeply buried values. Once they are uncovered, they assert themselves and give the patient a feeling of uniqueness, of usefulness, and a sense of life." De-reflection is said to be valuable in somatic preoccupations, neurotic sleep disturbances, and such sexual disorders as impotence and frigidity.

Frankl supports eclecticism in method and advocates, when necessary, a combination of logotherapeutic techniques with hypnosis, Schultz's autogenic training, behavior therapy, and pharmacotherapy.

The concept of "responsibility" is a cornerstone in logotherapy, as it is in other forms of existential therapy. This purports that individuals are responsible for making of their lives what they will—a thing of joy or a living hell. The interpretation imparted to his or her experiences is the arbiter; one possesses the means of changing one's destiny by altering one's values. The leading maxim of existential therapy, in the words of Frankl, may be phrased in this way:

Live as if you were living for the second time and you had acted as wrongly the first time as you are about to act now. Once one really puts oneself into this imagined situation, one will instantaneously become conscious of the full gravity of the responsibility that every human bears throughout every moment of his or her life, the responsibility for what he or she will make of the next hour, or how he or she will shape the next day.

Criticism of Philosophical and Religious Approaches

The utility of philosophical and religious approaches in promoting mental tranquility is evidenced by their universal employment. As a means toward providing institutionalized outlets for inner needs, of bolstering psychological defenses, and of facilitating more congenial relationships among people, they have served humankind from its earliest origins. Where they are supported by cultural sanctions, where environmental stress and inner conflict are not beyond coping capacities, they may sponsor a healthful adaptation. They have serious limitations, however, where they contradict the disposition of a culture, buttress crippling repressions, or endorse neurotic mechanisms, such as retreat from reality.

Once accepted, ideologies tend to be defended by a captious logic or transcendental dialectic that seeks to deny their inherent contradictions. Rationalizations suffuse the individual with the reasonableness of his or her own arguments and attempt to weld together into a completely coherent body that which even superficial examination shows to be spurious.

Many philosophies are predicated on the principle that the human mind, as it is constituted, is unable to understand the ultimate nature of things. Unique attitudes, values, and modes of feeling and behaving are then evolved to provide new meanings for existence. If all thinking, feeling, and striving can be channelized into a unified and unifying system—whether this be mystical, existential, hedonistic, skeptical, or other—emotional stabilization may be achieved, at least so long as the system remains intact. Should the system fail to secure inner peace, however, a search for new and more stabilizing prescripts will then ensue.

Psychotherapists are attracted to philosophical and religious helping practices partly in appreciation of the limitations of psychotherapy and partly because of their personal emotional needs. Because they have found their own lives enriched by certain points of view, they may adopt these as a basis for an approach that, in their hands, will probably prove to be fruitful. Yet the sponsoring of philosophies will not be useful for all patients; special needs and resistances will enjoin them to modify or reject the therapist's best efforts at indoctrination.

Philosophical promptings in themselves are not sufficient for the struggle with severe personality immaturities and deep neurotic conflicts. Indeed, they are too often used to reinforce neurotic strivings,

for instance, to bolster fears of authority, to negate sexual and aggressive impulses, to avert anxiety through obsessive rituals, to pander to self-punitive and masochistic leanings, to remove the individual from the demands of reality, and to identify with omnipotent extramundane forces with the intent of incorporating them within the self. Such ideologies may negate rather than help a constructive adjustment.

Arguments posed by scientists against the serviceability of religious practices are even more stringent (Freud, 1949; Reik, 1951). A good number of devotees of science admit that there are aspects beyond observable experience, but they are not willing to elevate these to a deistic substance or being in whose transcendent vision all phenomena are clear. Religion resents the implication of some scientists that the craving for God is an infantile or neurotic prompting, and it challenges the denial of the validity of an Almighty Being, since science can offer no experimental proof that there is none. What better evidence is there for God, protests religion, than the miracle of creation of living things, the source of which no scientist has been able to qualify, let alone quantify.

On more specific grounds, a point of conflict between science and religion is that the former regards moral deviation as a symptom, the latter as a sin. Science is apt to look on a human being as an irrational entity and on deviations as unwilled and manipulatory of the individual without his or her desire or awareness. Religion considers a human being a rational being and holds deviation to be an act against humankind and God to be judged in moralistic terms. It suspects science of belittling the individual's responsibility for his or her behavior, appeasing guilt feelings and encouraging the acting out of errant impulses and drives that are morally reprehensible. Thus, science is seen as acquitting anger, covetousness, envy, gluttony, lust, pride, and sloth—the seven deadly sins—as byproducts of an individual's past conditionings, the liability for their present manifestations falling on the shoulders of parents and not patients. Moreover, science is considered by some representatives of religion to encourage a closer relationship to the psychotherapist than to the pastor, hence diverting patients from seeking spiritual guidance. Science counters by pointing out that certain religious precepts contradict the biological nature of a human being and that a literal interpretation of the Bible will cast a shadow over healthy promptings that stir in all persons in the course of personality development, for instance, in relation to sexual and aggressive feelings. Relegating the individual to eternal damnation for sexual drives out of wedlock, for adulterous thoughts and fantasies, for interest in prurient materials, for

retaliatory aggression in the face of humiliation or exploitation, for rebellious impulses toward parental agencies—all of this serves merely to mobilize pathological guilt and shame, to sponsor masochistic, sadistic, and other neurotic responses, and even to cripple healthy drives for reproduction and self-defense. The meek, the poor, the sad, the peaceful are not necessarily blessed. Temporary anger, resentment, and bitterness may be justified and need not irreparably violate the spirit of Love. Mutilation is not a worthy punishment for fantasies that oppose monogamy and fidelity. Passive compliance cannot always be the response to those who promote evil, nor can one in the spirit of tolerance always love one's enemies.

There are some scientists who believe that any morality that proposes an absolute code, violation of which brings supernatural punishment, contains within it seeds of conflict, since the definition of what constitutes the proper morality is open to some question. Thus, obedience to authority and unquestioning submission conflicts with self-determination and independence. Un-worldiness, with its abandonment of natural pursuits, leads to passive alienation; shame and guilt in relation to bodily desires may inspire monastic self-torment and degradation of sexual desire with a repression of rage and aggression. Many of the sacrificial rituals in religion stem from this conflict. Religious systems, it is also claimed, may sponsor conflict and bad values, representing the bad in the form of an inhabitant of the underworld—devil, satan, Baal-Zebub—an evil representative who opposes God for the mastery of the universe. This struggle, recorded vividly in the Talmud and New Testament, and especially in the Apocryphal and Apocalyptic Books, is literally incorporated in the conviction that the devil is constantly on the alert to occupy an individual's body and to pervert that individual to his satanic purposes. This is a potent fount of anxiety, particularly when the religious individual feels incapable of living a perpetually sainted life. More in the form of an abstraction than in a pictorialized image of a cloven-footed, horned monster, the notion of an invasive devil may preoccupy those whose fundamentalist notions are rooted in medieval conceptions that continue to be a means through which they control and discipline themselves.

A conflict in moral values may furthermore be sponsored in religious systems that conceive of the right and ability on the part of the individual to do and think as he or she wishes, as theologically opposed to the idea of predestination. If we conceive of all humankind as "free," we must assume an autonomous morality with self-determinism and unpredictability dissociated from Divine foreknowledge. Science claims that sources of behavior are too often considered by religion to be the

product of moral judgments of which the individual is fully aware and which he or she may freely "will" and "choose." Very often, however, the determining factors in behavior are unconscious in nature, outside the awareness and control of the individual. One is frequently driven in one's choices by forces that are not apparent at moments of decision. A view reconciling these disputations, and one that psychotherapy endorses, is that moral choice is still the individual's in his or her freedom to exercise it; however, each person has the nature to misuse it. Awareness of one's unconscious enables the individual better to exercise moral control. Freedom of will does not imply capriciousness or irresponsibility.

Another conflict brews over the matter of fundamentalism. A believer must accept the Divine authorship of the Scripture, since the authors were merely the agencies for the transcription of sacred and unalterable doctrines. Deviation from the sentence and word, in the mind of fundamentalists, tends to discredit God. Science contends that the Bible is a human document, subject to the same kind of study and analysis as any other human document. Fundamentalists insist that biblical criticism, and the pointing out of discrepancies in the Scripture, are illusions of the devil. Reconciliation of opposing viewpoints is often attempted by the judgment that while the ideas in the Bible are Divine, the canons of Scripture are the product of the church on earth. A strong undercurrent of fundamentalism still exists that may disturb those who have no investment in orthodoxy. Fundamentalist conflict, incidentally, is not confined to the Bible; it invests many fields of thought, even scientific, where allegiance to the omniscience of founders of a movement tends to circumscribe one's thinking to the letter of published text or to interpretations of the text by self-appointed prophets.

We are currently witnessing a softening of the stand of science and religion toward each other. By integrating the findings of science, religion may be able to achieve its highest aims in encouraging values that make for a better world. By studying the forces activated by faith, scientists may be able to release the same healing elements more precisely in the medium of a scientific methodology.

In summary, philosophical and religious systems in the themselves do not suffice to control or rectify severe neurotic distortions. In an eclectic therapeutic framework, philosophical precepts may sometimes be incorporated to develop socially useful values helpful in promoting adaptation.