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Jerome D. Frank

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Jerome D. Frank, MD*

This paper, accompanied by the discussions and the preceding introduction, was delivered May 9, 1974 as part of an anniversary celebration commemorating a half century of existence for the psychiatric unit at Henry Ford Hospital. Established in 1924 by the late Thomas J. Heldt, M.D., as a division of neuropsychiatry in the department of medicine, the unit is generally believed to be the first to be incorporated into a general hospital anywhere. It was – and is – conducted without physical restraints of any kind, without isolation of patients, and without segregation of men and women.

Dr. Frank is a professor of psychiatry at Johns Hopkins University. Among his many publications one of the best known is the book, Persuasion and Healing.

PSYCHOTHERAPY has become a major, lucrative American industry catering to the needs of millions of consumers. It is crowded with entrepreneurs, each of whom proclaims the unique virtues of his particular brand of psychotherapy. Solidly based objective information as to the nature and efficacy of different psychotherapies, however, is sadly lacking. This is partly because of the intrinsic difficulty of the subject matter — human beings are highly complex and do not readily submit themselves to the discipline required to maintain research designs. Another obstacle is the understandable reluctance of psychotherapists to subject their claims to impartial examination. Most have spent much time and effort to master their particular method and both their economic security and self esteem, therefore, depend on its therapeutic efficacy. In the words attributed to Confucius: "A wise man does not examine the source of his well-being." Despite this sage advice, I should like to explore with you some questions as to the nature and power of the healing components of psychotherapy.

A good place to start is an experience at a two-day workshop at the National Institute of Psychotherapies about two years ago, attended by leading proponents of six schools of therapy: "Rolfing," bioenergetics, hypnosis, gestalt, implosion and direct psychoanalysis. Each participant gave a persuasive explanation of

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his rationale and technique, sometimes with an actual demonstration. At the final panel discussion, a member of the audience asked each of the panels members if there was any kind of patient they could not treat, and each replied, in effect, that his particular method was successful with any patient who was treatable by psychotherapy at all.

This position actually accords with the fact that so far no objective study has been able to demonstrate the superiority of one psychotherapeutic technique over others, with the exception that the short-term efficacy of behavior therapy with circumscribed phobias is superior to that of unstructured interview therapy; but circumscribed phobias comprise less than 3% of the complaints of our patients.

What are the implications of this strange state of affairs? The most uncharitable interpretation is that psychotherapy is no more effective than any other kind of help to which people turn when in trouble. According to this view, when people are in distress they look to others for help, such as family members, friends, clergymen and psychotherapists. The help may take various forms including all kinds of support, encouragement and advice, secular and religious, offered individually or in groups. The so-called spontaneous remission rate is really the result of this sort of help. If the person happens to go to a psychotherapist, his therapy gets the credit, but its effects are in reality no different than those offered by any other help-giver. To put it bluntly, psychotherapists live off of the spontaneous remission rate.

This position has sparked many polemics, but also much careful, critical review of the evidence, and the upshot is that it is not tenable.[1] Help offered in a systematic way by a trained person — that is, psychotherapy — is more beneficial, by and large, than that offered unsystematically by untrained help-givers.

There is no doubt, however, that many of the determinants of benefit from any form of help lie in personal qualities of the patient and his interactions with his immediate situation. Thus persons who have good ego-strength, have developed effective ways of coping with stress, and are skillful in communicating their feelings and thoughts can take full advantage of any helping relationship and are, therefore, good candidates for any form of psychotherapy. Furthermore, to the extent that they seek aid while in a crisis — that is, an environmental stress which temporarily overwhelms their coping capacity — they will improve when the crisis passes. In this connection, a recent report from the Menninger Psychotherapy Research Project emphasizes that much of the improvement, even of patients in long-term psychoanalysis, can be attributed to changes patients have made in their lives which lightened the environmental load, such as moving to a new location, divorce, job changes and the like, in which the role of the therapy was to offer the support which gave the patient the courage to make the changes.[2]

Returning to our panels of therapists, since the methods were superficially very different, their uniform success (if we may believe their proponents, as I am inclined to do) must depend on features they had in common. One of these, of course, was a gifted therapist, and I believe that next to the patient, the personal qualities of the therapist are the most important determinants of therapeutic success. A recent extensive study of encounter groups found, for example, that the most and least successful group leaders were both members of the same school.[3] One attribute of the therapist related to his success is

experience. It has been shown that experienced practitioners obtain better results than inexperienced ones of the same school of therapy. This may be partly because the former have achieved a better mastery of the method, but personal and attitudinal factors are probably also involved. The experienced therapist has more prestige, is older and is more secure, features which inspire the patient's confidence. Also, it seems a safe assumption that a cohort of experienced therapists will contain a larger proportion of persons who, for whatever reason, are good therapists than a pool of inexperienced ones. Over the years a process of self-selection occurs in which the less competent therapists weed themselves out and go into teaching, administration or research.

As to what qualities or attitudes make for a good therapist, we have only a few leads. Years ago Whitehorn and Betz showed that therapists who offered schizophrenics active personal participation obtained better results than those who preserved a more impersonal attitude,[4] and Rogers and his co-workers have shown that the therapist's ability to project empathy, genuineness and non-possessive warmth is related to his success with neurotics.[5] Finally, there is the fascinating finding of an elaborate study of psychoanalysis involving eleven therapists and fifty patients and using sophisticated methods of evaluation, the therapeutic process itself and improvement. It turned out that when all was said and done, the best prognosticator of improvement was the place the patient occupied in the therapist's roster. Of the eight patients who showed maximal improvement, four were the first in the therapist's roster and two were the second. On the plausible assumption that the therapist's zeal was greatest with his first patient and progressively diminished after that, this finding suggests that, in the words of the researcher, "prognosis is best when there is a willingness of . . . the therapist to become *deeply involved* . . . and to bear the tension that inevitably ensues."[6]

So far I have indicated that features of the patient, his environment and the therapist account for much of the improvement obtained by all forms of psychotherapy. What, then, is left for the therapeutic method?

All one can say at present is that this must be left open. To be sure, studies comparing different methods have failed to indicate the superiority of one over another, but failure to demonstrate a difference does not mean that no difference exists. Perhaps our research methods are too crude to find it. Differences between therapeutic outcomes of groups of patients may be obscured by the presence of large numbers of patients in each group who respond equally well or poorly to both therapies. Those who respond differentially may be too few to produce a statistically significant difference.

In any event, whether or not different forms of psychotherapy are differentially effective, it seems safe to conclude that psychotherapy in general is more effective than random, unsystematic help, and that all schools and methods of psychotherapy share certain ingredients which account for a large part of their effectiveness. If this is so, it must follow that underneath the diversity of symptoms and complaints that lead people to seek psychotherapy, there must be a common source of their suffering and disability which is counteracted by these common ingredients.

As a first approximation, this may be termed demoralization — a sense of varying degrees of hopelessness, helplessness and isolation which ensues when a person finds himself unable to

cope with some problems of living. The symptoms for which he seeks help may be direct expressions of this state of mind, such as anxiety and depression, or chronic self-perpetuating and self-aggravating attempts to solve the problem, such as many neurotic symptoms, or may have quite other sources, such as the thinking and perceptual disturbances of schizophrenics. Whatever their source, however, symptoms interact with demoralization. By reducing the person's coping capacity, they predispose him to demoralizing failures, and their severity seems to wax and wane with demoralization. Thus schizophrenics become more disorganized when they are anxious, and obsessions and compulsions are worse when the patient is depressed.

Patients present themselves to therapists with specific symptoms, and both they and their therapists believe that psychotherapy relieves these. The evidence I've presented so far, however, is more consistent with the assumption that the main effect of psychotherapies of all schools is to combat the concurrent demoralization, whereupon the symptoms disappear or, at any rate, become less troublesome.

Let us now turn to the features shared by all forms of psychotherapy which combat isolation, hopelessness and helplessness.

The most powerful antidote to both isolation and hopelessness is, of course, the steadfast interest of someone who cares and is able to help. All therapists convey these attitudes. Both in themselves and as representatives of society, their acceptance of the patient in itself combats his sense of alienation. Group therapy adds another dimension through what has been termed universalization — the discovery by each member that his problems are not unique.[7] Members of all groups from business leaders to psychotics are all astonished to find that others have similar troubles, and this is a potent source of relief.

An aspect of all psychotherapies which can be considered in terms of its role in the psychotherapeutic relationship is emotional arousal. It is a truism that therapy is ineffective unless it stirs the patient emotionally. Directive therapists do this by urging patients to enter situations or attempt activities they fear. Some openly criticize patients. Evocative therapists do the same indirectly through interpretations that are implicitly critical or that force patients to face unacceptable aspects of themselves. They also arouse patients by not responding as the patient expects, including not responding at all. As we all know, recently there has been a sharp recrudescence of popularity of methods which aim to produce emotional flooding or abreaction.

How emotional arousal, whether weak or strong, enhances the effectiveness of psychotherapy, if indeed it produces more than very temporary benefits, is unclear and fuller understanding probably awaits more knowledge of the functioning of the brain. At this point all that can be said with assurance is that it strengthens the influencing power of the therapist. Moderately intense emotional arousal sensitizes a person to environmental inputs and, if the emotion is unpleasant, leads him to search actively for relief. When this occurs in therapy, he naturally turns to the therapist. Arousal intense enough to be disorganizing further increases this dependence and, in addition, by breaking up old patterns may facilitate the achievement of a better personality integration. In any case, we found in experimental studies that a patient's attitudes toward concepts important to him could be shifted more

easily by the therapist while he was in the excitatory state produced by ether or immediately after it than if he were not so aroused.[8,9] Since ether also produces confusion, which might have accounted for the effect, we repeated the experiment using inhalation of vapor containing adrenalin with essentially the same result.[10]

In addition to the therapist, other features of all forms of psychotherapy combat hopelessness, another component of demoralization. In this connection, we may note first that a person's view of the future has a powerful effect on his present state. Hopelessness can retard recovery or even hasten death, while mobilization of hope plays an important part in many forms of healing in both non-industrialized societies and our own. Favorable expectations generate feelings of optimism, energy and well-being and may actually promote healing, especially of those illnesses with a large psychological or emotional component.

Unless the patient hopes that the therapist can help him, he will not come to therapy in the first place or, if he does, will not stay long; and his faith in the therapist may be healing in itself. As already suggested, the therapist potentiates the patient's hopes simply by accepting him for treatment, for this act implies that he believes he can help. The therapeutic setting, the therapist's reputation and his specific ministrations further enhance hope.

One research tool for studying hope is the placebo, since its effects depend solely on its being a symbol of the physician's healing power.

The determinants of the placebo effect have proved to be primarily situational and are exceedingly complex. One remarkable finding, however, is directly relevant to our concern. This is that the effect of a placebo on both psychiatric symptoms and the relief of pain is a constant fraction of the effect of the drug in double-blind studies. A placebo proves to be about 55% as effective in relieving pain as either darvon or morphine, even though morphine is a much more effective pain reliever than darvon.[11] Similarly, a double-blind comparison of psychoactive drugs and placebo with psychiatric outpatients revealed that if the dose of drug was doubled, thereby increasing its potency, the potency of the placebo also doubled.[12] In this series the efficacy of the placebo, amazingly, was as great as that of the medication. Apparently the therapist's conviction about the drug's potency, which he somehow communicates to the patient, is a mediator of its effectiveness. Put in other terms, at least 50% of the effectiveness of any pharmacological agent that affects subjective states is caused by the patient's expectations, transmitted to him by the therapist.

That much of the effectiveness of psychotherapy in relieving distress seems to depend on a similar potentiation of expectations is suggested by a repeated finding of ours that the mean effect of a placebo on reduction of psychiatric symptoms was virtually identical with that of three different forms of psychotherapy.[13]

If expectations of patient and therapist affect the outcome of treatment, it stands to reason that the more congruent these expectations are, the better the results of treatment should be. University students going to the counselling center and well educated persons seeking psychoanalysis and related treatments are usually so well informed about psychotherapy that they respond almost automatically to the demand character of the therapeutic situation, and the therapist can take it for granted that they know the rules of the game.

This is not true with lower-class patients and those referred through medical channels. In recognition of this, in the first therapeutic session experienced therapists of all schools usually review how they expect the patients to behave, what the patients can expect of them, and what the goals of treatment are. These considerations led us to devise a controlled experiment comparing the results of four months of therapy with patients who first received a preliminary "role induction interview" designed to coordinate their expectations with what they would receive, with patients who were treated identically but did not have the preparatory interview. As a group, patients receiving the role induction interview showed more appropriate behavior in therapy and had a better outcome than the controls.[14] This finding has since been replicated in other settings.[15,16] It should be emphasized that by leading the patients to behave better in therapy, the role induction interview made them more attractive to the therapists, so this interview also improved the patient-therapist relationship, which probably accounted for an indeterminate amount of its effectiveness.

So far we have identified three therapeutic components of all schools of therapy: the qualities of the therapeutic relationship, to which personal attributes of both patient and therapist contribute; emotional arousal; and the potentiation of positive expectations. One more remains to be considered, enhancement of the patient's sense of mastery or control.

Every person's feelings of security and satisfaction depend to a considerable degree on his sense of being able to exert some control over the reactions of others toward him as well as his own inner states. Inability to control feelings, thoughts and impulses not only shakes the person's confidence in himself but impedes his ability to control others by pre-empting too much of his attention and distorting his perceptions and behavior. The feeling of loss of control underlies the fear of going crazy which so many psychiatric patients have but are afraid to express, and gives rise to emotions which aggravate and are aggravated by the specific symptoms or problems for which the person ostensibly seeks psychotherapy.

The features of psychotherapy already mentioned all lead to *immediate* relief of distress. It seems reasonable to assume, however, that *maintenance* of improvement would depend on the patient's willingness to come to grips with problems which he had previously avoided and to handle them more successfully than before treatment. One important component of his ability to do this should be an enhanced sense of mastery. It is, therefore, not surprising that all schools of psychotherapy implicitly or explicitly include the aim of enabling the patient to gain increased mastery over himself and his social environment and that their procedures are related to these goals.[17,18]

All schools of psychotherapy enhance the patient's sense of mastery in at least two ways — by providing him with a conceptual scheme that labels and explains his symptoms and supplies the rationale for the treatment program, and by giving him experiences of success. Since the verbal apparatus is the chief tool for analyzing and organizing experience, the conceptual scheme, by making sense out of experiences that had seemed haphazard, confusing or inexplicable, and giving names to them, increases the patient's sense of control. This has been termed the principle of Rumpelstiltskin after the fairy tale in which the queen broke the wicked dwarf's power over her by guessing his name.[19]

To have this effect, interpretations, which are the primary means of transmitting the conceptual framework, need not necessarily be correct, but merely plausible.[20] One therapist demonstrated this by offering six "all-purpose" interpretations to four patients in intensive psychotherapy. An example is: "You seem to live your life as though you are apologizing all the time." The same series of interpretations, spaced about a month apart, was given to all four patients. In twenty of these twenty-four instances, the patients responded with a drop in anxiety level (two interpretations were rejected and two simply ignored). All patients experienced this move from the "pre-interpreted" to the "post-interpreted" state at least once.[21]

Success experiences, the other source of enhanced mastery, are implicit in all psychotherapeutic procedures. Verbally adept patients get them from achieving new insights; behaviorally-oriented ones from carrying out increasingly anxiety-laden behaviors. Flooding techniques, by demonstrating to the patient that he can withstand at their maximal intensity the emotions he fears and therefore avoids, yield powerful experiences of success.

In order to enhance a patient's sense of mastery, successes must be on tasks which he links to his self-esteem. In psychotherapy, any task set by the therapist is seen by the patient in this light.

Furthermore, performances which the patient regards as due to his own efforts would be expected to reflect more strongly on his self-esteem than those which he attributes to factors beyond his control, such as a medication or the help of someone else. In recognition of this, psychotherapists of all persuasions convey to the patient that his progress is the result of his own efforts. Nondirective therapists disclaim any credit for the patient's acquiring new insights, and directive ones stress that the patient's gains depend on his ability to carry out the prescribed procedures.

To investigate the role of enhancement of the sense of mastery in maintaining therapeutic change following psychotherapy, we devised an experiment to compare the immediate and long-term effects of the same therapy when patients were led to attribute therapeutic gains to their own efforts or to a placebo. We hypothesized that, because of the many nonspecific therapeutic factors in both conditions, both would produce equal immediate benefit, but that patients who attributed improvement to their own efforts would maintain it better after the treatment ceased.

The core of the experiment involved eight consecutive weekly sessions in which the patient performed on a reaction time task, a task testing his ability to grasp scenes presented tachistoscopically, and one which appeared to test ability to relax in the face of disturbing auditory and visual stimuli, as measured by skin resistance. The therapist linked performance in these tasks to aspects of the patient's personal problems as determined at the initial interview. At the end of each session the patient was given immediate feedback in the form of graphs which accentuated his actual progress. Half the patients received a placebo throughout, to which the therapist attributed their improvement (the placebo condition). At the final session the placebo was discontinued with the explanation that the treatment program had been completed and that the gains it produced would be expected to continue. The other half received no medication and were led to believe that improvement on the tasks was due solely to their own efforts (the "mastery" condition).

All patients were evaluated immediately at the close of treatment and again three months later. On the average, all patients showed significant clinical improvement at the end of therapy and there was no difference in improvement between the mastery and placebo groups. Three months after the close of therapy, however, patients in the mastery condition had maintained their improvement significantly better than those in the placebo condition.

I have briefly indicated some of the evidence that arousing the patient emotionally, enhancing his hopes and increasing his sense of mastery are attributes of all forms of therapy that probably account for much of their effectiveness. It must be added that we do not know how much. There remains one more possible source of therapeutic efficacy which may be the most potent of all, so I shall conclude by mentioning it even though doing so may open up Pandora's box. Two sets of healing phenomena demand attention. The first is the universal impression that some persons in every culture have unusual healing powers for both physical and psychological ills. Leaving out of account spiritual healers and those who claim to heal by laying on of hands, it is my impression, having watched films of some leading psychotherapists, that they emanate a quality which cannot be captured by conventional personality categories. The second puzzling phenomenon of healing is that the most spectacular and profound changes in bodily and mental health are produced by religious conversions or by the very rare, but well authenticated, so-called miracle cures that occur at shrines such as Lourdes.

In pursuing these leads, we quickly find ourselves in the quicksands of the paranormal, the world of impossible facts – quicksands which can swallow up a scientist's reputation overnight.

There is every reason for caution. So-called paranormal phenomena defy the laws of space and time and therefore cannot be reconciled with the cosmology of Western science. The field of the paranormal is heavily populated by the self-deluded and the charlatans who prey on them, and even reputable researchers tend to be enthusiasts out to prove the existence of paranormal phenomena rather than objective observers, hence are prone to errors of observation and reporting. The phenomena themselves, moreover, are inconstant, not uniformly replicable, and may be impeded if the observer or participant is in a critical state of mind, which is precisely what is needed to guard against being fooled.

Despite all these caveats and mindful of the aphorism that the weight of the evidence must be proportional to the improbability of the event, I am, nevertheless, convinced that the evidence for such paranormal phenomena as telepathy, precognition and psychokinesis is too overwhelming to be ignored. The only alternative would be to assume the existence of a gigantic worldwide conspiracy which over the ages has recruited many highly eminent, reputable scientists and philosophers into a campaign to deceive the rest of the world. This is even harder to believe.

A major reason for the recent upsurge of scientific interest in paranormal phenomena is that for the first time techniques have been devised which at last make it possible to subject them to study by conventional scientific experiments. These include the effect of laying on of hands on seedling growth,[22] the study of the auras of healers and subjects by Kirlian photograph,[23] and careful experiments on telepathic dreams in sleep laboratories.[24]

The most obvious bridge from psychotherapy to the paranormal is af-

forded by the finding, already mentioned, that an important healing ingredient is the therapist's empathy with the patient. This is the essence of therapy according to existential-humanist schools of psychotherapy, whose goal, as one proponent puts it, is "to reduce or even to dissolve the boundary between doctor and patient."[25] It is a very short step from empathy to telepathy, accounts of which abound in the psychoanalytic literature and which bears the imprimatur of Freud himself.[26]

Pushing empathy to the limit, a reputable psychologist claims to have trained himself to enter a state of consciousness in which he can briefly "merge" with his patients, and that this sometimes has unexpectedly beneficial effects. Furthermore, he has trained some of his colleagues to do the same, indicating that this procedure can be learned, like any other method of psychotherapy.[27]

Such reports lead me to believe that the near future will see a surge of research into paranormal phenomena relevant to psychotherapy. Unless we include them in our purview, I doubt if we will ever understand all the ways in which psychotherapy heals.

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I. Discussion of Dr. Frank's Paper

Jarl E. Dyrud MD*

IT IS a double pleasure for me to be here as part of the Fiftieth Anniversary Celebration of the Henry Ford Hospital. Double, because I was deeply pleased that my friend Jerry Frank asked that I be invited to discuss his paper, and also my classmate at Hopkins, Dr. Roy McClure, Jr., had led our group to have a high regard for the Ford Hospital, an early impression of excellence that has been confirmed over the years.

Twenty-seven years ago this summer, Jerry and I spent some time sailing on the Potomac. Summer sailing is a good time for conversation. At least in southern waters, the demand for attention to the sailing is minimal. At that time, I was just joining Jerry in a group therapy research project. He had completed his psychoanalytic training. I was beginning mine. It was an ideal time to talk about how psychotherapy works.

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We talked about the importance of charisma, that gift of grace bestowed on some therapists that seems to heighten their effectiveness, as well as karygma, the favorable moment in one's life for change. We talked about the capacity for faith and trust as it develops or is hindered in development in the family. Tonight, it seems we have come full circle and back to the essentials.

As tonight's paper illustrates, Dr. Frank has been single-mindedly developing what we might call an anthropological model for psychotherapy. I call it anthropological because it does involve trying to map the premises, assumptions, beliefs, values and rules people base their individual and social behavior on. As a good anthropologist, he has concerned himself not only with the conscious model of what a therapist thinks he is doing or how he explains his behavior, but also the unconscious model, not in the Freudian sense of the unconscious, but the underlying rules and relations that define the parameters of relationships as well as the possibilities of behavioral change. To paraphrase Martin Orne, the paradox of the therapist is that unless you have some belief in a specific factor, your nonspecific factors don't work. Therefore, the good therapist must split two roles in himself, the therapist-believer following his conscious model, and the researcher-critic seeing how this process relates to underlying structure.

I was pleased to hear Dr. Frank come down solidly on the side of training as being of use in spite of lingering on the side of relationship per se opposed to technique, because emotional arousal — surrounding unrealistic hopes coupled with a fraudulent sense of mastery — can only lead to a crash and increased demoralization. I would go one step further than he has, and say that not only is some program better than none, but some programs are better than others. The identification of specific behavioral deficits with specific competences to be developed can break down the category of mastery into subheadings. We find that hysterics who improve in treatment have, in fact, received what they need. That is, discrimination training. They simply start with too few conceptual categories for affect and experience in order to modulate their responses. Obsessionals, on the other hand, need to be catapulted into action. Schizophrenics who respond well have received unambiguous cueing that permits them to track better. Ambiguous cueing has been clearly demonstrated to increase schizophrenic confusion.

The reason I stress program is that I have some quarrel with the existential therapists, with their emphasis on the crux of therapy being a dissolution of boundaries between therapist and patient because they often seem to have no vehicle by which to reach that point. Michael Balint in his essay on new beginnings, *Primary Love and Psychoanalytic Technique,* spells out some of the many steps on the road to this sort of indwelling experience that can, in fact, be crucial to the resolution of the patient's deeply held distrust. For all these reasons I would be more inclined to stress the importance of a conscious technical model of therapy that takes into account the underlying real and possible changes in the patient's life. To this might be added at the end, the paranormal phenomena which like grace may come as an additional blessing after having done a good job rather than something ardently sought after from the beginning of a relationship.

II. Discussion of Dr. Frank's Paper

George Saslow, PhD, MD*

I WILL comment on a number of points in Doctor Frank's presentation but not all of them.

With regard to the paranormal phenomena which he draws to our attention, I can only remind us that self-deception, suspected and even publicly admitted fraud on the part of the persons who have produced or borne witness to such phenomena have been documented in many publications. Yet so strong is the human search for comfort and relief from distress that beliefs have persisted in the paranormal phenomena described by persons who have made public their deliberate deceptions to produce such states of belief. One must therefore continue seeking evidence of a kind which is both comprehensible and persistent over a time before one knows what to make of the kind of phenomena he mentioned.

Nevertheless, the extraordinary power of a person's own expectations to influence bodily function must not be forgotten. In the first edition of his book, *Persuasion and Healing,* Doctor Frank gives reference to a publication in a German medical weekly by Rehder which describes faith healing at a distance. The faith healing involved three severely disabled adult patients, all of whom had failed to obtain relief by conventional medical and pharmacologic methods, but did obtain marked relief when faith healing at a distance was carried out by a healer 500 miles away from them in another part of West Germany. The remarkable thing about the extraordinary improvement each of the patients showed was that the particular times when they were told to expect that the healing at a distance would occur was carefully arranged by the responsible physician to be times when the faith healer was definitely not "broadcasting" his faith healing messages. In these instances the faith healer was in no way visible or audible to the subjects, and was not even actively "healing at a distance", so their improvement can be ascribed only to their own hopes and expectations.

Let me turn now to the main subject of Doctor Frank's address, namely, what seems to him to be common to psychotherapy that is apparently practiced in very different ways according to quite different conceptual schemes. In 1949, a social worker and I published a paper called *Flexible Psychotherapy in Psychosomatic Disorders* in which we pointed out that a great many of the factors then thought to be pertinent to the improvement of patients with psychosomatic disorders (and in our view with any other kind of psychiatric disorder) who were treated by psychotherapy often did not occur in our work with patients who nevertheless did improve. At that time, I became convinced that what was common to

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psychotherapies was perhaps more important than what differentiated them. It was Doctor Frank who then turned his attention to investigating the dimensions of what was common to various psychotherapies, conducting the ingenious investigations which he has summed up tonight. My own interests turned elsewhere to a study of a basic tool in psychiatry, the two-person interview. But, in my practice of psychotherapy with patients, I thought then that my own observations and the published observations of others warranted my proceeding somewhat as follows. I schooled myself deliberately to reduce the use of jargon belonging to any one specific psychotherapeutic approach to as close to zero as possible. I elicited simple descriptions of behavior, preferably descriptions which could be easily comprehensible or could lead to observations made by other people who were either like the subject or asked to help the subject professionally. When possible to obtain two or three careful descriptions of events which involved the subject experiencing his characteristics symptoms, I attempted to draw inferences from these descriptions at a level of abstraction not very far above the original observations or descriptions in such a way as to formulate a relatively simple and plausible hypothesis which related antecedent and accompanying circumstances to the patient's symptoms and their consequences. Patients only in rare instances seemed to find it necessary to have more complex working hypotheses for them to get to work on their current problematic behaviors and symptoms. I made it a point to find out when the subject had been able to deal more successfully with the kinds of circumstances which at present generated symptoms and insisted that the person's capabilities, his assets, be identified and utilized in the therapeutic process. In this way as I see it now, taking into account Doctor Frank's work, I was encouraging hope in the patients. By generating simple working hypotheses closely related to the patient's experiences, I was strengthening the patient's view of himself or herself as a unique person with a right to be whatever that person was, in this way strengthening autonomy and initiative. By encouraging further detail of symptomatic experiences, I was, in Doctor Frank's language, encouraging experiences of emotional arousal which were also important in what then happened in psychotherapy. I planned agreed-upon monitoring sessions with the patient, at which we reviewed the patient's progress and I strongly supported the patient's attempts to move in the directions desired, needed and agreed upon by both of us. In this way, in Doctor Frank's language, I was encouraging the patient to increase his mastery of himself and to recognize the part he himself played in bringing about his own improvement. I came to use more and more a way of interacting with the patient which only recently I found well summed up in two words. These are words used by the Professor of Philosophy at Harvard in the last century, Charles Pierce, the founder of pragmatism as a philosophy, "contrite fallibility." I used the fallibility part of this expression to help the person become more accepting of his or her own imperfections. Being fallible meant that one would make mistakes. If one simply shrugged off the mistakes one would then be playing what, long after Pierce's time, came to be called by Eric Berne the game of "What can you expect from a person with a wooden leg?" Hence it was necessary to add to the concept of fallibility the notion that one can be contrite about having behaved imperfectly often to one's own or to someone else's detriment, and one could indicate that one was ready to try to do better. Much of my behavior had to do with helping a patient accept both components of Pierce's way of looking at human beings.

So far, the procedure I decided upon in 1949 seems to be one in which I was living out what you heard Doctor Frank describing tonight as a result of his systematic studies. There were two ways in which things have seemed different to me from what he has described tonight. Unlike those proponents of specific therapeutic orientations who stated at the symposium that he referred to that their particular conceptual approach and method could be applied with any patient, I have observed in specific persons that no matter what I did with them there were limits to my success in solving problems which I thought the proponents of some specific procedures and ideas could get beyond. Hence I have had no hesitation in referring a patient at a particular point in my work with him or her to a knowledgeable psychopharmacologist, a skill hypnotherapist, or an experienced Gestalt therapist; often with excellent results, and a subsequent resumption of therapy with me. In addition, I found also that no matter how a patient and I worked together and symptoms became less frequent, less severe, even to the point of disappearance, such changes during psychotherapeutic work might have very little to do with the patient's mastering needed skills in interpersonal relations and in devising and using prostheses of an environmental kind to deal with temporary difficulties. Specific suggestions which came from observations on patients with similar problems, or from experiences in the published literature, were necessary for the patient to practice to the point of desired mastery. It is here that I have found recently developed behavioral approaches extremely useful in solving problems, learning new behavior, and developing interpersonal competence, that previously I could not help patients solve by the methods earlier known to me.

Doctor Frank would look upon my referring a patient to another therapist for a specific conceptual and procedural approach as belonging to his notion that novelty in therapy can itself facilitate improvement. While I agree with him that novelty is important in any educational procedure including psychotherapy, I have (in my view) by no means been successful just because I introduced novelty in the person of another therapist who had a particular therapeutic orientation and approach; I have sometimes had to use a second such referral for a given patient, after a first failed. One can perhaps explain this in terms of the special characteristics of a particular therapist to whom I referred a patient not being sufficiently congruent with the expectations of the patient, with my procedures, and with the patient as a person; but I am not sure that these differences can be explained so easily.

In conclusion then, except for these differences between the kinds of procedure I decided upon in 1949 and what would seem to follow from Doctor Frank's subsequent careful studies of the elements common to psychotherapy, we seem to have been behaving with patients in very similar ways. What name to give such a psychotherapeutic approach no one appears to have solved to the satisfaction of anyone else, for the term *eclectic* does not seem quite to cover all the issues.