DIAGNOSIS AND RATIONAL PSYCHOTHERAPY

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In a previous paper, the question of whether diagnosis is a prerequisite of psychotherapy was discussed. On the one hand we have Thorne's statement that "it seems elemental that rational therapy cannot be planned and executed until an accurate diagnosis has been made." On the other hand, Rogers writes that "diagnostic knowledge and skill are not necessary for good therapy." Thorne bases his argument upon an analogy between mental disease and physical disease. Consideration of the characteristics of mental and physical disease, however, raises doubt as to the appropriateness of the analogy. The nature of the disease processes differ; on the one hand, the disease primarily involves the physiology and chemistry of bodily functioning, while in mental disease it is primarily a disorder of psychologic and social behavior and adjustment. Moreover, while in physical disease etiology may be traced to specific, identifiable or empirically verifiable chemical and bacteriologic agents, or viruses, in functional mental disease no such etiology has, as yet, been verified. Finally, while in physical or internal medicine specific experimentally or empirically verified remedies exist, this is not the case in the field of psychotherapy. Thus, it is not possible in mental disease to make differential diagnoses on an etiologic basis and select the appropriate specific remedy or therapy.

In practice, differential diagnosis has little rational connection with the choice of a technique of psychotherapy.* Techniques depend more upon the training, experience, preferences and skills of the therapist than upon diagnostic indications. Efforts to develop a "rational" psychotherapy on the basis of diagnosis, in terms of indications and contraindications for various techniques have not been particularly successful or convincing. The severity of the condition, rather than its specific nature, may have an influence in determining whether a supportive or uncovering technique is used, but aside from this there is little rational connection between particular conditions and particular techniques.

An adequate etiologic understanding and classification of mental disorders might be expected to provide a basis for rational selection of therapy. Such a classification does not appear possible, however, at least in our present state of understanding. Even in the judgment of a specific case, on the basis of a detailed case history, in terms of etiology and psychodynamics,

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no agreement can be reached among, or within, professional groups (Elkin). In such a state of affairs we certainly cannot set up a diagnostic system based upon etiology or psychodynamics.

In our earlier paper, referred to above, it was suggested that possibly all functional maladjustments are essentially alike in terms of basic etiology, so that there are no fundamental or essential differences upon which to distinguish discrete classes of mental disorder. The various behavior manifestations, or symptoms are determined from this point of view by contingent influences, including accidents of the environment and particular experiences of the individual. It would follow that a classification upon the basis of symptomatology would lead to confusion, since individuals essentially unlike might be grouped together.

From this point of view, a rational therapy would be based on an understanding of the basic, common element or elements of maladjustment, and the development of principles and techniques of therapy which would be effective in reaching and remedying the condition, If there is a common factor in all maladjustment, it should follow that there would be certain principles, and techniques implementing these principles, which should be basic or common to all psychotherapy.

Since maladjusted behavior must be understood and interpreted in the same frame of reference as normal or adjusted behavior, the factor or factors common to maladjustment must be derived from an understanding of behavior in general. Therefore, an attempt was made to develop an outline of a theory of behavior and its maladjustments, from which therapeutic principles and practices could be derived. Certain assumptions concerning behavior are necessary to begin with. These may be briefly stated as follows:

Postulate I: The living organism, by definition, is in a state of constant activity, contracting or expanding, approaching or withdrawing from its environment.

Postulate II: All living matter tends to seek a state of equilibrium, both within itself (homeostasis) and in relation to its environment, and to attempt to maintain its organization when threatened.

Postulate III: Psychologically, this characteristic is exhibited by the tendency of the individual to become and remain integrated and consistent within itself, and to adapt to its social milieu.

Postulate IV: Since the organism is continuously stimulated, from within and without, equilibrium is never maintained for long, but is dynamic and unstable.

Postulate V: This dynamic equilibrium results in change, so that all living organisms are normally characterized by growth and development, from lesser to greater complexity of behavior, from immaturity to maturity, from dependence to independence. In other words, there is a capacity to grow and to learn.

On the basis of these postulates, certain principles of behavior may be developed:

Principle 1**:** The activity of the organism is not random, but is directed or motivated by needs, drives, wishes, desires, etc.

Principle 2: The organism reacts to its environment or to a stimulus as it is perceived and experienced, i.e., interpreted by the organism.

Principle 3: Motives are directed toward the preservation and enhancement of the organism.

Principle 4: All behavior is thus goal-directed, toward the satisfaction of the needs of the organism.

Principle 5: Behavior which succeeds in satisfying a need or desire results in the reduction of tension, or an approach toward equilibrium or integration, and tends to be repeated in similar circumstances until it becomes fixated (learned) and habitual.

Principle 6: When a need or desire is frustrated, either by external conditions or conflict with another incompatible drive or desire, a state of physiologic and/or psychologic tension is maintained.

Principle 7: Under such conditions of unsatisfied needs, the organism seeks substitute or compromise satisfactions.

Principle 8: Such substitute satisfactions may or may not result in complete tension reduction, or may create additional tensions.

Principle 9: Behavior becomes maladjusted when substitute satisfactions do not lead to tension reduction, or violate the integrity of the organism's organization, or result in behavior unacceptable to the organism's environment.

Principle 10**:** The repression of conflicts, or of unsatisfied needs and desires, is the result of the tendency of the organism to maintain its integration and organization. Conflicts and tensions may thus exist on an unconscious level.

Principle 11**:** Substitute satisfactions are retained because they afford temporary or partial reduction of tension, and thus become fixated, preventing further growth and development or the attainment of more adequate satisfactions.

This theory of behavior and its maladjustment provides an etiologic explanation of maladjustment in terms of common elements. Basically, all maladjustment results from inadequate resolution of tensions resulting from frustration of needs and desires as a result of conflict. From such a theory of behavior and its malad- justment, certain principles of psychotherapy would appear to derive:

(1) Differential diagnosis in terms of symptomatology, or etiology or even knowledge of the content of the conflict involved, is not a prerequisite of therapy, since it is the presence of conflict and tensions, rather than its content, which determines the technique of therapy.

(2) A formal case history does not appear to be essential before undertaking therapy, since its functions, other than for diagnosis, as listed by Thorne, are satisfied during therapy.

(3) Therapy should allow repressed conflicts to become conscious, so that the unsatisfied needs and desires resulting in tension, and the inadequate satisfactions, may be recognized.

(4) A rational therapy should aim at providing an opportunity for the patient consciously to discover more satisfactory, direct, and acceptable satisfactions for his needs. Therapy should, therefore, be more than symptomatic, palliative, supportive, etc.

(5) Therapy should avoid creating dependence of the patient upon the therapist, since the aim of development is the ability to adapt and adjust in a mature, independent manner. The patient should be aided in solving his own problems rather than having his problems solved for him.

(6) The inherent capacity of the organism for growth, and the tendency toward organization and integration, are forces which motivate the patient toward the solution of his own problems. Therapy should free this positive energy in the patient.

(7) The therapeutic situation is an emotional learning situation. This means that the patient will learn what the situation demands, whether dependence or independence, immaturity, or maturity, irresponsibility or responsibility for himself, where to go to have his problems solved or how to solve his own problems.

Some techniques or practices which would appear to be consistent with these general principles may be stated:

(1) Repressed conflicts and attitudes may be brought into consciousness by:

(a) the conveying of a sense of understanding and acceptance in a noncritical, nonjudgmental relationship, conducive to the expression of negative attitudes, with the release of tension and the assimilation of negative feelings by the patient, with a recognition of his needs and desires;

(b) the creation by the therapist of a free, permissive atmosphere in which the patient can explore his problems and conflicts on a conscious level;

(c) the clarification of expressed attitudes and feelings, enabling the patient to see himself in a somewhat different perspective, leading to the recognition of more adequate satisfactions of his needs.

(2) The positive growth forces will manifest themselves in the patient if:

(a) he is given responsibility for himself;

(b) he is allowed the freedom to explore his own attitudes, feelings and problems;

(c) the drive toward maturity and independence is recognized, and the patient is given the opportunity to practice and learn independence through experience.

(3) The avoidance of techniques, such as suggestion, persuasion, support, reassurance, sympathy, etc., which create dependence of the patient upon the therapist.

(4) The avoidance of techniques, such as questioning, probing, advice, interpretation, etc., which restrict the freedom of the patient in exploring and solving his own problems.

The implications of the foregoing for the practice of psychotherapy are far-reaching, and it is impossible to discuss them adequately here. The literature on nondirective therapy is concerned with many of these principles and techniques. It may be interesting, however, to consider them in relation to a recent attempt to develop a rational psychotherapy growing out of traditional psychoanalysis (Alexander and French). The discussion will be organized, in general, under topics discussed by Alexander and French. A difficulty presenting itself is the fact that French in his contributions quite frequently differs from Alexander. This lack of agreement is most apparent in the discussions of transference, and interpretation and insight.

Aims of Therapy. Alexander and French discuss the aims of therapy in terms very similar to those employed above: "The essence of psychoanalytic therapy is to bring into the patient's consciousness emotions and motivations of which he is not aware, or in other words to extend the patient's conscious control over his behavior (p. vi) . . . . In every case the same psychodynamic principles are applied for the purpose of therapy: inducing emotional discharge in order to facilitate insight, and exposing the ego to those unresolved emotional constellations which it has to learn to master" (p. vii).

Etiology. Alexander and French find the etiology of neuroses and psychoses in "a failure of the ego in performing its function of securing adequate gratification for subjective needs under existing external conditions" (p. viii). By ego, the authors "refer to the organ system whose anatomical and physiological substratum is made up of the highest integrative centers of the central nervous system" (p. viii). "The integrative function of the ego ... consists in the complex harmonious co-ordination of simultaneously existing, partially conflicting, subjective needs and impulses with each other and with external conditions upon which their gratification depend" (p. ix). "Conflicting standards contribute more than anything else to that emotional insecurity which is the most common basis of neurotic disturbance. Although the patterns or symptoms may vary greatly, we find this basic struggle in an astounding number of persons" (p. 4).

It is apparent that this formulation is similar to the conflict-frustration-tension process outlined above, though couched in psychoanalytic terminology. In terms of basic etiology, therefore, psychoanalysis is in agreement with our thesis that there is a common fundamental process involved in all functional maladjustment. Indeed, not only psychoanalysis but most standard texts concerned with the psychology of adjustment assume a common source for maladjusted behavior, although the implications of this in therapy have apparently never been explicitly developed.

Traditional psychoanalysis, in following the same procedure in every case, apparently operated upon this assumption. Alexander and French, however, reject this practice of treating every case in the same manner, and advocate the application of various techniques and methods, although still adhering to the dynamic principles of psychoanalysis. They thus

introduce the problem of choice of techniques in the individual case, a problem which, as we have indicated above, has not been satisfactorily solved, and which may not be capable of solution for the reasons given there. Alexander and French "lay stress on the value of desi ning a 'plan of treatment,' based on a dynamic-diagnostic appraisal of the patient's personality and the actual problems he has to solve in his life conditions" (p. 5). As suggested by the study referred to earlier (Elkin), disagreement concerning a dynamic diagnostic formulation between psychoanalysts and other psychiatrists and psychologists, as well as among psychoanalysists, would lead to doubt as to the reliability and validity of such an appraisal.

Plan of Treatment. In the attempt to make psychotherapy rational, Alexander and French place great emphasis upon a plan of treatment, which "requires a thorough knowledge of the patient's personality structure" (p. vii). "We must find the technique most applicable to the individual case" (p. 6). Here they also, like Thorne, draw an analogy between internal medicine and mental maladjustment. In their rejection of the "more-or-less passively watching therapist following the lead of the patient's material as it unfolds before him" (p. 5), as practiced in traditional psychoanalysis, they propose a more active role for the therapist, which requires systematic planning. The principles and techniques developed above, however, are closer to traditional psychoanalysis, in this respect, than to the modifications of Alexander and French.

The Principle of Flexibility. The planning of the course of therapy does not mean that it is inflexible. Alexander and French write that not even after the initial diagnostic appraisal can we foretell what technique will be necessary for a later phase of the treatment. As we now practice psychoanalytic therapy, we seldom use one and the same method of approach from the first to the last day of treatment" (p. 25**)**

Although all variations of technique are directed toward the fundamental alms of therapy, and supposedly based on the psychodynamic principles of psychoanalysis, it is likely that therapy will become inconsistent, at least from the point of view of the patient, a condition whi--h many therapists feel is unfavorable.

Flexibility of technique includes not only directive questioning and probing, giving suggestions and directives to the patient, and altering his environment, but changing the frequency of interviews and employing interruptions of treatment-all in an attempt to shorten the analytic process. Recognizing the dependence fostered by daily interviews, Alexander and French reduce their frequency, with good results.

The manipulation of frequency of interviews places a responsibility upon the therapist which he may be unable to assume, or which possibly could, and should, be assumed by the patient himself. It is quite possible that therapy cannot be hurried by the therapist-that is, beyond the pace at which the patient is able to progress. The resistance of patients to premature interpretation is an illustration of this. In the type of therapy outlined above, the patient determines the frequency of interviews.

The Transference Relationship. Alexander and French discredit the belief that a complete transference neurosis is unavoidable in psychoanalysis. This should be comforting to those therapists who have practiced psychotherapy without ever experiencing such a situation. It is even recognized that the development of a transference neurosis is responsible for the extreme

length of some psychoanalyses. "It is realized that frequently such a transference neurosis is not merely unnecessary or undesirable, it is sometimes almost impossible" (p. 43). The transference neurosis is in a sense the creation of the therapist, developed by the attitudes, activities and interpretations, of the therapist and the roles which he takes. These same factors account for the transference relationship, which Alexander and French utilize as a technique to be manipulated.

As in the case of frequency of interviews, “one of the most important ... technical problems is to decide what kind and degree of transference relationship is the most useful ... to avoid the growth of an amount of dependence or resistance which would prolong the analytic process" (p. 45). Here, as in the case of frequency of interviews, in the therapy described above the therapist does not allow himself to become involved in an emotional relationship with the patient, but instead always remains permissive, but not the object of the patient's displacements, understanding, but not supporting, encouraging or sympathetic, accepting and noncritical, but neutral, and not condoning or condemning. This does not mean that that part of the transference relationship which is in essence rapport is lost. It does mean that the therapist is not involved as an emotionally charged figure in the patient's life.

Whereas in the type of therapy here proposed the therapist maintains a constant and consistent attitude of acceptance and permissiveness to allow the conflicts of the patient to rise into conscious expression, Alexander and French attempt, on the basis of an understanding of the history of the patient's emotional development, to revive and reactivate the original conflict situations, in order to provide, by the therapist's attitudes or even role-taking, "corrective emotional experiences." The therapist thus changes his attitude and role during the process of therapy, and may appear to be inconsistent and unpredictable to the patient. The progress of therapy may be delayed thereby, since one of the things the patient needs is a stable, dependable relationship.

Interpretation and Insight. French contributes a valuable discussion on insight in therapy. He recognizes that "attempting to give a patient insight has therapeutic value only for a patient who is capable of tolerating such insight; and indeed, even in a standard psychoanalysis there are often periods of stubborn resistance in which a patient becomes incapable of tolerating insight into his conflicts. . . . In such cases it is important to remember it is the emotional readjustment which may result from insight that is our real therapeutic goal, and not insight for its own sake. Indeed, not infrequently the relationship between insight and emotional readjustment is just the opposite from the one we expect in a standard psychoanalysis. In many cases it is not a matter of insight stimulating or forcing the patient to an emotional reorientation but rather one in which a very considerable preliminary emotional readjustment is necessary before insight is possible at all" (p. 127). "If an emotional readjustment has not already taken place to make the patient able to tolerate an insight that previously could not be tolerated, then of course the patient will be quite unable to make use of the therapist's interpretation" (p. 128).

This realization that insight is a concomitant or resultant of the adjustment process, and not even an invariable or necessary accompaniment or result, has impressed itself upon many "non-directive" therapists. Insight, by any rigid definition, is intellectual and conscious, although some therapists speak of "emotional insight," presumably unconscious, and it is generally recognized that intellectual understanding will not cure maladjustment. True insight, as

differentiated from intellectual verbalization, is impossible in maladjustment, since it is as a result of maladjustment that the patient is unable to see his problems rationally, rather than maladjustment being the result of lack of insight.

It would appear from this point of view that interpretation for the purpose of forcing insight is a mistake. French apparently agrees with this, but Alexander in another chapter views interpretations as an essential aspect of therapy. He recognizes the opposition and resistance aroused in patients by interpretation, but interprets this as evidence for the validity of the interpretation, and encourages the therapist to "follow up such resistance reactions to demonstrate the correctness of the original interpretation" (p. 78). He also recognizes that "one of the most frequent causes of a transference neurosis is the need to hide or cloak such frank resistance reactions" (p. 78), on the part of the patient.

In the method of therapy proposed in this paper, the problem of when not to give and when to give interpretation is avoided by not using frank interpretation as a technique. Again, reliance is placed upon the patient to arrive at his own interpretation, which will not be couched in psychoanalytical terminology, but is nevertheless real and valid.

Therapy and Learning. Alexander and French touch briefly upon the place of learning in therapy. Considerable discussion of this aspect of therapy has recently appeared. Although everyone recognizes that learning or re-education is involved in therapy, no one has yet successfully shown just what the relationship is, perhaps because we do not yet understand, or are unable to agree upon, exactly what learning is. Critics of nondirective therapy have suggested that if therapy is learning, then nondirective techniques are not appropriate, since we do not teach arithmetic or spelling by nondirective methods (although progressive education has approached these methods). However, teaching is merely a way of allowing learning to take place, providing the tools, the resources, the information and the optimum conditions for learning to take place. Once the resources, tools and information are made available, by directive methods if you will, then no amount of direction will guarantee that learning will occur. In fact, it appears that the optimum conditions for learning are those of "nondirection", or freedom, independence, understanding, etc.

In maladjustment, as Alexander and French point out, learning has been interrupted, and it is the function of therapy to facilitate the learning process by providing an atmosphere in which learning can occur. In emotional maladjustment it is in most cases not necessary to provide the resources, tools and information necessary for learning. These the patient usually possesses, but he is unable to utilize them. What he needs is a situation where he will be free to utilize them. He will be able to do so in a situation to which he can adjust, where he can feel secure, not threatened, even if only temporarily. Therapy provides such an environment. The fact that the therapeutic situation is unreal, artificial, unlike anything the patient meets in everyday life, is not a handicap but a necessity, if he is to achieve adjustment. In a situation to which he can adjust, he is able to exercise his capacity to learn. It is through the experience of success in adjusting to a simple, protected situation that strength and confidence is acquired for successful adjustment in more difficult situations. The therapist is not a teacher in the usual sense of one who provides tools, resources and information.

He is a teacher in the sense that he creates an atmosphere favorable to learning, in which the patient is relieved of the pressure of his emotional conflicts, and in which he is at least temporarily adjusted, so that his learning potentiality is freed to assist him in utilizing the resources, tools and information which he already has.

There are thus a number of similarities, and a number of differences, between the rational method of therapy developed here, and the methods of Alexander and French, which, although apparently rational, are at variance or inconsistent on several points, and not clearly derived from any general theory or set of principles of behavior. While in many instances the departures of Alexander and French from standard psychoanalysis are advances in therapy, in other instances they would appear to be a step away from a unified, consistent, rational therapy. It is felt that the approach described here is a consistent, systematic, rational therapy, based upon a theory of behavior which is in agreement with many students of the psychology of adjustment. It is hoped that discussion and criticism will be stimulated, leading to a more complete development of therapeutic principles and practices upon a rational basis.

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